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Help-Seeking Attitudes among Clinicians in Training: The Influence of Psychological Defensiveness

Alexander Daniel Palmer

HELP-SEEKING ATTITUDES AMONG CLINICIANS IN TRAINING: THE INFLUENCE OF PSYCHOLOGICAL DEFENSIVENESS

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Alexander Palmer, M.S.

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This Dissertation was submitted by **Alex Palmer** under the direction of the Chairperson of the Dissertation committed listed below. It was submitted to the College of Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology at Nova Southeastern University.

Approved:

9/20/2021
Date of Defense

Alex Cuc, PhD
Chairperson Name & Title, Chairperson

Jen Davidtz, PhD
Committee Member Name & Title

Barry Schneider, PhD
Committee Member Name & Title

4/15/2022
Date of Final Approval

Alex Cuc, PhD
Chairperson Name & Title, Chairperson

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Abstract

The current study investigated whether psychologically-defensive clinicians-in-training were more resistant to engaging in personal therapy while pursuing a graduate degree in a mental health discipline. Participants were selected from graduate level mental health counseling and clinical psychology programs. Three groups were of interest: 'manifestly distressed' (MD), who report high levels of subjective distress; 'illusory mental health' (IMH), defined as individuals who report low levels of subjective distress but are identified by the Early Memories Test (EMT) as defensive; and 'genuine mental health' (GMH) individuals, rated as non-defensive on the EMT while reporting low subjective distress levels. The following measures were used to assess for the variables of interest: the Early Memory Index, the Trainees' Attitudes Toward Seeking Psychotherapy Scale, and the Subjective Distress Scale. Findings included equally high ratings on the TATSPS among each of the three mental health groups and a substantial number of treatment hours reported by each of the three groups. Compared to GMH participants, IMH and MD participants attended significantly more hours of personal therapy, and mental health grouping influenced treatment seeking over and above the influence of attitudes measured with the TATSPS.

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CHAPTER I

Review of the Literature

Personal psychotherapy has a time-honored place in the education of psychotherapists but is no longer an educational requirement for most. This study examines the attitudes of clinicians-in-training toward seeking personal therapy while in a clinical psychology graduate program. Previous research on this topic indicates that mental health professionals regularly fail to seek treatment when appropriate (Bearse et al., 2013). However, a relatively high number of psychologists seek therapy compared to members of the general population, and research depicts psychologists' explicit attitudes towards mental illness and therapy seeking as more favorable than those of the lay public (Digiuni, et al., 2013).

Since most American psychologists eventually do seek their own therapy (Norcross & Connor, 2005), it seems that psychotherapists do internalize a more accepting, personally relevant, and actionable attitude towards personal psychotherapy eventually. At the beginning of training these processes may still be incomplete. As statistics on psychopathology in psychotherapists attest (Bearse et. al., 2013), being a member of the mental health profession does not make one exempt from emotional and psychological difficulties. While limited research exists on the more specific topic of defense mechanisms in clinicians (a rare exception found in Bernard et al., 2012), therapists are only human and are therefore vulnerable to both frank psychopathology and more subtle emotional disturbances. Our understanding of the factors that influence clinicians' own help seeking behavior is certainly far from exhaustive and more research is needed in this area to identify barriers operating to prevent this important facet of self-

care. Existing literature has produced measures specifically geared towards assessing the attitudes which differentiate between student clinicians who have and have not attended therapy themselves (Farber, 2000). However, the question of whether certain defense mechanisms could influence the decision of therapists-in-training about whether to seek treatment has not been explored. Observing psychologists while they are still in training may enable an examination of more individuals who have not yet been in personal therapy. The proposed study endeavors to identify connections between psychological defensiveness, explicit attitudes toward personal therapy, and therapy-seeking behavior.

The current study focuses on three empirical questions. First, do trainees with underlying emotional difficulties have less positive views toward seeking treatment than those who are consciously distressed or healthy? Given that clinical psychology graduate students are in the process of transitioning from members of the "general population" to the role of a practitioner, it also makes sense to ask whether emotional defenses may slow the process of internalizing less-stigmatizing attitudes towards personal therapy that are held by more established professionals. Secondly, do individuals with defenses that prevent them from being aware of their own emotional difficulties utilize therapy at lower rates than individuals without distressing symptoms or those that are subjectively aware of troubling symptoms? Thirdly, does examining defensiveness improve our ability to predict therapy utilization more accurately than looking at attitudes alone?

Arguments for clinicians' own psychotherapy

Personal psychotherapy (PP) is highly-valued as a way to prepare future mental health professionals, but has not been an educational requirement in the training of psychologists since the 1949 Boulder Conference established the scientist-practitioner

model; the result of that conference was to prioritize training in being a scientist, and created different requirements than those established for psychoanalysts, such as a training analysis (Wampler & Strupp, 1976). Authorities in the field have previously made strong statements to the effect that it is essential for student therapists to undergo their own personal therapies since the beginning of the field of talk therapy. Sigmund Freud stated, "But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is in an analysis of himself" (Freud, 1964, p. 246). Similarly, in 1950, Frieda Fromm-Reichmann warned, "…because of the interpersonal character of the psychotherapeutic process itself, any attempt at intensive psychotherapy is fraught with danger, hence unacceptable, where not preceded by the future psychiatrist's personal analysis" (p. 42).

Literature on PP suggests that it is an important method for achieving self-understanding that helps therapists better relate to patients by becoming aware of blind spots that can hinder abilities to work in an unbiased manner with certain individuals (Nierenberg, 1972). Furthermore, PP is thought to help student clinicians develop a sense of conviction in the effectiveness of therapeutic work through experiencing positive effects for themselves, assist in developing mastery of techniques through observing a more experienced therapist as a role model, improves trainees' mental health and neurotic issues, and provide support so the stress of clinical work may be repaired or mitigated.

An international study surveying 3,629 psychotherapists from 13 countries found that 88% reported positive outcomes from their PP, with some variation in the percentage from each country (Orlinsky et al., 2001). Students and established therapists noticed benefits to their clinical work, and students especially valued learning from the therapist

as a role model, experiencing the client role, and increasing their sense of competence in the role of the therapist (Bellows, 2007; Daw & Joseph, 2007; Holzman et al., 1996; Macaskill & Macaskill, 1992; Moller et al., 2009). Additionally, personal therapy was deemed important in the development of a sense of professional identity (Murphy, 2005) and addressed personal issues such as depression and relationship problems (Norcross & Connor, 2005). Studies have identified several common reasons clinicians seek PP: depression, anxiety, general unhappiness, marital problems, other relationship problems, low self-esteem, lack of self-confidence, desire for self-understanding, and adjustment problems (Pope & Tabachnick, 1994; Bike et al., 2009).

Prevalence

Psychotherapists in the United States are about three times as likely to seek personal therapy as adults from the general population (75% vs. 25%, Norcross & Guy 2005) with variations seen according to theoretical orientation and professional activities. Professionals in non-treatment roles were less likely to attend therapy than those providing psychotherapy, and those practicing within a cognitive-behavioral orientation (44-66%) were less likely to have sought treatment than those practicing in a psychodynamic or psychoanalytic framework (82%–97%). Among American doctoral level psychotherapists, the number is even higher than the population of psychotherapists without a doctoral degree, with only 9% reporting never attending personal therapy (Orlinsky et al., 2011). The same study reported that 87% of psychotherapists across 6 English-speaking countries had been in therapy at least once, with some variation by country. In comparison, only 65% of British psychologists had done so. Surveys on help-seeking in graduate student populations found that seventy percent (70.2%) had been in

therapy during or prior to entering graduate school, with 54.3% beginning a new episode of treatment during school (Dearing et al., 2005).

Predictors of Help Seeking in Professionals and Students

Clinical research to date has further studied predictors of therapy-seeking in the general public. As a result, we may extrapolate some of the data from those findings in order to supplement the smaller base of literature specifically looking at the behavior of therapists. Stefle and Prosperi (1985) identified the four most prevalent barriers to help-seeking in the general population as 1) affordability, 2) availability (awareness of the services), 3) accessibility (transportation concerns), and 4) acceptability (stigma). Other factors associated with reluctance to seek psychological services include low interpersonal dependency (Bornstein et al., 1993), tendency to conceal negative and distressing information about the self (Kelly & Achter, 1995), and stronger male gender role endorsement and male gender role conflict (Good & Wood, 1995).

Examining the relationship between level of psychological distress, treatment avoidance, and treatment-seeking history, Kushner and Sher (1989) found that increased distress was positively correlated with both fears of treatment (avoidance motivation) and probability of seeking services (approach motivation). An interaction effect was observed between gender and fears of treatment, showing women have more fears of psychological treatment but are also more likely to attend than males. The authors explained that latent fears about aspects of the clinical situation are activated as it becomes more likely that the patient will actually encounter them and proposed that high levels of fear may persist during treatment. Additionally, they questioned whether such fearfulness might be one of the reasons for the high rate of dropouts early in treatment. Regarding the individuals

who were not currently seeking therapy, the highest level of fear was seen in those who had felt a need for therapy but never sought it ("avoiders"), followed by those who never felt they needed treatment. Those who previously sought treatment showed the lowest level of fears about treatment of all the groups.

Therapists differ from the lay public in that they have generally more knowledge of available resources and how to access them, insight into the process itself, less internalized stigma for help-seeking, and more positive attitudes towards psychotherapy (Digiuni, et al., 2013). In common with laypeople, therapists cite concerns about confidentiality, exposure fears, and difficulty finding a suitable therapist (Norcross & Connor, 2005). Mahoney (1997) reported that 41.3% of psychologists reported concerns about the financial burden of treatment.

In a recent survey of 260 professional psychologists, personal stigma and threats to one's professional reputation through stigma were not considered influential to the decision not to seek therapy (Bearse, et al., 2013). Therapists in that sample cited time constraints and difficulty finding a therapist as the most pressing barriers to seeking treatment, which is notable considering that 59% of the sample thought there was a time they would have benefited from treatment but did not seek it. However, the study did not query reasons for failing to seek therapy at those times, and the authors expressed an interest in future research which would identify connections between higher symptomatology and perceived obstacles to seeking therapy.

Although most studies have been completed with licensed psychologists, there is also a smaller pool of research focusing specifically on mental health trainees. In particular, research has found that student therapists may be more likely to seek treatment

than other university students due to more favorable attitudes toward therapy and mental illness and the ability to view it as a means of professional development rather than for mental illness (Moller et al. 2009). Moller's qualitative study identified a few unique barriers for clinical psychology students as well, such as concerns that they will be labeled a fraud or "too ill to conduct therapy," feeling that they are being coerced into treatment by their institution, and fear that opening up in therapy will render them emotionally raw and unable to complete their studies.

Digiuni and colleagues (2013) surveyed 555 clinical psychology students looking at the connection between perceived social stigma and attitudes towards seeking treatment in the United States, Argentina, and Great Britain. These three countries were selected since the British are reportedly reluctant to seek help unless in grave difficulty; Argentina has possibly the most positive attitudes toward therapy of anywhere in the world (Ibid), and the culture of the United States was thought to fall somewhere in between. American students were found to perceive the highest level of social stigma against therapy while also having highly positive attitudes toward therapy seeking. Both Argentinian and American students had significantly more positive attitudes than the English, but American students were unique in that their views toward seeking therapy differed markedly from those of the surrounding population's (negative) views. In Argentina, students' attitudes toward seeking treatment were predicted by their perception of faculty's views on therapy for therapists and experiences in prior therapy. English students' attitudes were not influenced by previous therapy experience, only faculty's views and their perception of social stigma against it. American students had the

highest perceived levels of stigma but still held positive attitudes themselves and they were not influenced by their faculty's attitudes.

Dearing and colleagues also examined factors that predict personal therapy seeking in clinical and counseling psychology students during training (Dearing et al., 2005). They asked participants to complete a questionnaire on attitudes toward seeking personal therapy, demographic information, personal experiences in therapy, perceived obstacles, and perceived faculty attitudes about students in therapy. Participants rated 11 potential concerns in terms of their importance in the decision about whether or not to enter therapy: availability, accessibility, acceptability, affordability, confidentiality, dual relationship concerns, and concerns about faculty reactions or therapy interfering with school obligations. Those who scored highest on confidentiality concerns also valued therapy as professional development the most and held more positive attitudes toward therapy seeking were more likely to have received therapy while in school. Perceived faculty attitudes and cost concerns were not found to predict help seeking in this sample either. Confidentiality concerns, attitudes toward therapy, and students' views of personal therapy as a means toward professional development were found to predict therapy use in this retrospective design.

