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Trainee Clinical Psychologists' Attitudes toward Seeking Psychotherapy: The Influence of Interpersonal Perfectionism and Perceived Attitudes of Others

by

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ABSTRACT

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TRAINEE CLINICAL PSYCHOLOGISTS' ATTITUDES TOWARDS SEEKING PSYCHOTHERAPY: THE INFLUENCE OF INTERPERSONAL PERFECTIONISM AND PERCEIVED ATTITUDES OF OTHERS

Anna Theresa Weller

The first chapter of this thesis consists of a systematic literature review exploring the negative effects of personal therapy for psychotherapists. The review was necessary to redress bias within the literature to report and explore positive effects of personal therapy for psychotherapists. The review found that personal therapy can produce a number of negative effects, including placing emotional strain on the therapist, disruption to clinical work by reducing therapists' ability to attend to their clients and negatively impacting upon therapist development. Variables relating to negative effects included client and therapist factors, and process issues within therapy. More primary research is needed to understand the impact of negative effects of personal therapy for psychotherapists, and to explore variables associated to these effects.

Due to research demonstrating that trainee clinical psychologists fail to access adequate support for their mental health difficulties, the empirical paper explored the role of interpersonal perfectionism and the perceived attitudes of others in influencing trainee clinical psychologists' attitudes towards seeking psychotherapy. More than 60% of participants had lived experience of mental health difficulties. Perceiving others within the professional group to view experience of mental health difficulties and help-seeking as acceptable was related to trainees' holding more positive attitudes towards seeking psychotherapy. A test of mediation showed that perceived attitudes of others also mediated the relationship between interpersonal perfectionism and trainees' attitudes towards seeking help. Implications for the wider profession are discussed.

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Declaration of Authorship

I, Anna Weller, declare that this thesis and the work presented in it are my own, and has been generated as the result of my own original research.

Trainee Clinical Psychologists' Attitudes toward Seeking Psychotherapy: The Influence of Interpersonal Perfectionism and Perceived Attitudes of Others

I confirm that:

This work was done wholly or mainly while in candidature for a research degree at this University;

Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

Where I have consulted the published work of others, this is always clearly attributed;

Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

I have acknowledged all main sources of help;

Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

None of this work has been published before submission.

Signed: …….

Date: …….

Acknowledgements

Firstly I would like to thank those who gave their time to participate in the study, without whom this research would not have been possible.

Thank you to everyone who has supported me throughout this process, particularly my family and friends who have been a continual source of support throughout the course and have all too often heard the phrase “I can’t, I’m working!” Mum, thank you for looking after me (even though I am 32!), and Dan, Lou and Em thank you for always encouraging me. To my colleagues on the course who have become lifelong friends; turns out we were #goodenough. Henry, Kenneth, Harry, Buster and Missy, thank you for the breaks and joy you brought.

A special thanks must be given to my supervisor, Dr Nick Maguire for your unwavering patience and for letting me chew your ear off for hours on end!

Finally, I dedicate this research to the memory of my Dad. I’ll never stop trying to make you proud.

Definitions and Abbreviations

AAI	Adult Attachment Interview
ACT	Acceptance and Commitment Therapy
APA	American Psychological Society
APA Division 12	Division of Clinical Psychology
APA Division 17	Division of Counselling Psychology
APA Division 29	Division of Psychotherapy
APA Division 42	Division of Psychologists in Independent Practice
BPS	British Psychological Society
B.I.T.E	Bulimic Investigatory Test Edinburgh
CALPAS	California Psychotherapeutic Alliance Scale
CASP QRC	Critical Appraisal Skills Programme Qualitative Research Checklist
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CP/s	Clinical Psychologist/s
CINAHL	Cumulative Index of Nursing Allied Health Literature
DSM	Diagnostic and Statistical Manual of Mental Disorders
DQCCP	Development of Psychotherapists Common Core Questionnaire
DV	Dependent Variable
ED	Eating disorder
GHQ-28	General Health Questionnaire 28 item version
GSI	General Symptom Index
HCPC	Heath and Care Professions Council
ICD	International Statistical Classification of Diseases and Related Health Problems
IPA	Interpretative Phenomenological Analysis
IV	Independent Variable
MH	Mental Health
MMAT	Mixed Methods Appraisal Tool
MMPI	Minnesota Multiphasic Personality Inventory
MMPI D	Depression scale of the Minnesota Multiphasic Personality Inventory
MMPI Es	Barron’s ego strength scae of the Minnesota Multiphasic Personality Inventory