Lastly, Farber (2000) developed an instrument that was able to differentiate between individuals who had engaged in PP from those that had not in a sample of 275 master's and doctoral level student trainees. The initial item pool was developed by asking students in a pre-practicum class to report reasons "why they would or would not seek psychotherapy for themselves" (p.344). Factor analysis revealed four factors, and the subscales were (1) Important for professional growth; (2) Concern with professional

credibility, reflecting concern that one will be viewed as incompetent for attending PP; (3) Concerns about confidentiality, revealing reluctance that one will be "found out" as attending PP; and (4) Need for self-sufficiency, which identifies whether one believes psychologists should be able to solve their own problems.

Effects of Personal Psychotherapy on Therapeutic Skill

Attempts to demonstrate that personal therapy impacts client outcomes have found mixed results, typically ranging from identifying positive effects or no effect, and very rarely studies have shown negative effects. Polling clinicians yields almost universally positive sentiments attesting to the benefits reaped in the service of their personal growth, professional growth, and development of one's identity as a helping professional (Bellows, 2007; Daw & Joseph, 2007; Holzman et al., 1996; Macaskill & Macaskill, 1992; Moller, et all., 2009). Given the large amount of literature bearing on this problem, I will cover just a subset of the studies that bear most directly on the research questions posed here.

Positive Effects

Therapists who have experienced PP have reported that they learned how to cope better with patients who had boundary issues, expressed feelings for the therapist, and were better able to see the impact of nonverbal communication (Grimmer & Tribe, 2001). Therapists also found they were better able to differentiate between their wishes and those of the client, were less likely to project their wishes onto clients, and were less likely to interrupt the client's own process (Hamilton & Kivilighan, 2009). Similarly, they noted that they understood the impact of their unresolved personal issues that emerged during training (Murphy, 2005) and found it helped them to admit their own

human frailness and better respect the individual rhythms of their patients (Otieza, 2010). Additionally, PP-experienced therapists have been rated by observers as demonstrating increased empathy and genuineness as number of hours in PP increase but no more warmth than those who did not attend therapy (Peebles, 1980). PP is believed to help clinicians in training learn about the strong emotional reactions that occur for their patients in therapy from direct experience, which helped them better tolerate their own emotions (Rake & Paley, 2009); increased their feelings of safety, confidence, and personal cohesion during work with patients (Rizq & Target, 2008); and reported less burnout (Wiseman & Egozi, 2006).

It is important to note that most of the studies reviewed above utilized clinicians' perceptions of what they had learned through their therapy, how it impacted their therapy practice, and their own ratings of their performance. The studies by Peebles (1980) and Hamilton and Kivlighan (2009) were exceptions that incorporated measures that did not rely on self-report. In those investigations the researchers observed their formulation skills or treatment technique. Peebles' (1980) study allowed this by asking clinicians to submit sample tapes of their work to judges to rate the sessions on empathy, genuineness, and warmth. Hamilton and Kivlighan (2009) utilized an analogue study by asking clinicians to read clinical vignettes and identify the patient's core relational theme, then compared those to the relational themes of the therapists themselves. The judges identified instances when they confused their own dynamics with those of the patients as projection and noted that it was less common in therapists with more PP experience.

Gold and Hilsenroth (2009) collected ratings of symptom severity and therapeutic alliance from both graduate therapists and their patients. Results indicated that patients

of graduate student therapists who had engaged in PP did not rate the therapeutic alliance differently than those working with clinicians who had no personal therapy experience. However, therapists with PP felt there was less disagreement on the goals and tasks of therapy, were more confident in their professional abilities, saw their patients as more committed and confident in therapy, and kept their patients in therapy for twice as many sessions. In a later study, also with clinicians in training, clinician's personal therapy alliance was positively related to their patients' ratings of their own improvement in symptoms and overall functioning (Gold et al., 2015).

Negative Effects

Negative effects of PP on the clinician or failure to demonstrate improved clinical outcomes for patients have been documented as well. McEwand & Duncan (1991) surveyed 400 therapists from British Colombia, and 44% felt they had a poor clinician, which resulted in less subjective benefit from treatment. Other risks identified in that sample included dropping out of school due to increased stress from PP or adopting stylistic elements of the techniques used by an unskilled therapist. Additionally, 49% reported some sort of problematic dual relationship, 33% felt unsafe due to fears about whether information from their treatment could be used against them at school, 23% were concerned about the impact of mandated therapy, and 22% reported feeling that unnecessary therapy is not a wise decision.

Moller, Timms, & Alilovich's (2009) qualitative study of clinical and counseling students did not find evidence for a clinically significant relationship between PP and client outcome. This was attributed to therapists' fears of observation and the possibility that their client outcomes would be seen as representative of their own functioning, the

large number of contributing variables on outcome (e.g. competency, training, skill at building the alliance, years of practice), and the difficulty of treating PP as a singular variable. Interpretive phenomenological analysis studies with established therapists have reported that PP can induce a sense of destabilization resulting from the change processes occurring in their own treatment (Rake & Paley, 2009). Other studies found that the theme shared by all participants, including individuals with both insecure and secure attachment styles, was a felt loss of agency during their own treatment (Rizq & Target, 2010). Individuals with insecure attachment styles in PP that was part of an educational requirement were particularly sensitive to the power differential that existed in mandatory therapies. For instance, they felt they could not disagree with their therapist, felt dominated and coerced, and were too afraid to voice their concerns or leave a poorly matched therapist for a better one (Rizq, 2011). While all participants in the study were aware of the inequality of power in the therapeutic relationship, insecurely-attached therapists "described a feeling of inequality as most preoccupying, problematic, and significant" (p.179). Unable to voice feelings of anger and frustration, they adopted strategies to counterbalance the perceived power dynamics in the relationship such as keeping disappointment to themselves to assuage fears of making the therapist angry or found a sense of triumph from keeping significant emotional material hidden from the therapist (Rizq, 2011).

An examination of the relationship between PP and client outcomes in a study with 756 Swedish patients found very little relationship between the therapists' PP and patients' ratings of satisfaction and improvement, although a weak curvilinear finding did emerge (Sandell et al., 2006). Those with seven to eight years of personal therapy had the

best outcomes, while those with over 13 or less than five showed worse patient outcomes. The authors noted that it was not possible to equate the groups on patient severity, introducing an important caveat to consider when interpreting finding that the most experienced therapists had worse outcomes. By accepting patient referrals with particularly severe pathology, the treatment outcomes of the most experienced therapists may have been constrained as severely ill patients were more likely to fail to benefit from treatment.

Implicit Measures Compliment Self-Report Data

As observed in the studies reviewed above, self-report is the most common method for measuring patient and therapist variables such as outcome of therapy, psychopathology, and psychological distress. This applies to reports on therapists' perceived benefits of PP, patients' changes in their psychotherapy, and attempts to identify predictors and barriers to help seeking for clinicians and patients. Referring to the limitations of their own study almost 20 years ago, Komiya and colleagues (2000) succinctly stated a criticism that still applies to the majority of the literature today, "the study relied on self-report measures; such measures may fail to adequately distinguish between genuinely high psychological functioning and the illusion of high functioning that results from denial or other psychological defenses" (p. 142). At this point it is necessary to discuss the limitations introduced when much of the literature relies exclusively on self-report measures of distress and how researchers have attempted to improve on these limitations by introducing other means of evaluation.

When investigating mental health or psychopathology, there are two broad categories of barriers to obtaining accurate self-report information: (a) the limits of

introspection which vary according to individual differences in self-awareness and (b) response factors that lead people to conceal or misrepresent their difficulties due to self-presentation concerns, for example demand characteristics (Orne, 1962), social desirability (Edwards, 1957), faking (Cronbach, 1990), or impression management (Tedeschi et al., 1971). Some authors have suggested there is only one true set of beliefs or traits to be measured, so variation between explicit and implicit measures represents error variance. Others have theorized that implicit and explicit measures reflect different mental representations. In this view, implicit measures access cognitive domains that are not assessed by self-report measures and as a result, implicit measures enable us to predict different behaviors than do explicit measures (Asendorpf et al., 2002).

Investigations into the connection between self-report and implicit measures of the same construct have often found only a small to moderate correlation between the two modalities, even when the implicit measure has been deemed psychometrically sound. In a study of shyness (Asendorpf et al., 2002), 139 young heterosexual adults were asked to complete a measure asking them to rate their personality in terms of shyness (the explicit measure), a shyness Implicit Attitudes Test (IAT), and engage in a short video-taped interview with another participant in order to get to know them and later rate one another's personality. The situation was designed to induce shy behavior through the evaluative context and use of an unfamiliar, above-average physically attractive, opposite sex peer (the research confederate) as a conversational partner. The explicit measures of shy self-concept predicted shy behavior that was under conscious control (amount of speech and movements illustrating speech) while the IAT of shyness uniquely predicted

spontaneous behavioral manifestations of shyness (self-stimulation, fidgeting and body tension).

In order to test the validity of the distinction between spontaneous and consciously controlled behaviors, a second study asked half of the participants to behave in such a way as to present themselves as outgoing and not shy in order to make a good impression on a new boss (Asendorpf et al., 2002). The other half of the participants were told they would rate the personality of their conversational partner, identical to the first study. With instructions to "act confident for a job interview", participants talked more and illustrated their speech with more gestures but failed to suppress spontaneous shy behaviors of self-stimulation and body tension. The researchers noted that participants' nervous movements tended to counteract their attempt to appear non-shy. As a result, observers rated the participants as only marginally less shy than when they were interacting naturally with the confederate. The researchers concluded that the participants' failure to control the behaviors labeled "spontaneous" when instructed to appear outgoing and confident (indeed, they displayed even higher rates of spontaneous shy behavior) meant that they were correctly labeled as being outside the influence of conscious attempts to act in a more socially desirable manner. In other words, they were not able to fake the results. The findings of this study demonstrate that implicit measures of personality can be used to predict behaviors which are only weakly connected to individuals' own judgments about their own personality. These behaviors are outside of conscious control and hypothesized to be mostly beyond the limits of introspection. Below I will review studies that apply this kind of reasoning to the investigation of psychological defenses and mental health.

Empirical and Theoretical Perspectives on Defense

The concept of psychological defenses began with Freud's observation that the emotionally damaged people he was seeing were trying to avoid re-experiencing what they thought would be unbearable pain, and in so doing, paid a heavy toll on their overall functioning (McWilliams, 2011). He came to believe they would need to feel the seemingly overwhelming emotions so they could free up the energy they were perpetually investing in preventing those from coming to the surface. Although psychological defenses are often seen as negative, when a variety of them are used flexibly they can be adaptive.

In a review of empirical findings that have supported psychoanalytic concepts of defense, Phoebe Cramer (as cited in McWilliams, 2011, p.102) showed that psychological defenses "(1) function outside of awareness; (2) develop in predictable order as children mature; (3) are present in normal personality; (4) become increasingly used in times of stress; 5) reduce the conscious experience of negative emotions; (6) operate via the autonomic nervous system; and (7) when used excessively, are associated with psychopathology.

A healthy person is not one without defenses, but one who relies predominantly on mature defenses such as humor, sublimation, isolation of affect, or intellectualization (McWilliams, 2011). Mature defenses are considered more adaptive because they are more discriminating compared to primitive defensive processes. Primitive defenses such as dissociation, denial, projection, and splitting "operate in a global, undifferentiated way in a person's total sensorium, fusing cognitive, affective, and behavioral dimensions" while those that are more mature "make specific transformations of thought, feeling,

sensation, or behavior, or some combination of these" (p.102). Primitive defenses can be traced to the pre-verbal period with two characteristics, loss of the reality principle and inability to perceive boundaries and constancy of the self and others.

Since psychological defenses function outside of awareness, clinicians may be just as poorly equipped as members of the general public to report on their own defensive mental operations. Because of the unconscious nature of defense mechanisms, it is one topic where self-report is particularly poorly equipped to identify the phenomena in question. Countertransference refers to the psychotherapist's emotional reactions to patients, and unchecked they may interfere with the clinician's ability to differentiate between their own feelings and issues and those of their patients (Hamilton & Kivlighan, 2009). But one's emotional reactions to patients can go beyond being sources of possible distraction. Skillfully handled, they may allow one's understanding to go beyond the surface level or manifest content of the session in order to infer information about the work of unconscious processes in treatment and in the maintenance of psychopathology (Betan et al., 2005).

The concept of countertransference encompasses both awareness of one's blind spots on the one hand, and the deeper understanding of the patient on the other (McWilliams, 2011). The use of PP to better understand one's countertransference can help the clinician learn to distinguish between their feelings towards the patient in two broad categories, 1) those that are informative about their own functioning (idiosyncratic reactions to the patient based on the therapist's own history represent the "classic" or "narrow" definition of countertransference) and 2) those that help them to better understand the patient's experience or characteristic way of engaging important people in

their life which lead to misunderstandings and interpersonal problems (Betan, et al., 2005). Once a clinician has identified they are reacting strongly to a patient because they are reminded of an important person from their own past or a pressing need of their own, the countertransference falls into the first category. At that point one is enabled to choose a different course of action than acting out their feelings, for example, "I am reminded of a childhood friend that I often fought with and am noticing myself wanting to convince the patient of xyz. I need to remember that my role is to explore rather than debate the patients' values."

The second category of countertransference shares the common theme them that you learn something about the patient- "just as the patient's behaviors with the therapist could provide in vivo insight into his or her repetitive interpersonal patterns and associated thoughts, feelings, and motives, so too, could the clinician's responses to the patient provide insight into patterns the patient wittingly or unwittingly evokes from significant others" (Betan, et al., 2005, p. 890). It is for this reason that countertransference is meant to be understood rather than eliminated.

Limited empirical research exists on the impact of psychological defensiveness in clinicians on their clinical work, although warnings about the danger of an un-analyzed therapist abound in the professional literature (Freud, 1964; Fromm-Reichmann, 1960; Nierenberg, 1972). One unique study directly investigated the connection between the defensive operations of medical professionals and their ability to perform in their role. Bernard and colleagues (2012) measured the defensive operations of oncology clinicians (13 oncology physicians and 18 nurses) who were enrolled in a communication skills training (CST) course. CST training takes 2 days, followed by individual supervision and

a six month follow up meeting. Each clinician completed a videotaped interview with a mock cancer patient before CST and 6 months after the training finished. The researchers compared the sample interviews with a prototype of an "ideally conducted" interview which was designed by using the Psychotherapy Process Q-set based on the descriptions of nine CST experts. The Defense Mechanism Rating Scales for Clinicians (DMRS-C) was used to rate clinician defensiveness during their mock patient interviews. The DMRS-C identifies 30 individual defenses according to level of adaptation and assigns a number one through seven to denote level of adaptive functioning of the clinician's defenses. High adaptive defenses include sublimation, humor, or self-affirmation, and low adaptive defenses include acting out, denial, and projection.

The authors questioned whether "repeated use of less adaptive defenses, such as denial, may allow the clinician to avoid or reduce distress, but…also diminishes his ability to respond to the patient's emotions, to identify and to respond adequately to his needs, and to foster the therapeutic alliance" (Bernard, et. al., 2012, p. 400). They found that clinicians with higher level defensive functioning prior to the training improved their communication skills while those that relied on less adaptive defenses failed to benefit from the training. To conclude, they stated, "clinicians with less adaptive defenses, like projection or denial, may not adequately perceive the external reality (i.e., the subjective reality of the patient) favoring self-protecting strategies" (p. 401). The researchers suggested the use of supervision that confronts the defensive functioning as an effective way to find more satisfactory means of relating to patients during emotionally loaded discussions about diagnoses and treatment options. This points the way to another

possible solution for psychologically defensive doctors and therapists who struggle to connect with the affect in themselves and their patients.

Shedler, Mayman, and Manis (1993) utilized the Early Memories Test (EMT) alongside standard self-report measures of psychological distress in order to demonstrate that expert clinical judgment provides additional information about the subject that cannot be detected by self-report measures. They found that the EMT could distinguish between genuine mental health and the defensive façade characteristic of individuals managing their emotional turmoil with denial. This distinction is not visible with face-valid self-report scales typically used in research environments on psychopathology and psychotherapy. Individuals that "looked good" on self-report scales and were judged distressed by clinical experts were identified as demonstrating "illusory mental health." Participants demonstrating this incongruence had markedly more intense reactions to laboratory stress induction procedures than "healthy" or "manifestly distressed" individuals. Measures of heart rate and blood pressure were chosen to operationalize the cost of defensive activity, based on the relation of those measures to many medical illnesses. Subjects with "illusory mental health" had physiological reactivity that was about twice that of the "healthy or manifestly distressed" groups.

Chronic heightened coronary reactivity is a known risk factor for medical illness. This finding was further explored in a later study comparing the EMT with a range of commonly used self-report scales of mental health, perceived stress, stressful life events, and mood states in order to predict health outcomes (Cousineau & Shedler, 2006). The EMT demonstrated significant prospective correlations with verified physical illness and medical treatment utilization, while the self-report measures did not predict health events.

Subjects also completed a word association task where defensive activity was coded if subjects commented on the wording of a stimulus phrase to avoid the content, misinterpreted the phrase, could not think of a response, did not complete a thought after beginning to relate it, took longer than eight seconds to respond, or retracted a response (Shedler et al., 1993).

In this examination, the IMH subgroup demonstrated higher verbal defensiveness than the healthy or manifestly distressed groups. The authors concluded that face-valid measures of distress such as the Beck Depression Inventory, Rosenberg Self-Esteem Scale, and Spielberger State-Trait Anxiety Inventory are not invalid, but are skewed so that high levels of distress can be interpreted in a straightforward manner, but low levels of distress can reflect either health or denial. Individuals in denial "preserve a belief in their 'adjustment' by disavowing much of their emotional life, and so have little awareness of their needs, wishes, and feelings" (p. 1117). In a follow up study, the authors were able to produce a standardized rating system for scoring the EMT called the Early Memories Index (see appendix C) that codified the decisions made by the expert clinicians (Shedler et al., 2003). Graduate students were able to reproduce the judgments of the expert clinicians using it, demonstrating that the results were replicable rather than the result of idiosyncratic skill of the highly experienced clinical judges.

Repressive Coping

The repressive coping literature documents the connection between physical health outcomes and defensiveness in a closely related concept to IMH. Individuals who test high on traits of self-restraint and defensiveness while reporting low levels of psychological distress are described as having a "repressive coping style" (Weinberger,

1998). Shedler acknowledged the similarities between the concept of repressive coping style and IMH, but suggested that IMH represented an umbrella category. He believed that repressive coping style, while similar, represented a more specific subcategory describing one particular possible form of defensive denial (1993), although that is an empirical question which has yet to be investigated. Interestingly, estimates of the prevalence in non-clinical populations for these two conceptualizations of defensiveness are similar: repressive coping found in approximately 10-20% of the population (Myers & Reynolds, 2000), while the prevalence of IMH in non-clinical populations is approximately one third (Shedler et al., 1993; Shedler et al., 2003; Bram et al. 2018). The latter estimates must be viewed as tentative since large scale, representative sampling techniques have not yet been used to establish the level of IMH present in the population.

Individuals described as "repressors" characteristically demonstrate a contradiction between their conscious experience of anxiety and physiological arousal levels. While they report and seem aware of only low levels of distress, behavioral and physiological measures indicate high levels of arousal (Myers, 2000). The finding of disconnection between participants' lack of subjective awareness of distress and physiological measures of heightened arousal similar in "repressors" is highly reminiscent of observations in the original research on IMH (Shedler, et al., 1993).

Increased mortality after myocardial infarction and failure to benefit from, or even deterioration in response to, routine follow-up care has been observed in repressors as well (Frasure-Smith et al., 2002). Those authors suggested that giving information to repressive copers was interfering with their preferred mechanism of coping (ignoring the threatening information). Writing about predictors of adverse clinical events in coronary

disease patients, Denollet and colleagues (2006) pointed to the problems for clinical research posed by the ambiguous meaning of low self-reported distress due to defensive denial of distress: “These findings suggest that the adverse effect of stress and negative emotions may have been underestimated in previous research. Individuals reporting little distress typically have been assigned a low-risk status whereas, in fact, the low-risk reference group in these studies includes a subgroup of ‘false negative’ individuals who are characterized by repressive coping. The tendency of repressive patients to report low levels of distress may go some way toward explaining the lack of an association between self-reported distress and cardiac events” (Denollet et al., 2008, p. 306).

Therapist Variables Predicting Experience of Personal Psychotherapy

Orlinsky et al. (2001) found in a large international survey of psychotherapists, 88% found their personal therapy to be a highly positive experience. Although very high, this statistic reveals a small number of negative responses to personal therapy, and little is known about the characteristics of trainees that may predict a negative therapeutic reaction. Rizq’s (2011) qualitative study into the experiences of 10 therapists enrolled in graduate programs that mandated psychotherapy. She highlighted a lack of research attention into the personal characteristics of trainee-therapists that may influence how therapy is experienced during training. This investigation found important differences between therapists with secure and insecure attachment styles. Insecure therapists were more likely to view their therapy experience as coercive and uncomfortable, and seemed hyper attuned to the power imbalance in the relationship with their therapist. They tended to hide their discomfort and suffer through treatment reluctantly. In contrast, securely attached therapists were more likely to voice their displeasure and leave therapy

relationships they found inadequate if necessary. In this investigation, insecure therapists also reported being more likely to engage in only the bare minimum treatment duration while secure therapists tended to continue after the requirement had been satisfied.

Dismissively attached individuals are thought to demonstrate emotional regulation strategies biased toward emotional suppression, down-regulating negative emotions by attentional strategies that redirect away from danger cues, ultimately denying stress (Mikulincer & Shaver, 2007). Paralleling repressive coping literature (reviewed below), dismissive attachment style has sometimes been identified as a type of resilience due to lower reporting of distress and higher scores on measures of well-being. Given the similarity between descriptions of the coping strategies favored by IMH and dismissive-avoidant attachment, a qualitative investigation similar to Rizq's (2001) may provide a window into the similarities of these kinds of functioning in therapist populations and their experiences in psychotherapy.

For individuals who are generally at ease with themselves (GMH) or openly struggling, it may be easier to adopt a common frame of reference in treatment that allows them to perceive their therapist as an ally with whom they share a common goal. In contrast, it may be that individuals with IMH are more likely to feel they are at cross-purposes with the therapist, especially early on in treatment since they are theorized to view themselves as "normal" with no psychological issues (Shedler et al., 2003). Conflict could erupt when IMH trainees' therapists begin working to enable them to voice their pain and their difficulties, interfering with their perception of themselves as well adjusted. While IMH individuals often seem healthy to the lay person (successfully representing the façade of mental health), research in this area finds that therapists often

assign a higher rating to patient symptom severity than the patients themselves (Ziem & Hoyer, 2019).

Wahlstrom (2021) noted in his review of qualitative studies reporting on paradoxical outcome that some individuals seemed aware of a need for treatment but externalized their difficulties, resisting attempts to establish an internal locus of change (Teyber & Teyber, 2016). They blamed their discomfort on the behavior of friends and partners and when they acknowledged problems, preferred to deal with them by seeking to control others or denying their existence (Wahlstrom, 2021). These individuals expressed dissatisfaction with treatment and attributed any improvement in their mood and functioning to changes in life circumstances rather than to their work with the therapist, whom they viewed as having provided inadequate support in the form of advice and challenge. These observations suggest the possibility that IMH may be expected to be associated with increased experiences of unsatisfactory or conflictual psychotherapy relationships.

Summary and Hypotheses

The psychoanalytic tradition has placed the most emphasis on Socrates' imposition to "know thyself" (McWilliams, 2011), and this is reflected in their insistence on including personal psychotherapy (PP) as a compulsory component of training for psychotherapists. This is also reflected in the near universal rate of engagement in PP by therapists that identify as psychodynamic or psychoanalytic. In comparison, behavioral and cognitive schools of psychotherapy have put less emphasis on PP in the training of their therapists. One of the main goals of exposing therapists in training to PP is to improve their therapeutic effectiveness by reducing blind spots and increasing the ability

to empathize with patients. Though therapist defensiveness is suggested to impede one's effectiveness in clinical work, no studies to date have been conducted to explore whether the presence of psychological defensiveness may have an influence on the therapy seeking behavior of trainees. Research on illusory mental health suggests that some troubled individuals may appear healthy due to psychological defenses that cause them to present a facade of mental health. This concept is utilized in the present study to investigate defensiveness in a population of psychotherapists in training.

The first hypothesis predicted that psychotherapists in training who are identified as displaying IMH would seek fewer hours of psychotherapy than their peers. This hypothesis was based on theorizing that individuals with IMH would perceive themselves as subjectively untroubled by symptoms of psychopathology and therefore be unlikely to pursue psychotherapy.