MMPI K	Correction scale of the Minnesota Multiphasic Personality Inventory
MMPI Pt	Psychasthenia scale of the Minnesota Multiphasic Personality Inventory
MMPI Sc	Schizophrenia scale of the Minnesota Multiphasic Personality Inventory
MPS	Multidimensional Perfectionism Scale
N/A	Not Applicable
NHS	National Health Service
PT	Personal Therapy - Engagement in personal psychological therapy
Pt/s	Participant/s
PSP	Perfectionistic Self-Presentation
PSPS	Perfectionistic Self-Presentation Scale
Psychotherapist	A professional trained in delivering psychological therapy, used interchangeably with the terms ‘therapist’ and ‘psychological therapist’
Psychotherapy	Psychological therapy
RF	Reflective function
RFS	Reflective-Self Function Scale
SCL-90	The Symptom Checklist-90
SD	Standard Deviation
SE	Standard Error
SPSS	Statistical Package for the Social Sciences
TA	Thematic analysis
TATSPS	Trainees’ Attitude Toward Seeking Psychotherapy Scale
UK	United Kingdom
US	United States
QAC	Quality Assessment Criteria for Evaluating Primary Research from a Variety of Field

1 A Systematic Review of the Literature Exploring the Negative Effects of Personal Therapy for Psychotherapists

1.1 Introduction

1.1.1 History of personal therapy for psychotherapists.

Freud (1937) first argued that personal analysis was imperative in the training and continued growth of therapists to develop awareness of countertransference and projection issues. The influence of personal therapy on psychotherapists' wellbeing and professional practice has since been a focus of research (Ivey & Waldeck, 2014).

1.1.2 Psychotherapist engagement in personal therapy.

Large, multinational studies and reviews have shown that a substantial proportion of psychotherapists, 59–75%, have participated in at least one episode of personal therapy (Norcross & Guy, 2005; Orlinsky & Ronnestad, 2005). Psychotherapists enter personal therapy for personal and professional reasons, although the two are arguably indistinguishable in a profession requiring heightened personal awareness (Norcross & Connor, 2005).

A number of variables influence therapist engagement in personal therapy, including gender and theoretical orientation; with female and psychodynamic therapists the highest consumers of personal therapy (Pope & Tabachnick, 1994). A United States (US) survey by Norcross, Strausser and Faltus (1988a) found psychologists to be the most avid users of personal therapy, with 75% having participated compared to 67% of psychiatrists. United Kingdom (UK) psychologists access less therapy than their American counterparts, as Darongkamas, Burton and Cushway (1994) found only 41% of 321 clinical psychologists to have experienced personal therapy.

1.1.3 Positive effects of personal therapy for psychotherapists.

Studies have consistently shown that personal therapy produces predominately positive effects for qualified and trainee psychotherapists (Orlinsky, Schofield, Schroder, & Kazantzis, 2011; Rake & Paley, 2009). In Norcross et al's. (1988) study, over 90% of more than 500 therapists described positive outcomes from personal therapy. Orlinsky and Ronnestad (2005) later found 88% of 4,000 therapists cited positive effects of their

personal therapy. A brief overview of the nature of these effects is discussed, however a full review is beyond the scope of this report.[1]

Although research has failed to demonstrate that psychotherapists' personal therapy translates into improved client outcomes, a review by Orlinsky et al. (2005) concluded that personal therapy facilitates change across therapists' cognitive, behavioural and emotional domains. This includes improved insight, and reduction in behavioural and emotional symptoms leading to enhanced work and social functioning.

Mechanisms by which positive effects are achieved from personal therapy require further exploration and face methodological limitations, however a number of general assumptions have been made (Coleman, 2002; Fleischer & Wissler, 1985; Grimmer & Tribe, 2001; Guy, 1987; Macaskill, 1988, 1999; Macran & Shapiro, 1998; Macran, Stiles & Smith, 1999; McNamara, 1986; Norcross, Strausser-Kirtland, & Missar, 1988b; Peebles, 1980; Wogan & Norcross, 1985), as described:

- Personal gains:
    - Protects and enhances the psychological health of the therapist by providing a platform to relieve stressors and attenuate emotional strains of a demanding job;
- Professional gains:
    - Experience of the client role develops therapists' ability to display empathy, genuineness and warmth to create an environment conducive to therapeutic change;
    - Exposure to and development of therapeutic skills from observation and modelling of the therapists' own therapist;
    - Socialisation to the psychotherapist role;
    - Increased awareness of interpersonal processes within the therapeutic relationship, including the practitioner's own difficulties, biases and conflicts to engender increased recognition of countertranserefence;
    - Increased belief in the value and effectiveness of psychotherapy, and the translation of theory into practice.

[1]Interested readers are directed to reviews in this area by Macran and Shapiro (1998) and Wigg, Cushway and Neal (2011).

1.1.4 Personal therapy as a component of training.

Mandatory personal therapy requirements differ between professions. Personal analysis remains a mandatory requirement of most psychoanalytic/psychodynamic training courses in the UK and Europe (Kumari, 2001; Sandell et al., 2006). Although still a mandated requirement for accreditation, The British Psychological Society's (BPS) Division of Counselling Psychology has recently dropped its requirement for trainees to accrue a minimum of 40 therapy hours (Kumari, 2017). UK Clinical psychologists are not currently required to have personal therapy (Wilson, Weatherhead, & Davies, 2015), which is surprising given the reflexive scientist practitioner philosophy underpinning the profession (Hall & Llewelyn, 2010).

The issue of mandating an emotionally intrusive, psychoactive process has caused much controversy (Murphy et al., 2018), and there is ongoing debate as to whether imposing therapy is ethically sound (Ivey, 2014).[2]

1.1.5 Trends and limitations in the literature to date.

Although the value of personal therapy for psychotherapists is anecdotally supported (Macran & Shapiro, 1998), empirically demonstrating its worth has proven challenging.

Quantitative approaches attempting to isolate improved client outcomes and evidence therapists' therapy experiences predominated early studies (Macran & Shapiro, 1998), yet research has failed to demonstrate that therapists' personal therapy leads to any determinable improvements in client outcome (Macran & Shapiro, 1998). Poor quality research may, in part, account for this.

Reviews by Macran and Shapiro (1998) and Orlinsky, Norcross, Ronnestad, and Wiseman (2005) concluded that many studies in this area were not controlled or randomised, introduced bias through self-selecting recruitment, used inadequate sample sizes to demonstrate effect, and failed to adequately control for confounding variables. The high volume of confounding variables inherent in such research (including therapist motivation for accessing personal therapy, level of therapist distress, competency of therapist, therapeutic modality, response biases related to the model, complexity of client

[2] The ethical dilemmas of mandatory personal therapy are beyond the scope of this review; however the area continues to invite investigation. Interested readers are directed towards a recent systematic review and meta-synthesis from Murphy, Irfan, Barnett, Castledine and Enescu (2018).

need and homogeneity of client groups) make isolating improved client outcomes as a result of psychotherapists' personal therapy challenging (Sandell, et al., 2007).

Furthermore, research has focussed predominately on psychodynamic therapists (Macran & Shapiro, 1998), has largely overlooked clinical psychology (Wigg, Cushway, & Neal, 2011) and concentrates on therapy during training, despite evidence showing therapists continue to engage in personal therapy throughout their careers (Wiseman & Shefler, 2001).

Following Macran and Shapiro's (1998) recommendation for research to shift focus to the *process* of personal therapy for psychotherapists, recent research has assumed a predominately qualitative stance to understand *how* it influences professional development and practice. Nine qualitative papers exploring this topic were published from 2001-2011 (Ivey & Waldeck, 2014).