The second hypothesis predicted that trainees displaying IMH would have less positive views towards psychotherapy for therapists. Due to the lack of theorizing about IMH and psychotherapists in particular, this hypothesis was largely exploratory in nature.

The third hypothesis was that mental health grouping would contribute to the prediction of therapy seeking behavior, over and above the influence of attitudes toward seeking psychotherapy. This was exploratory as well since defensiveness and conscious attitudes towards psychotherapy have not previously been studied empirically side by side.

CHAPTER II

Methods

All study materials and procedures were approved by the Institutional Review Boards at Nova Southeastern University and Adelphi University.

Recruitment

Participation was solicited by requesting that professors at various universities containing graduate level psychotherapy programs forward the participation request flyer to their students via email (see Appendix F). Additional participants were recruited through snowball sampling by asking students to forward the email to others who may be interested and eligible to participate. The flyer identified the study as an investigation into psychotherapy students' perceptions of personal psychotherapy and explained that they would be asked to recall memories from childhood and rate their current level of psychological distress. All volunteers were permitted to participate as long as they were enrolled in a graduate level psychotherapy program and able to read and respond to the study materials in English.

Participants

The demographic questionnaire included questions about the race, gender, year in graduate program, mental health treatment history, and theoretical orientation of trainees. Study participants (N = 53) were student therapists/trainees enrolled in graduate programs preparing them to enter the mental health field. The sample predominantly identified as women (88.7%; one participant did not share their gender identity), and Caucasian (69.8%, see Table 1). There were fewer Master's level trainees (32.1%) than Doctoral (67.9%) level trainees. Most participants were in their first (39.6%) or second (28.3%) year of graduate school, with the remainder in the third year or beyond (see Table 2). The most common theoretical orientation as reported by the participants was

"primarily psychodynamic or psychoanalytic" (32.1%), followed by "primarily cognitive, primarily behavioral, or cognitive behavioral" (22.6%). See Figure 1 for a depiction of the number hours of personal therapy reported by participants.

Table 1

Frequencies and Percentages: Participant Demographic Variables (N = 53)

Variables	Frequency	%
Gender		
Men	4	7.5
Women	47	88.7
Transgender	1	1.9
Ethnicity		
Asian	4	7.5
Black	4	7.5
Hispanic	7	13.2
Middle Eastern	1	1.9
White	37	69.8

Table 2

Frequencies and Percentages: Participant Demographic Variables (N = 53)

Variables	Frequency	%
Type of Degree		
Ph.D.	5	9.4
Psy.D.	31	58.5
Master's	17	32.1
Theoretical Orientation		
Psychodynamic/Analytic	17	32.1
Cognitive-Behavioral	12	22.6
Humanistic-Existential	9	17.0
I don't know	9	17.0
Other	6	11.3
Year in Program		
1st	21	39.6
2nd	15	28.3
3rd	4	7.5
4th	1	1.9
5th or more	12	22.6
Ever Received Therapy		
No	11	20.8
Yes	42	79.2

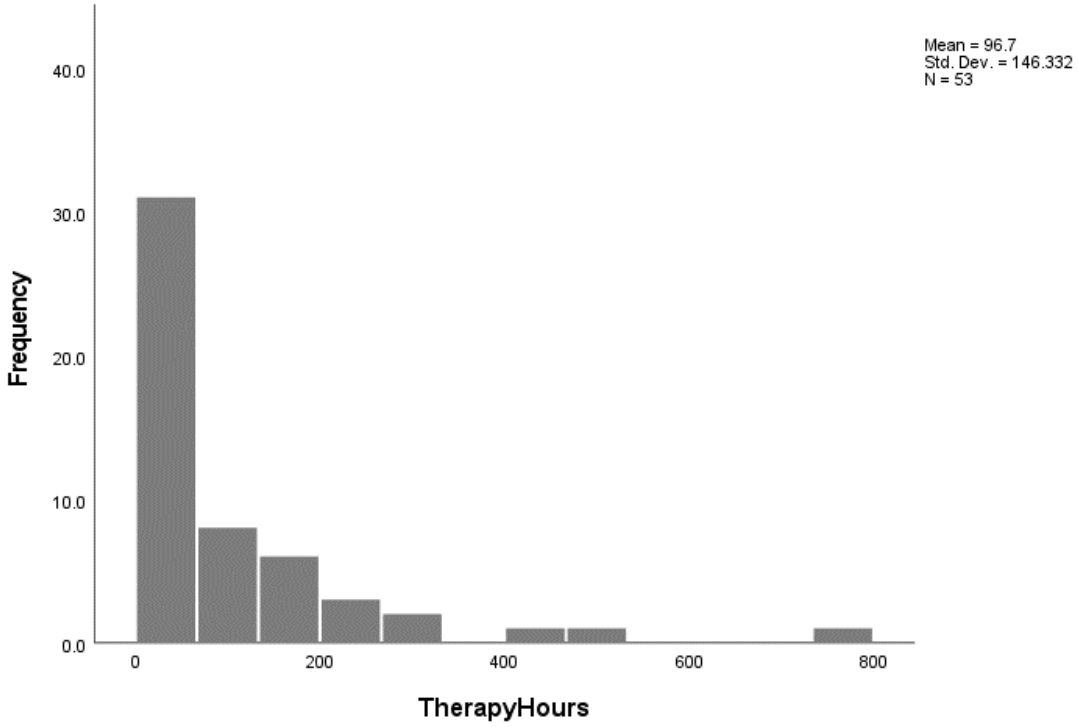

Figure 1. Frequency of personal psychotherapy hours reported.

Trainees in their first three years of graduate school (n = 40) reported attending fewer hours of PP (M = 82.5) than advanced trainees (n = 13) with four or more years of graduate training (M = 140.5), though the effect was not significant, $t(51) = 1.248$, $p > .05$. There was no significant effect of program type, $t(50) = .237$, $p > .05$, despite master's level trainees (n = 17) reporting slightly more hours of PP (M = 102.7) than doctoral level trainees (n = 35; M = 92.3).

Procedure

Participants followed a link from the participation request email to a Google Forms document that contained the study materials. They completed the demographic questionnaire (see Appendix E), the Subjective Distress Scale (SDS; Shedler, Karliner, & Katz, 2003; see Appendix A), a written version of the Early Memories Test (EMT;

Shedler, Karliner, & Katz, 2003; see Appendix B), and the Trainees' Attitudes Toward Seeking Psychotherapy Scale (TATSPS; Farber, 2000; see Appendix C). The Subjective Distress Scale (SDS) was completed first across the sample as it may stimulate defenses against awareness of distress, which are the focus of the EMT.

Participants reporting high levels of subjective distress on the SDS were labeled manifestly distressed (MD); participants who report low levels of subjective distress but are identified as distressed on the EMT were labeled illusory mental health (IMH); and genuine mental health (GMH) individuals are those rated as healthy on the EMT with low subjective distress levels. Following the procedure of Shedler et al. (2003), high and low distress was defined as a median split on the SDS based on the sample characteristics. The cut-point for the EMT scores derived from the Early Memories Index was the median. Regarding choosing cut points, I used the formula proposed by the authors of the EMT who stated,

> "We recommend experimenting with a variety of cut points, using the median as a starting point. The optimal cut point is the one that maximizes group differences (between subjects with illusory and genuine mental health) with respect to the criterion variable(s) of interest. Because such a procedure will capitalize on chance, the soundest research procedure would be to establish a cut point in one sample, then cross-validate the findings in a second independent sample" (Shedler, Karliner, & Katz, 2003, p. 645).

Materials

The written form of the EMT asks participants to recall 5 memories, their associated feeling tone, and impression of self and other (Shedler et. al., 2003).

Participants describe the very earliest memory, next earliest, earliest memory of father, earliest of mother, and a memory of a high point in their life. The rating scale (Early Memories Index) includes nine items, identified through factor analysis, to reproduce expert judgment of the EMT. The rater judges the memories as a set rather than assigning individual scores to each memory. Example items on the EMI include "Predominant affect tone is positive," "Subject comes across as confident, self-assured;" "Memories have predominantly negative outcomes;" "Caregivers are portrayed as abandoning or underprotective." The questions are rated on a five-point scale (one = not applicable, three = somewhat applicable, five = highly applicable). Lower scores represent more emotional difficulties. Items two, four, six, eight, and nine are reverse scored. Published inter-rater reliabilities ranged from .56 to .85 based on the Spearman-Brown formula (Shedler et. al., 2003).

The SDS scale is a measure of general psychological distress that includes 20 true or false items (Shedler et. al., 2003). Higher scores indicate greater distress, and items 10, 13, and 14 are reverse scored. It was designed specifically for research on illusory mental health and correlates with many popular self-report scales. Example items include "at times I think I am no good at all" and "I feel anxious much of the time." In a college sample (N = 385) it correlated with the BDI (r=.72), Eysenck Neuroticism scale (r=.84), and the Spielberger Trait Anxiety Inventory (r=.71), and showed good reliability (r=.84), with scores approximately normally distributed (Shedler, et al., 2003).

The TATSP scale is a 22-item scale which measures future psychotherapy practitioners' attitudes toward seeking their own psychotherapy (Farber, 2000). Higher scores represent more positive views toward psychotherapy. Items consist of statements

that are rated on a 5-point Likert-type scale (strongly disagree to strongly agree). Four subscales have been identified through factor analysis- importance for professional growth/ effectiveness- high scores suggest belief that PP enhances professional effectiveness (8 items); concern with professional credibility- low scores reflect concern that PP would lead colleagues to view one as incompetent (6 items); concerns about confidentiality- low scores reveal reluctance to allow others to discover one is seeking PP (4 items); and need for self-sufficiency- low scores suggest a belief that psychotherapists should be able to solve their own problems (4 items). Items 3, 7, 9, 11, 14, and 16 are reverse scored. Internal consistency for the scale computed using Cronbach's alpha was .88. Concurrent validity was supported by a .65 correlation with the Fisher and Farina Attitudes Toward Seeking Professional Psychological Help Scale. Criterion validity is supported by a .52 correlation with the variable of having sought psychotherapy in the past or not. Scores range from 22-120.

Doctoral (M = 8.1) and master's level trainees (M = 8.2) reported nearly identical levels of emotional discomfort as measured by the Subjective Distress Scale. Master's level trainees reported significantly less positive attitudes (M = 78.88) than doctoral trainees (M = 84.80) on the TATSPS, $t(50) = 2.133$, $p < .05$. Trainees that identified their theoretical orientation as psychodynamic (n = 17) reported significantly more hours of PP than CBT trainees, $t(27) = 1.717$, $p < .05$. See table 3 for PP means for each theoretical orientation.

Table 3
Theoretical Orientation and Personal Psychotherapy Attendance (N = 53)

Orientation	Frequency	M
CBT	12	47.8
Humanistic/ Existential	9	53.3
"I don't know"	9	119.3
Other specified	6	146.7
Psychodynamic	17	124.7

CHAPTER III

Results

Statistical Assumptions Testing

Therapy hours scores were not normally distributed for the GMH ($p < .001$) or MD ($p = .002$) groups, as assessed by Shapiro-Wilk's test. A log transformation was performed on the therapy hours scores to achieve an approximately normal distribution (see Figure 2). Observing Shapiro-Wilk's test ($p = .711$) after transformation confirms that log transformation achieved an approximately normal distribution of the therapy hours variable. There was no evidence of outliers in the transformed data, as indicated by visual inspection of a box plot. There was homogeneity of variances on the transformed therapy hours variable, as assessed by Levene's test for equality of variances ($p = .229$).