1.1.6 Rationale for current review.

Despite the overwhelming literature supporting personal therapy for psychotherapists, there is an inconvenient yet significant subset of therapists who experience negative effects from personal therapy. This is perhaps to be expected, as Atkinson highlights, "An intervention which is potent enough in its effects to bring about positive change can do the opposite: therapy can do harm" (2006, p.408).

1.1.6.1 Prevalence of negative effects of personal therapy for psychotherapists.

The prevalence of negative effects reported by psychotherapists as a result of personal therapy varies from conservative estimates of 1%, to more alarming rates of up to 40% (Macaskill, 1988l; Macaskill & Macaskill, 1999; Norcross, 1988b; Norcross & Guy, 2005; Orlinsky et al., 2005).

Documented negative effects include disruption to personal relationships, increased psychological distress, emotional withdrawal and disruption to clinical work (Macaskill & Macaskill, 1992; Macaskill, 1988).

1.1.6.2 Bias within the literature.

There is a stark bias within the literature to investigate, report and theorise the mechanisms underpinning *positive* effects of personal therapy for psychotherapists. There is a comparative persistent failure within the literature to robustly explore the nature of negative effects, the factors associated with them and their impact on clinical practice (Kumari, 2011; Wigg et al., 2011). This is supported in a recent review by Wigg,

Cushway, and Neal (2011), who remarked that negative effects of personal therapy for psychotherapists "were not fully explored" (p. 351) within the primary research.

Missed opportunities for balanced investigation are exemplified in Buckley, Karasu, and Charles' (1981) survey exploring long-term effects of psychotherapy for psychotherapists. Here the authors stated the prevalence of negative effects, but failed to report or perform analysis on qualitative data describing the nature of these effects, although this is clearly gathered (with examples given). The authors instead privileged positive outcomes of psychotherapy by including measures to intentionally capture the nature of these effects.

A further study by Williams et al. (1999) investigated counselling psychologists' experiences of personal therapy. They found negative effects of psychotherapy primarily related to difficulties with professional practice and development; and cited problems with placement, training, supervision, hampered development of theoretical orientation and impaired insight into professional issues. Despite the potential gravity of these effects, the authors minimised the importance of these findings; stating "Possibly these effects were not serious or lasting and may have been seen as part and parcel of the therapeutic process" (Williams, Coyle & Lyons, 1999, p. 552). Despite more than a quarter of participants citing negative effects, the authors failed to conduct any further analysis on this data, as "so few effects were reported as negative" (p. 551).

The above examples highlight a concerning lack of scientific scrutiny and inbuilt bias to reporting positive effects within the literature. Psychotherapists have an understandable investment in their profession, and may therefore be prejudiced towards over-estimating the value of therapy in research in this area (Bellows, 2007; Shapiro, 1976). Bias towards positive effects may, in part, also result from poor response rates to survey studies and self-selecting recruitment; with individuals who have had positive experiences of personal therapy potentially more likely to provide data compared to those who have had negative experiences and may feel less motivated to participate (Bellows, 2007; Macran & Shapiro, 1998).

Furthermore, negative effects of personal therapy for psychotherapists have historically been dismissed by many researchers as an expected and transient part of the therapy process, yet there is no known empirical data to support these claims. Garfield and Bergin (1971) for instance referred to the "usual turbulence attendant to being analysed" (p. 253), but failed to contextualise or support this statement.

1.1.6.3 Emerging need to explore negative effects of personal therapy.

Given that the limited research to date has shown that accessing personal therapy whilst delivering therapy can produce negative effects for psychotherapists' personal lives, and "deleterious" (Macaskill, 1988, p. 219) effects on their clinical practice, there is an ethical imperitive to explore the nature of adverse effects on therapists and the vulnerable clients they support. Research specifically exploring negative effects of personal therapy for psychotherapists has been advocated within the published literature (Daw & Joseph, 2007), and will help to redress the bias within the research to produce a more balanced understanding of this potentially powerful process (Kumari, 2017).

Understanding potential negative effects of personal therapy is perhaps even more important given the widespread nature of mandatory training therapy. Informed consideration of possible adverse effects is essential for therapy professions to exercise caution and awareness when advocating personal therapy to therapists and trainees. Identifying factors associated with negative outcomes may help practitioners/organisations to formulate and plan to minimise risk of these effects to protect the wellbeing of psychotherapists and their clients (Mohr, 1995). There is currently no guidance for practitioners in this area, as highlighted by Macaskill and Macaskill (1992).

1.1.7 Aims and scope of the review.

To the author's knowledge, no systematic reviews of the literature exploring negative effects of personal therapy for psychotherapists have been conducted in the English language. Systematic literature reviews are a reproducible and transparent approach to reviewing and synthesising outcomes from existing research (Booth, Papaioannou, & Sutton, 2012). Conducting such reviews is essential to identify and make sense of key research trends and outcomes from rapidly proliferating primary research to inform clinical practice; thereby ensuring clinical work adheres to the evidence base (Booth et al., 2012).

The current review aimed to address the highlighted gaps in the literature, and to identify and synthesise empirical research data to answer the following research questions:

1) What are the negative effects of personal therapy for psychotherapists?
2) What are the factors associated with negative effects of personal therapy for psychotherapists?

Within the scope of this review, 'negative effects' refer to negative *outcomes* resulting from personal therapy (to the clinician's personal life or professional practice, or outcomes for the clients they are working with) where the therapist is themselves a client,

negative *experiences* of personal therapy, and negative *aspects/features* of personal therapy (referring to wider issues such as ethical concerns). This includes perceived negative effects and experiences from the perspective of practitioners who have undergone personal therapy, or more objective measures of negative outcomes (for instance derived from quantitative data).

To be considered a negative effect, the data must have cited a deterioration or decline resulting from personal therapy or a negative/unhelpful experience; it did not refer to cases where personal therapy was ineffective or unsuccessful. The term 'personal therapy' refers to any mode of psychological therapy that the psychotherapist had engaged in, either as part of their training or outside of this, and for any reason. The term 'psychotherapist' refers to professionals who were trained in the delivery of psychological therapies and is used interchangeably with the term "therapist".

1.2 Method

1.2.1 Identification of literature.

1.2.1.1 Search strategy.

Initial scoping searches were performed using Delphis; an online search platform hosted by EBSCO and provided by the University of Southampton. Papers were identified through database searches and extensive reference searches of literature known to the author. The latter searches were necessary due to the bias within the literature to report positive effects of personal therapy for psychotherapists. Negative effects were often not cited within the title or abstract.

Four electronic databases, Scopus, PsychArticles, PsychInfo and the Cumulative Index of Nursing Allied Health Literature (CINAHL), were searched to identify papers for inclusion in the review.

Search terms were developed to capture three key elements of the first research question; 'negative effects', 'personal therapy' and 'psychotherapists', as summarised in Table 1. Developing sensitive terms to capture the concept of 'negative effects' proved challenging, as this could be described in a variety of ways in the literature. Terms frequently encountered in scoping searches of relevant literature were therefore chosen as these appeared most relevant to the research area. MESH terms were used in databases that employed a thesaurus function (all except Scopus) in addition to free text to increase the search depth.

Table 1. *Search terms entered into databases.*

	Negative effects	**Personal Therapy**	**Psychotherapists**
Search Terms	Risk*	"Personal psychotherapy"	Psychotherapist*
	Harm*	"Personal therapy"	Therapist*
	Danger*	"Individual therapy"	Psychologi*
	Negative*	"Personal analysis"	Psychoanalyst*
	Deleterious	DE "Personal therapy"	Counsel*
	Detriment*		DE Psychotherapists
	Ethic*		DE Therapists

An asterisk denotes truncation of term.*
Quotation marks highlight words searched as a phrase.
'DE' denotes a MESH term.