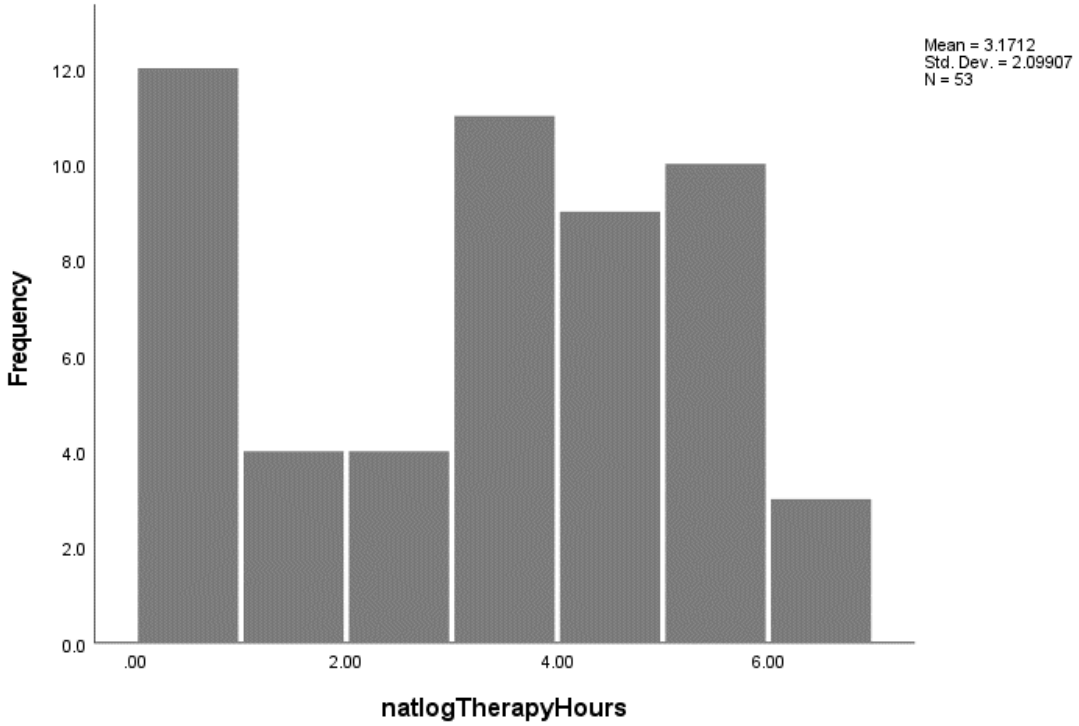

Figure 2. Histogram of therapy hours after log transformation.

Hypothesis 1

Engagement in personal psychotherapy increased from the Genuine Mental Health (n = 20, M = 73.55, SD = 175.86) to Illusory Mental Health (n = 13, M = 101.69, SD = 119.85), to Manifestly Distressed (n = 19, M =117.47, SD = 136.27) groups, in that order (see Figure 3).

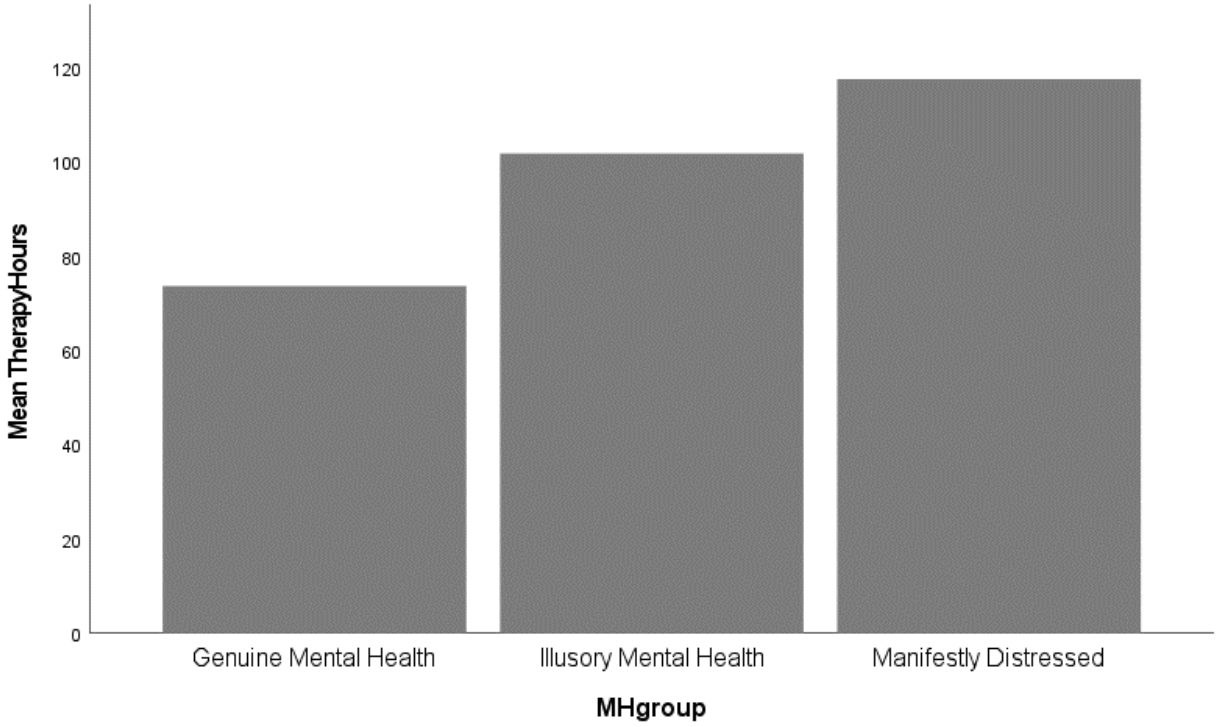

FIGURE 3. These values are the average of the raw, untransformed number of therapy hours reported by each mental health group.

After dummy-coding the categorical predictor MH group into binary variables GMH, IMH, and MD, a forward stepwise regression procedure was run to predict log transformed therapy hours from the 3 dummy coded variables. Forward stepwise regression identified GMH to be the only significant predictor. Therefore, the hypothesis that IMH individuals would attend fewer hours of therapy than GMH and MD individuals was not confirmed.

Linear regression established that mental health grouping (GMH) predicted hours of personal therapy, $F(1, 50) = 5.159$, $p = .027$ and mental health grouping accounted for 9.4% of the explained variability in personal therapy, a medium effect size according to Cohen (1988). GMH participants were predicted to attend 20.5 fewer hours of personal

therapy than IMH and MD participants. Table 4 depicts the distribution of participants across each mental health category. One participant could not be categorized due to failure to complete the EMT.

Table 4
Frequencies and Percentages: EMI Results (N = 53)

Variables	Frequency	%
Mental Health Group		
Genuine Mental Health	20	37.7
Illusory Mental Health	13	24.5
Manifestly Distressed	19	35.8
Not Categorized	1	1.9

Hypothesis 2

The prediction that IMH individuals would show less positive attitudes towards personal psychotherapy was not confirmed. Linear regression established that mental health grouping did not predict hours of personal therapy, $F(1, 50) = .250$, $p = .650$. TATSPS scores were uniformly positive across the three groups (GMH = 83.4; IMH = 84.4; MD = 81.8). See Figure 4 below.

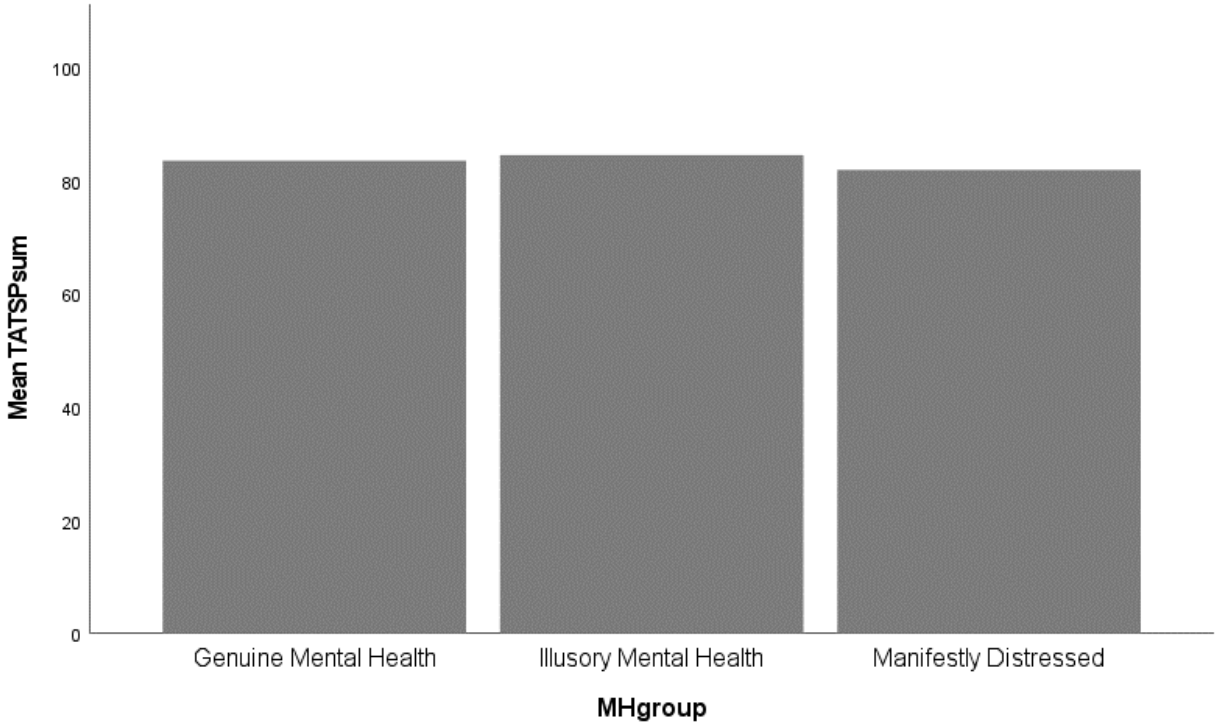

Figure 4. Average of TATSPS scores by mental health group.

Hypothesis 3

A hierarchical multiple regression was run to determine if the addition of the binary variable GMH vs else improved the prediction of number of therapy hours over and above TATSPS scores alone. The prediction that mental health grouping would influence treatment seeking while controlling for TATSPS scores was confirmed. More specifically, the GMH group reported significantly fewer hours of therapy (n = 20, M = 73.55) than all other participants (n = 32, M = 111.06) while TATSPS scores were held constant.

Linearity was confirmed by inspecting a scatterplot of the studentized residuals against the predicted values. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values.

There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations. There was one leverage value greater than 0.2, but no values for Cook's distance were above 1. The assumption of normality was met, as assessed by Q-Q Plot.

The full model containing both GMH and TATSPS score (Model 2) was statistically significant, $R^2 = .252$, $F(2, 49) = 8.234$, $p < .001$, adjusted $R^2 = .221$. The addition of mental health group led to a statistically significant increase in R^2 of .100, $F(1, 49) = 6.559$, $p = .014$.

CHAPTER IV

Discussion

The current study applied the EMT (Shedler et al, 2003) procedure for assessing the presence of Illusory Mental Health in a population of trainee therapists. The aim was to investigate what influences on therapy-seeking behavior can be detected by supplementing self-reported mental health symptoms and conscious attitudes towards psychotherapy with a tool developed to harness clinical judgment to identify Illusory Mental Health in individuals. The psychotherapy outcome literature at large has taken as axiomatic the problematic assumption that self-report measures are accurate for all individuals, although research identifies a sub-group of individuals that appear healthy but for whom the accuracy of such measures may be compromised.

Illusory Mental Health and Trainees' Attitudes Toward Seeking Psychotherapy

Equally positive attitudes were observed in each of the three mental health groups, disconfirming the prediction that the illusory mental health group would have less positive attitudes toward personal therapy than their peers. The conclusions offered

by Asendorpf and colleagues (2002) might explain why conscious attitudes were unrelated to grouping on the mental health variable. Their review of the evidence for the double dissociation hypothesis suggests that (self-report) measures of explicit attitudes and beliefs, if they correlate at all, do so only weakly or moderately with measures of implicit attitudes and personality trends. Furthermore, they argued that implicit measures and explicit measures may predict different classes of behavior, that is, spontaneous behavior compared with behavior available to conscious control.

One explanation for the lack of correspondence between mental health grouping and beliefs about psychotherapy is to acknowledge that the TATSPS is a measure of conscious, explicit beliefs, while the EMT procedure was designed as a performance based, implicit measure. By including a performance based, implicit measure of defensive functioning (EMT) alongside traditional face-valid self-report mental health scales, both controlled and spontaneous kinds of behavior may be predicted. With this in mind, it is necessary to consider what kind of behavior therapy seeking is most accurately labelled. Previous research confirms that it is at least in part a consciously controlled behavior, as it can be predicted by the explicit TATSPS measure. Might there be some component of therapy seeking that is less consciously mediated?

In a critical review of the last 30 years of literature on implicit measures, researchers suggested that "there are many more instances where implicit measures have failed to provide any added utility in predicting behavior above and beyond simply asking people what they think, feel, or do" (Dessel, Cummins, Hughes, Kasran, Cathelyn, & Moran, 2020, p. 225). In contrast, the results of this study suggest that one's reasons for seeking and continuing one's own psychotherapy are multiply determined. Both

mental health group and attitudes, implicit and explicit measures respectively, additively contributed to the prediction of therapy seeking behavior.

Personal Psychotherapy in Illusory Mental Health Therapists

Shedler (2006) stated clearly that the denial of emotional suffering which characterizes individuals with illusory mental health means they are very unlikely to seek mental health services: "individuals with illusory mental health regard themselves as psychologically healthy and appear healthy to observers. They do not have psychiatric diagnoses" (p. 229). No studies to date have offered predictions for how IMH may manifest specifically in a population of trainee psychotherapists, so that question formed the backbone of the present study. I hypothesized that IMH therapists would avoid seeking psychotherapy in line with Shedler's prediction. If this were true, it would be problematic given the extensive literature in support of the myriad benefits of PP for clinicians (Nierenberg, 1972; Orlinsky, et al., 2001; Bellows, 2007; Daw & Joseph, 2007; Holzman et al., 1996; Macaskill & Macaskill, 1992; Moller et al., 2009). Perhaps fortunately, the psychotherapists in training in this sample did not conform to the therapy-avoidant patterns predicted for individuals with IMH.

Despite reporting few symptoms of psychological distress, IMH trainees reported attending more hours of personal therapy than their colleagues identified by the EMT as truly low distress (GMH). Furthermore, results showed that IMH and MD trainees differed to a statistically significant degree from GMH trainees in their number of hours of PP. Although trainees in the IMH group occupied an intermediate position between the low of the GMH and the highest levels found in the MD group, they were not statistically distinguishable from the MD group. Future research with larger sample sizes is certainly

needed- it is an empirical question whether greater statistical power would find the IMH group to be distinguishable from the MD, or if the groups would look more similar in a larger data set. In this sample, the IMH trainees resembled their openly distressed peers more than they resembled their colleagues who reported similarly (to the IMH group) low amounts of distress in the GMH group. While this is a surprise from the standpoint of this study's predictions, it is also the finding most supportive of Shedler and colleagues' contention that a unique subgroup can be distinguished among individuals who report low levels of subjective distress (Shedler et al., 1993).

These results suggest that at least in a population of trainee psychotherapists, individuals with IMH do present for psychotherapeutic treatment, and seem to have some ability to assess their need for additional engagement with personal psychotherapy. These findings hint that trainees rely on different indicators for the decision to seek treatment than distress levels which are tracked by common symptom-based inventories, since they sought similar levels of treatment to their high-distress colleagues. Whether this is true in the general population, or indeed in the population of trainee therapist at large is an important area for investigation, although research attests to substantial differences in the therapy seeking behavior of mental health professionals compared to the general population. Norcross and Guy (2005) reviewed 14 studies estimating the prevalence of PP among mental health professionals in the United States, and the average estimate was 75%. In comparison, a 2019 survey of the general population found that only 9.2% of adults received some form of psychotherapy that year (Terlizzi & Zablotsky, 2019). National surveys and epidemiological studies estimate lifetime utilization rates for adults

that have received mental health care (a more inclusive category than therapy) around 25%, substantially lower than utilization rates of therapists (Norcross & Guy, 2005).

The results of this study may be interpreted as a testament to the unique insightfulness and unusually positive attitudes towards therapy seeking in a population of future psychotherapists. Future studies must investigate the connection between IMH and therapy seeking in non-therapist populations to see if the counterintuitive results of higher-than-expected therapy seeking among IMH individuals is observed there as well. Although defensive individuals were predicted to be unlikely to seek therapy because they theoretically would perceive no source of discomfort to remedy, psychotherapists in training have unique qualities that serve as pathways to PP that do not require the presence of significant psychological distress. For example, professional values largely support personal therapy as a method to advance one's career through modeling and increased empathy through familiarity with the client/patient role (Nierenberg, 1972).

An important consideration bearing on the present study is the possibility that Shedler would consider this population (trainee-therapists) largely inappropriate for IMH research. For example, he seemed to argue that individuals currently attending psychotherapy were, by definition, not displaying IMH in respect of the fact that they displayed problems severe enough to drive them to seek care, or to bring them to the attention of a mental health professional (Shedler, 2006). In this view, IMH individuals must not only be identified as distressed by clinicians via ratings of the EMT, but they also must be *apparently* healthy enough to be described as presenting a façade of mental health- any frank psychopathology or maladaptation would result in them being identified

as manifestly distressed instead, *irrespective of their responses on self-report indices of mental illness*.

While reasonable on theoretical grounds, this assertion raises methodological difficulties for studying IMH individuals as they interact with mental health services. The expectation that one cannot have IMH if they are in psychotherapy would make it nearly impossible for therapists to display IMH, since fully credentialed therapists almost universally attend PP. How could future studies on IMH in therapist trainee populations distinguish which participants should be disqualified via this exception? Approximately 80% of the therapists in this study would have been thrown out via this rule, since they had previous experience in psychotherapy. Perhaps one could argue that psychotherapists in training can be expected to seek out personal psychotherapy for reasons other than acknowledging that they are struggling with a psychiatric diagnosis. This reasoning brings us to consider that they would not necessarily be appropriate to exclude from IMH research on the basis of former treatment.

The literature documents a litany of benefits therapists may expect from PP which may offer alternative motivations to seek treatment not related to acknowledgment of emotional suffering: experience that provides professional modeling, firsthand experience of the craft they hope to practice themselves, or aim to fulfill expectations from training programs that one undertake a personal analysis as a condition of training, as is common in psychoanalytic programs in the U.S. and most therapist training programs in the U.K. (Norcross & Guy, 2005; UKCP, 2001). Future researchers in this are will need some method for distinguishing between therapists that are excluded from being identified with

IMH on account of acknowledging psychological suffering great enough to warrant treatment from those who sought treatment for other reasons.

It seems that disqualifying individuals from being characterized with IMH if they have sought treatment may make the phenomenon prohibitively difficult to study. There are also reasons to believe that individuals who struggle to acknowledge their suffering do in fact wind up in treatment. Individuals seeking psychotherapy without reporting high levels of have been documented in the literature. For example, a large-scale naturalistic study of students seeking college counselling services in Denmark investigated pre- and post-intervention self-report data for symptomatic distress (Østergård et al., 2019). Approximately 10% of those clients reported intake scores in the non-clinical range, raising the possibility that IMH may have masked their distress on intake measures.

Another possibility is that other reasons exist for the general population to seek counseling other than high distress, just as we have suggested therapists in training may do, although at higher rates. If future research were to discover that IMH individuals outside the mental health profession routinely seek psychotherapy, then the concept of IMH may be in need of an update. In that case, rather than being a lack of awareness of personal suffering motivated by an attempt to maintain an image of oneself as well adjusted, a better explanation may be that IMH identifies a more subtle type of psychological vulnerability that is not well captured by symptom focused self-report measures, although this vulnerability may still drive individuals to seek treatment. In other words, perhaps their suffering is invisible through the lens of symptom inventories, but could be expected to come into focus more clearly through other methods of assessment.

The Promise of Qualitative Measures

A small number of recent articles used the theory of IMH to make sense of "paradoxical outcomes" in psychotherapy and counseling research. Although limited follow up research exists on the Early Memories Test procedure (Shedler, et al., 2003), there is a small base of literature using other avenues to examine the problems inherent to the self-report/symptom counting approaches to assessment of mental health and treatment outcome research. Wahlstrom (2021) explains

> Paradoxical outcome may manifest itself as a discrepancy between two or more assessment methods, one showing an attainment of treatment goals and another a failure, or an unexpected course of the treatment process, notably when the client moves from the nonclinical to the clinical range of the assessment measure. Instances where the treatment, on an outcome measure, is assessed to be successful but the client is unsatisfied with the process can also be counted as paradoxical outcome. (p. 6).

Inherent in the discussion of paradoxical outcome is the acknowledgment that relying solely on self-report measures necessarily gives a limited angle of vision on the complexity of the process of therapeutic change and the diversity of problems patients seek treatment for. Supplementing such measures with qualitative and proxy generated assessments of therapeutic goals has the potential to improve process and outcome research more broadly (Stanicke & Mcleod 2021).

Although calls for multi-modal assessment of mental health concerns reach back over 40 years (Strupp & Hadley, 1977), in practice, researchers are unlikely to go to the trouble of assessing people thoroughly in this way. Some of the reasons for this are

practical; face valid mental health inventories claim many strengths to their name (Stanicke & McLeod, 2021). They are widely available, easy to administer, require little time for participants to complete, and often require no more than a basic grasp of arithmetic to score (and little more expertise to interpret). Literature has documented sources of limitation to tests relying on introspection and self-report alone, but corrections are rarely included in research contexts. Some researchers have attempted to supplement their self-report measures shortcomings, for example by routinely including measures of social desirability to identify subgroups that display underreporting of distress, although this is hardly the norm (Weinberger, 1998). Many researchers seem to have largely resigned themselves to the conclusion that any distress that patients cannot describe is best considered error variance.

Literature identifies several directions for exploration and follow up to enlarge the nascent IMH research tradition- these include supplementing self-report with clinician judgment, implicit measures, and probing of client goals; these may shore up some of the shortcomings inherent to symptom checklist style outcome and progress monitoring (Stanicke & Mcleod, 2021). Multimodal assessment methods provide the ability to identify complexities in the therapeutic change process, such as those documented by the paradoxical outcome literature, which would go unnoticed without multimodal assessment. Therapists routinely rely on qualitative data drawn from the content of their sessions to track patient progress in psychotherapy contexts, but similar data is rarely included when therapy outcomes are studied in the quantitative outcome literature (Daniel & Mcleod, 2006). As self-report measures of distress are increasingly regularly administered on a weekly basis for the purpose of progress monitoring, the concerns

about paradoxical outcome have real world clinical impacts. For example, the practice of some psychotherapy clinics of using intake scores on brief symptom inventories to distinguish which patients are admitted or denied treatment may be unethical and scientifically indefensible.

After observing that healthy and *apparently* healthy individuals do seem to pursue mental health services, one might question why individuals with low distress choose to seek treatment at all. Some authors have suggested this finding may be an artifact of viewing the goal of psychotherapy primarily in terms of symptom reduction. Stanicke and McLeod (2021) questioned what they believe are unexamined and possibly misguided assumptions that are frequently made by psychotherapy process and outcome researchers in several areas: that client's goals are usually, primarily, or most meaningfully defined in terms of symptom reduction/increase scale; and that mental health can be accurately represented as a linear change process moving along a bipolar scale with health on one side and distress on the other. Clients' qualitative reviews of their own therapy often indicate that that both improvement/satisfaction and disappointment/failure to meet some treatment goals can co-exist alongside one another. While certainly some clients speak in the language of symptom reduction or disorder criteria in rating their therapy experience, others use more commonsense criteria for understanding emotional suffering. In addition to or instead of those criteria, clients often speak of negative identity repair ("I was able to get my life back on track") and enhanced agency ("I learned some really helpful skills that I can use when I feel scared") to describe positive outcomes for therapy (McLeod et al., 2021). The commonsense perspectives used by clients themselves reveal a perspective that includes the possibility

for transformational change, which represents a more fundamental movement than symptom reduction.

Including qualitative measures of patient defined goals for therapy would enable exploration into the question of whether therapists in each mental health group identified by the EMT procedure may have distinct reasons for seeking treatment that are not well captured by symptom rating scales. This is particularly relevant in the low distress groups, as they are the ones most obviously at odds with the view that symptom reduction is the primary goal of treatment. However, Stankicke and Mcleod's (2021) examination of paradoxical outcome highlights how relying primarily on symptom measures as a proxy for improvement in therapy also limits understanding of the change process even for individuals for whom such measures can be considered to track distress fairly well. Kernberg likewise argued that assessing patients only in terms of symptomatology is likely to miss significant features of the difficulties in living for which patients initially sought treatment (1984).

Psychodynamic Theory and Defenses

How can we make sense of the observation that trainees classified as IMH in this sample attended more hours of therapy than GMH trainees, but fewer hours (though not statistically significantly fewer) than the MD trainees? One perspective might view this as an indication that IMH trainees are experiencing an intermediate level of psychological disturbance. Wahlstrom (2021) offered an alternative explanation to the viewpoint that IMH individuals only "appear" healthy, arguing "I would suggest that such self-ratings also can be perceived as 'genuine' markers of the respondent having attained a tolerable level of coping and symptom relief, and thus as a positive achievement (p. 13). Indeed,

psychoanalytic concepts of psychological defenses depict them as developmental achievements which protect us from being overwhelmed by painful affect, and view them as present in normal personality as well as in psychopathology (McWilliams, 2011).

Wahlstrom (2021) argues that these individuals are somewhat successfully coping with their distress in the sense that they are subjectively unbothered, having banished awareness of their conflictual feelings. Kernberg (1984) has pointed out that strong defenses against awareness of conflictual feelings are sometimes successful in the sense that they prevent the person from becoming symptomatic, although their personality may be organized around fears of abandonment. As long as their preferred coping mechanism is available (e.g., clinging to a partner who is viewed as more capable than oneself to assure one's safety), individuals are unlikely to become symptomatic. However, circumstances that block the individual from availing themselves of such safety strategies may unleash painful awareness of those fears of abandonment and feelings of inadequacy to make daily decisions. This describes the surfacing of the defended against conflicts, at which the individual becomes openly symptomatic.

However, this subjective sense of ease may be purchased at a steep price. While defenses are functioning to suppress significant conflict, psychoanalytic thinkers predict that there may be a toll on the body as distress is believed to be forced to find expression somatically rather than psychically (Kernberg, 1984). Research findings have been mixed regarding the hypothesis that defensive denial leads to somaticizing. In support, one study indicated that IMH is prospectively associated with greater healthcare utilization (Cousineau & Shedler, 2006). IMH has also been evaluated in individuals with chronic fatigue syndrome to explore whether the condition may be explained as a somatic

expression of emotional distress (Bram et al., 2019). While IMH was not identified in all CFS patients (some patients did experience distress as they carried psychiatric diagnoses), it was found to be associated with increased physical symptoms in a subgroup of patients lacking access to emotional distress. The authors concluded tentatively that CFS is best not understood as resulting from emotional denial across the board, but a subgroup does exist that are observed to suffer greater physical symptoms in association with IMH.

The Challenge of Assessing for Illusory Mental Health

Since an important goal of IMH research is to identify a subgroup for whom common self-report measures of subjective distress are inaccurate, researchers should generally avoid relying solely on such self-report measures when investigating this topic. Joiner, Brown, Perez, Sethuraman, and Sallee (2005) exemplify the way in which attempts to study IMH with a poorly thought out method of assessment can end up repeating the very methodological mistakes that Shedler (1993) attempted to call attention to. Joiner and colleagues (2005) argued for the inclusion of third data sources in assessment and treatment research that are not confounded by the bias in self-report, and chose to include biomarkers of anxiety to this end. However, they also made the questionable decision to use a verbally administered self-report questionnaire (the Hamilton Anxiety scale) as a stand in for clinical judgment. When the self-report measure did not correctly identify patients whom had been identified as anxious by patient self-report and biomarkers for anxiety, they claimed to have demonstrated the failure of clinical judgment to compare to the accuracy of self-report in children. Of course,

administering a self-report measure of anxiety verbally does not mean clinical judgment is being exercised by virtue of the fact that the interviewer happens to be holding the pen.

Another methodological strategy that runs afoul of Shedler's categorization can be observed in a recent German study that attempted to make use of the IMH framework (Spitzer et al., 2019). Those authors compared clinician ratings of patient impairment with patient self-ratings via the Global Severity Index of the SCL-R-90 (Derogatis & Savitz, 1999) and found that 14% of the 4088 inpatients in their study rated themselves in the healthy range. In comparison, clinicians rated only 6% of the sample as healthy. With Shedler's (2006) suggestion that patients with pathology severe enough to result in referral to a mental health professional should be considered manifestly distressed, it seems clear that individuals experiencing psychiatric emergencies dangerous enough to warrant hospitalization would not be considered appropriate for IMH research. An investigation into Chronic Fatigue Syndrome made the same blunder; while actually using the same method published by Shedler and colleagues (2003) to identify IMH, they included both healthy samples and those diagnosed with depression (Bram, et al., 2003).

Many researchers have largely misunderstood the core concept of repressive coping in a similar fashion and present conclusions based on flawed methodology as a result. One such study administered self-report measures of psychopathology to widows compared the responses of repressive copers to non-repressive copers (Bonanno & Field, 2001). Upon finding that levels of depression, anxiety, and adjustment disorders in the repressive coping group were lower, they concluded that repressive coping represented a form of resilience, rather than a hindrance as previous theoretical and empirical evidence suggested. It is distressingly common for researchers to overlook foundational aspects of

the theory they are studying (when the population of interest is specifically defined by their quality of being unable to accurately represent their distress on self-report measures, and researchers proceed to test the critical hypothesis using such indices anyway).

While self-report measures of distress are clearly inappropriate in populations of defensive deniers of distress, self-report measures aimed at identifying defensiveness itself or personality variables associated with a defensive style should be examined alongside IMH in future research (Marlowe-Crowne Social Desirability Scale, Weinberger, 1998; L-scale on the Minnesota Multiphasic Personality Inventory II, Graham, 1993; dismissive/avoidant attachment orientation, Mikulincer & Shaver, 2007). Investigation into areas of empirical and theoretical overlap as well identifying the distinct features of each of these methods for identifying psychological defensiveness can profitably expand the nature of our understanding of assessing defenses in research contexts.

Future research must incorporate indicators of mental health or illness and indicators of change in psychotherapy that are less vulnerable to the limitations of self-knowledge that plague self-report measures. Physiological measures seem to present a promising and underutilized method for supplementing self-report. Several physiological measures that have been observed to correlate with IMH also have putative mechanisms to explain the deleterious effects of defensively disavowed distress on physical health. The literature on IMH and repressive coping has documented increased changes in heart rate and blood pressure (Shedler et al., 1993) and skin conductance level (Yoshino et al., 2005) during laboratory stressor tasks. Coronary reactivity and skin conductance should

be included as targets for tracking change in future psychotherapy outcome research with IMH individuals to see if improvement results in reduced physiological reactivity.

Distinct biological correlates specific to individual mental health diagnoses are notoriously difficult to identify, but availability of disorder non-specific measures of vulnerability to emotional and physical stress (e.g. coronary reactivity and cortisol levels) represent an incredibly valuable, relatively objective complement to self-report measures of mental health and pathology (Deits-Lebehn et al., 2020). Since these physiological markers have been observed to be elevated in populations of defensive deniers, use of biological data presents a way (less subject to defensive distortion) to measure the success of psychotherapeutic interventions with a population that is notoriously difficult to accurately assess via self-report. Some researchers have offered impassioned pleas in favor of the utility of investigating physiological correlates of change processes in a study published just last year suggests that such attempts remain unfortunately rare, but these may be expected to see more research attention in the near future (Deits-Lebehn et al., 2020).

Limitations of the Current Study

The first set of limitations in the design of the present study concerns the sample size of 53 participants. With only 12 participants in the IMH subgroup, statistical power was limited and prevented the investigation of more specific group comparisons. Although this sample was comparable in size to the number of participants in the original IMH studies (Shedler et al., 1993), those investigations boasted much greater statistical power due to the use of repeated-measures designs, as they recorded a series of readings on several tests of physiological reactivity with each participant. High levels of

variability is common in studies collecting data on number of therapy hours for psychotherapists, as there is an extremely large range of commonly observed values; for example, reviews of PP prevalence in psychologists have found subjects commonly reporting values from just a few hours to well over 1000 (Norcross & Guy, 2005). As Cohen (1988) explained, the 4 factors that affect the power of a statistical test are alpha level, difference between group means, variability among subjects, and sample size. With a high level of variability expected on the variable of PP hours and low sample size, power was reduced as a result. The challenges of collecting data in an exclusively "remote" format during COVID-19 were multiple, and likely constrained recruitment efforts in a significant way.

In addition, the sample population was highly homogenous, containing primarily Caucasian women. While it is not uncommon for graduate student populations in psychology to be made up of more women than men, future research would benefit from expanding the diversity of the subject pool. Literature attests to the differences in treatment seeking behavior of men and women in the general population, and it is possible this would extend to mental health professionals as well. Furthermore, while the entire field of psychology is striving to better represent the cultural and ethnic diversity in professionals as well as research populations, the current research into help seeking behavior must be further investigated in samples that are more representative of the larger population of student therapists that we hope to generalize these findings to.

A related threat to the validity of these findings concerns selection bias. Individuals that volunteered to take part in the study may not be representative of the wider population of trainee therapists. Individuals that agreed to take part in the study

after reading the participation email describing a study on attitudes towards personal therapy may be expected to have relatively more positive in their attitudes and be more likely to attend psychotherapy than the general population of student therapists. Observation of the range of scores on the TATSPS in the current study suggested that few individuals with relatively negative feelings towards PP opted to participate. However, the percentage of students reporting some therapy history in this sample (79.2%) was similar to other published estimates (70.2% in Dearing, et al., 2005).

The second limitation involves the cross-sectional design employed. Data collected from a single observation in time poses problems for interpreting the relationship between mental health grouping and therapy seeking as individuals may change their classification as a result of treatment. While proponents of symptom inventories generally assume that scores rising indicates deterioration, while lowering scores indicates improvement (Stanicke & McLeod, 2021), Shedler argues that for some individuals (IMH), increased distress scores may represent an improvement as they become more accepting or aware of their underlying distress and become able to more accurately respond to self-report measures (i.e. representing a move into the manifestly distressed category; 1993). However, no studies to date have investigated whether such a counterintuitive pattern can be observed when IMH individuals engage in psychotherapy. The cross-sectional nature of the present study does not allow for such inquiry, but a longitudinal, prospective design study could observe whether IMH individuals who do make it into treatment display such a pattern. If IMH individuals respond to psychotherapy with reports of increased distress once the therapy starts to affect them, then gradually decrease their distress as successful treatment progresses, it would seem to

provide some support for the hypotheses Shedler has offered: that IMH is characterized by defensiveness that initially kept suffering out of awareness, and that the goal of treatment is to enable them to bring these issues into awareness so they can be more directly resolved.

Other, more nuanced possibilities exist, and would be difficult to measure with symptom-based measures alone. Researchers have also raised the possibility that some cases of paradoxical outcome could result from the manifest symptoms being resolved, seemingly representing a successful treatment, but the patient may yet report being unsatisfied with the therapy experience because of deeper issues being left unaddressed (Wahlstrom, 2021). This raises the question of whether some therapeutic issues do not present in the form of distress detectable by common symptom focused self-report measures, but the patient could nonetheless be aware of them and be able to report them on a qualitative assessment of patient goals.

In addition to changes in mental health due to treatment, people may become more or less defensive with time and changing life circumstances. While no research to date has empirically investigated the fate of an IMH population receiving treatment over time, researchers have extensively documented the prevalence of the closely related concept of repressive coping style in different populations. For example, while repressive coping is estimated to exist in 10-20% of the general population, empirical research has observed repressive coping in 50-80% of populations afflicted with chronic illness, suggesting the possibility that it is a dynamic response to hardship rather than a stable personality level characteristic (Myers, 2000).

A longitudinal design would enable future researchers to investigate possible mediating processes and proximal variables that transmit the effects of mental health group on the distal outcome of therapy attendance. Should future investigations confirm statistically and clinically significant different levels of therapy attendance between these groups, a plausible next step would be to proceed to search for the mechanisms responsible for producing group differences on therapy attendance. Questions to investigate include whether individuals in each of the mental health groups are attending therapy at different rates (once per week or less vs multiple times per week) or are their average start times staggered? Perhaps the trainees with genuine mental health started most recently as graduate students, since their professional goals rather than personal distress led them to engage with a therapist, or perhaps they may be more likely to experience more rapid progress towards their therapeutic goals, while the problems of MD and IMH groups prove more resistant or slow going in work? A prospective study design would be best to answer questions such as those, and could also look at the patterns of moving from one mental health grouping to the next (e.g. from IMH to MD, or from MD to GMH) over time.

A final limitation is related to the immature state of the literature utilizing the specific method and materials utilized described by Shedler and colleagues (2003) to identify IMH. While this study closely reproduced Shedler's assessment methods, the distribution of scores on the Early Memories Index and the Subjective Distress scale have not been investigated in a large scale validation sample. As a result, cut scores using the median are idiosyncratic to the sample characteristics of each study, a point that the authors have acknowledged (p. 645). Comparison across the few studies completed to

date is made even more challenging since have elected not to report the median scores observed in their samples (Shedler et al., 2003; Shedler & Cousineau, 2006; Bram et al., 2018). Conceptually and statistically, a median split seems to offer little distinction between those individuals scoring around the average on the Subjective Distress Scale. Perhaps future research could explore tertile groups to introduce more statistical and conceptual distance between the categories of defensive and openly distressed.

Strengths and Conclusions

This study was largely exploratory in nature due to the relative dearth of research on the concept of illusory mental health. It also represents one of only a handful of studies following the procedure developed by Shedler and colleagues (2003) specifically for identifying illusory mental health, rather than applying a homegrown definition with novel measures of unknown utility. Although results did not confirm all of the a priori predictions offered in this study, the results do suggest that separating illusory mental health from genuine mental health individuals may help us understand the therapy seeking behavior of therapists in training, supporting the utility of continuing investigation in this area.

Trainees demonstrated in their therapy seeking behavior that despite their low scores on subjective distress measures, they are aware of their need for treatment. This need would go unnoticed if they were required to make the decision based on the results of a Beck Depression Inventory (Beck et al, 1988) or any other popular, face-valid inventory of psychological distress, as patients from the general population are often categorized. However, the design of the current study could not provide insight into what factors drove each group to seek psychotherapy. Future research is recommended to

explore how measures of IMH and qualitative measures of patient identified therapeutic goals and progress can supplement self-report measures of psychopathology.

As Shedler and colleagues (1993) argued nearly 30 years ago, the fact that a sizable subgroup of individuals are not accurately assessed by self-report measures of psychological distress has the potential to be a broadly disruptive issue in the psychological literature. This study is an attempt at bringing greater attention to an important issue that has the potential to greatly improve our assessment practices for a frequently overlooked sample of psychotherapy patients and participants in outcome research. The methods employed here have shown consistently promising results in identifying this subgroup in a research setting, and psychometric research into the characteristics of the instrument is extremely important if the Early Memories Test is to be employed on a larger scale. Validation studies estimating population characteristics in large samples will allow researchers to use empirical data to identify appropriate cut points for various populations (clinical vs. general populations, psychotherapists vs. other health practitioners) rather than relying on local data for each study, and greatly strengthen the validity of this measure.

Additionally, the impact of the pandemic has been widely discussed, and has been reported to have an enormous impact on the mental health and treatment seeking behavior of individuals across the globe. Researchers are just beginning to present empirical findings on this impact, and the early data suggests dramatic changes in demand for psychotherapy.

A recent survey of psychologists found that 70% reported increased demand for treatment for depression, and 82% reported increased demand for anxiety disorder

treatment compared to the previous year (APA, 2021). One can speculate that this enormous increase in human suffering and demand for psychotherapeutic services is likely to bring with it large scale cultural changes in attitudes towards therapy seeking in the general public, and likely in mental health professionals as well. The same survey describes 62% of psychologists reporting increased referrals, 68% reporting longer waitlists, and nearly half (46%) reporting burnout due to the increased professional demands placed on them by the influx of patients. Over half of the psychologists sought peer support or consultation to manage their burnout, and it is likely that treatment for professionals will be increasingly in higher demand as a result. As our collective mental health strains under such pressure, it will be important to continue to expand our investigation into how these changes are impacting both professionals and the general public in their awareness and behavior in relation to help seeking.

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Appendix A: Subjective Distress Scale

For each statement below, check the box marked "T" if you feel the statement is true for you, or check the box marked "F" if you feel the statement is false for you.

	T	F
1. At times I think I am no good at all.	[ ]	[ ]
2. I feel anxious much of the time.	[ ]	[ ]
3. I worry that I look much less attractive than I used to.	[ ]	[ ]
4. I often worry about things I should not have done or said.	[ ]	[ ]
5. I frequently find myself worrying about one thing or another.	[ ]	[ ]
6. My mood often goes up and down.	[ ]	[ ]
7. I have thoughts about killing myself (whether or not you would actually carry them out).	[ ]	[ ]
8. When I look back on my life, I see mostly failures.	[ ]	[ ]
9. I feel I have nothing to look forward to.	[ ]	[ ]
10. I am not usually self-conscious.*	[ ]	[ ]
11. I sometimes feel "just miserable" for no reason.	[ ]	[ ]
12. I sometimes feel that I am about to go to pieces.	[ ]	[ ]
13. I believe I am no more nervous than most others.*	[ ]	[ ]
14. I am happy most of the time.*	[ ]	[ ]

15. I have sometimes felt that difficulties were piling up so high that I could not overcome them.	[ ]	[ ]
16. I am often troubled by feelings of guilt.	[ ]	[ ]
17. I cry all the time.	[ ]	[ ]
18. I sometimes feel completely useless.	[ ]	[ ]
19. I often feel fed up.	[ ]	[ ]
20. My feelings are easily hurt.	[ ]	[ ]

*Score 1 point for each endorsed item. Items marked with an asterisk (*) are reverse scored (i.e., a False response is scored as 1 point).

Appendix B: The Early Memory Test (EMT-S)

In the next few pages, we will ask you to remember some of your earliest memories, and to tell us about these memories in writing. These memories are very important to us. Please do not rush, but take the time to describe your memories in detail.

We will ask you to recall a total of five memories. Before you turn the page, take a moment to relax. Let your thoughts go back to your childhood, think back as far as you can, and try to recall your very *earliest* childhood memory. Try to remember a specific incident or event, not just a fragmentary impression.

When you have recalled this earliest memory, turn ahead to the next page where there will be space to write about it.

1. Please write down your earliest memory in as much detail as you can remember. Please write legibly.

    1a. As you look in on this memory, what are your impressions of yourself and of each of the other people in the memory?

    1b. Is there a mood or feeling tone that goes along with this memory? Please explain.

2. Now try to recall your next earliest memory. Please write down your next earliest memory in as much detail as you can remember. Please write legibly.

    2a. As you look in on this memory, what are your impressions of yourself and of each of the other people in the memory?

    2b. Is there a mood or feeling tone that goes along with this memory? Please explain.

3. Next, we would like you to recall your earliest memory of your mother. (Do not repeat a memory you have already given. Choose another, if necessary.) Please write down this memory in as much detail as you can remember. Please write legibly.

3a. As you look in on this memory, what are your impressions of yourself and of each of the other people in the memory?

3b. Is there a mood or feeling tone that goes along with this memory? Please explain.

4) Next, we would like you to recall your earliest memory of your father. (Do not repeat a memory you have already given. Choose another, if necessary.) Please write down this memory in as much detail as you can remember. Please write legibly.

4a. As you look in on this memory, what are your impressions of yourself and of each of the other people in the memory?

4b. Is there a mood or feeling tone that goes along with this memory? Please explain.

5) Last, we would like you to recall a memory you feel was a high point in your life. (Do not repeat a memory you have already given. Choose another, if necessary.)
Please write down this memory in as much detail as you can remember. Please write legibly.

5a. As you look in on this memory, what are your impressions of yourself and of each of the other people in the memory?

5b. Is there a mood or feeling tone that goes along with this memory? Please explain.

(Allow one full page for each memory, with approximately half the answer space allocated to the memory itself, and the remaining space divided between the two follow-up questions.)

Appendix C: Early Memory Index Scoring Sheet

1=not applicable 3=somewhat applicable 5=highly applicable

1. Predominant affect tone is positive (e.g., memories convey happiness, contentment, well-being, excitement, etc.).

1 2 3 4 5

2.* Predominant affect tone is negative (e.g., memories convey sadness, anger, frustration, fear, hurt, etc.).

1 2 3 4 5

3. Others are depicted as benevolent; they are seen as sources of gratification, pleasure, comfort, security, etc.

1 2 3 4 5

4.* Others are depicted as malevolent; they are seen as sources of frustration, pain, punishment, injury, etc.

1 2 3 4 5

5. S comes across as confident, self-assured.

1 2 3 4 5

6.* S comes across as insecure, needy, ignored, or deprived.

1 2 3 4 5

7. The memories have predominantly positive outcomes (e.g., S ultimately succeeds, experiences gratification, etc.).

1 2 3 4 5

8.* The memories have predominantly negative outcomes (e.g., S ultimately fails, experiences pain, frustration, etc.).

1 2 3 4 5

9.* Caregivers are portrayed as abandoning or underprotective.

1 2 3 4 5

* reverse-scored item

Appendix D: Trainees' Attitudes Toward Seeking Psychotherapy Scale

The items are responded to on a 5-point scale (strongly agree to strongly disagree).

Factor 1—Important for professional growth/effectiveness (high scorers support importance)

11R Seeking psychotherapy would make me a stronger therapist.

14R Seeking psychotherapy is an important part of a psychologist's personal and professional growth.

16R Psychologists who undergo psychotherapy make better therapists than those who don't.

19R It is the ethical responsibility of psychologists to seek help if they are having problems.

25R It should be mandatory for all counseling/clinical psychology students to undergo therapy as a part of training.

3R Going through one's own psychotherapy is important for a psychologist's professional growth.

7R Undergoing my own psychotherapy would enhance my ability as a psychologist.

9R In order to help others, psychologists need to address their own issues through psychotherapy.

Factor 2—Concern with professional credibility (high scorers are less concerned)

10 If I were to seek psychotherapy for myself, my colleagues would see me as incompetent.

12 Seeking psychotherapy for myself could ruin my chances for a successful career.

15 I would not trust a psychologist who has sought psychotherapy for his or her own problems.

17 Graduate programs in psychology should not accept students who have a history of seeking psychotherapy.

18 If I were to seek psychotherapy for myself, my colleagues would see me as weak.

5 Seeking psychotherapy would damage my credibility as a therapist.

Factor 3—Concerns about confidentiality (high scorers have less concern)

2 I would feel uneasy seeking psychotherapy for myself because of what some people would think.

22 If I were to seek psychotherapy for myself, I would be afraid that I might be "found out."

23 I would be embarrassed if I were to come into contact with a former therapist of mine in the workplace.

24R If I were to seek psychotherapy for myself, I would gladly let my classmates know.

Factor 4—Need for self-sufficiency (high scorers report a lower need)

1 Psychologists should be able to resolve their personal problems on their own.

13 It is important to me that I be able to solve my personal problems on my own.

21 Psychologists should at least be able to deal with minor problems on their own.

8 A competent psychologist should be able to use his or her skills to solve his or her own psychological problems.

R = Reverse Scored

Appendix E: Demographic Questionnaire

1. What is your age in years?
2. Which category best describes you? Mark all that apply: (Asian; Black or African American; Hispanic, Latino, or Spanish; Middle Eastern or North African: White; I prefer not to answer; other- please specify)
3. How do you currently describe your gender identity?
4. What degree will you graduate with? (e.g. Psy.D. in Clinical Psychology; M.A. in Marriage in Family Therapy, M.S. in Mental Health Counseling)
5. What year of your program are you currently in? (1^{st}; 2^{nd}; 3^{rd}; 4^{th}; 5^{th} or more)
6. What do you consider your primary theoretical orientation? (Cognitive, behavioral, or cognitive-behavioral; Humanistic or Existential; Psychodynamic or Psychoanalytic; Family Systems/Systemic; Interpersonal; I don't know; Other)
7. If you have participated in your own psychotherapy (as a client/patient/group member), please estimate the number of hours you have attended. If you've never engaged in psychotherapy, please enter "0". (This question refers to treatment that is primarily talk based with a professional such as a counselor, psychotherapist, psychologist, or social worker in an individual (one to one) or group format. Please do not include treatment modalities that are primarily biological in nature (with a professional such as a psychiatrist, nurse practitioner, general practitioner, etc.). Please respond in whole numbers.

Appendix F: Participation Letter

Subject: Research Study Participation

Hello! I hope this email finds you well. I am writing regarding a research study examining the views of trainees in mental health (including clinical, counseling, marriage and family therapy, school psychology, etc.) programs on personal psychotherapy, and the factors that influence these views. I am a student in Nova's Clinical Psychology Ph.D. program, and this study is my dissertation project. I'm hoping that you will consider participating to help me reach my goal of engaging 100 participants by the end of May.

If you have already completed the survey and/or have forwarded it to others in your program, thank you! You can feel free to disregard this message. If you have not taken the survey yet, we would greatly appreciate it if you would consider taking the survey yourself, as well as forwarding this information on to other graduate students in your program.

The IRB-approved survey (NSU Protocol Number 2020-597; Adelphi University #020321) will take approximately 30 minutes of your time, and participation is entirely anonymous. Please note that individuals must be able to complete measures in English to participate. This study's results may have implications for understanding issues surrounding therapists in training and their decision about whether to pursue personal psychotherapy.

The survey link is available here:
https://forms.gle/xCd2AkiHhJMYp8Uv9

If you have any questions about this study, please do not hesitate to contact me by email (alexpalmer.38@gmail.com or phone (941-306-6937).

Best,
Alex Palmer, M.S.
Principal Investigator
Psychology Trainee
Nova Southeastern University