1.2.1.2 Eligibility criteria.

Papers identified through database searches and reference reading were screened to ensure they met eligibility criteria, summarised in Table 2. Studies were required to be empirical and to explore negative effects of personal therapy for psychotherapists (where the psychotherapist has been the client/recipient of personal therapy). The latter included *perceived* negative effects of personal therapy for psychotherapists where participants had engaged in personal therapy and were in an informed position to comment. Papers were required to be peer reviewed to ensure quality and scientific scrutiny (Gannon, 2001). Research from 1970 onwards was eligible for inclusion due to the limited research on this topic to date and continued relevance of studies from this time.

Quantitative, qualitative and mixed methods research designs were eligible for inclusion to ensure all available data could be captured given the embryonic nature of the research question[3]. Furthermore, this approach reflected the scope and evolution of research in this area. Case studies were excluded as they lack generalisability (Steinberg, 2015).

Quantitative studies were required to provide a full description (or analytically summarised account) of the negative effects of personal therapy for psychotherapists; i.e. it was not sufficient to simply state the prevalence of negative effects, or give examples of some of these effects. Qualitative studies were deemed to contain sufficient detail for

[3] Previous systematic reviews in this research area have set a precedent for including studies of multiple designs (Wigg et al., 2011)

inclusion if negative effects either formed or informed a theme or subtheme within the research.

Studies were included if the review author interpreted results of the research to show negative effects of personal therapy for psychotherapists, even if the original author did not interpret or discuss them as being negative. This was particularly important given the bias in the literature to dismiss negative effects. Any papers that did not meet the inclusion criteria were excluded.

Research included participants belonging to any psychotherapy profession, to any theoretical orientation, and with any reason for entering therapy (E.g. mandatory or voluntary, as part of training, to alleviate symptoms, for personal growth or professional development etc.). As the literature suggested psychotherapists frequently have therapy both during training and outside of training, studies involving both qualified and trainee practitioners were included.

Studies that informed the primary research question were examined to consider if they also informed the secondary research question. Research was deemed appropriate to answer the second research question if it explored factors that were found to be related to the occurrence of negative effects (either through statistical analysis or qualitative report).

Studies were excluded if they delivered second hand accounts of therapists' experiences of accessing therapy due to potential biases and errors in the accounts. Studies exploring psychotherapists' perceived risks of personal therapy where the psychotherapists surveyed had not themselves experienced personal therapy were excluded as their perceptions would be largely speculative.

Table 2. *Eligibility criteria for paper inclusion.*

Inclusion criteria	Exclusion criteria
• Research printed in the English language • Empirical research • Peer reviewed research • Research published from 1970 onwards • Quantitative, qualitative or mixed methods approaches • Quantitative studies provide a full description (or summarised account) of negative effects found • Negative effects to form or inform a theme or subtheme within qualitative papers • Research to explore/discuss negative effects of personal therapy for psychotherapists • Participants belonging to any psychotherapy profession • Participants belonging to any theoretical orientation	• Research not available in print in English • Research not empirical (E.g. reviews) • Research that has not been peer reviewed • Research published prior to 1970 • Quantitative studies that do not provide a full account of negative effects • Qualitative studies in which negative effects do not form or inform a theme/subtheme • Research that cites lack of effect of personal therapy, but no deterioration, harm or negative experience • Research that is related to, but does not discuss/explore negative effects of personal therapy for psychotherapists (E.g. deterrents to entering personal therapy) • Case studies • Studies citing second-hand accounts of psychotherapists experiences of personal therapy • Studies exploring negative effects of psychotherapy from the training institutes' perspectives • Studies exploring psychotherapists' perceived risks of personal therapy where the psychotherapy participants had not underdone personal therapy

1.2.2 Study selection.

Figure 1 shows the systematic approach used to screen and exclude papers. A total of 707 titles were initially screened for their relevance to the research question, with those deemed irrelevant or failing to meet the inclusion criteria excluded. The remaining 81 papers were then screened at the abstract level, leading to the exclusion of 44 papers. The remaining 37 papers were read in full, with final exclusions producing a total of 18 papers. Four papers contained data that had been split across multiple publications. These were recombined to the original two studies, as suggested by Booth et al. (2012), producing a total of 16 studies to be included in the review. Ten of these studies were identified through reference searches.

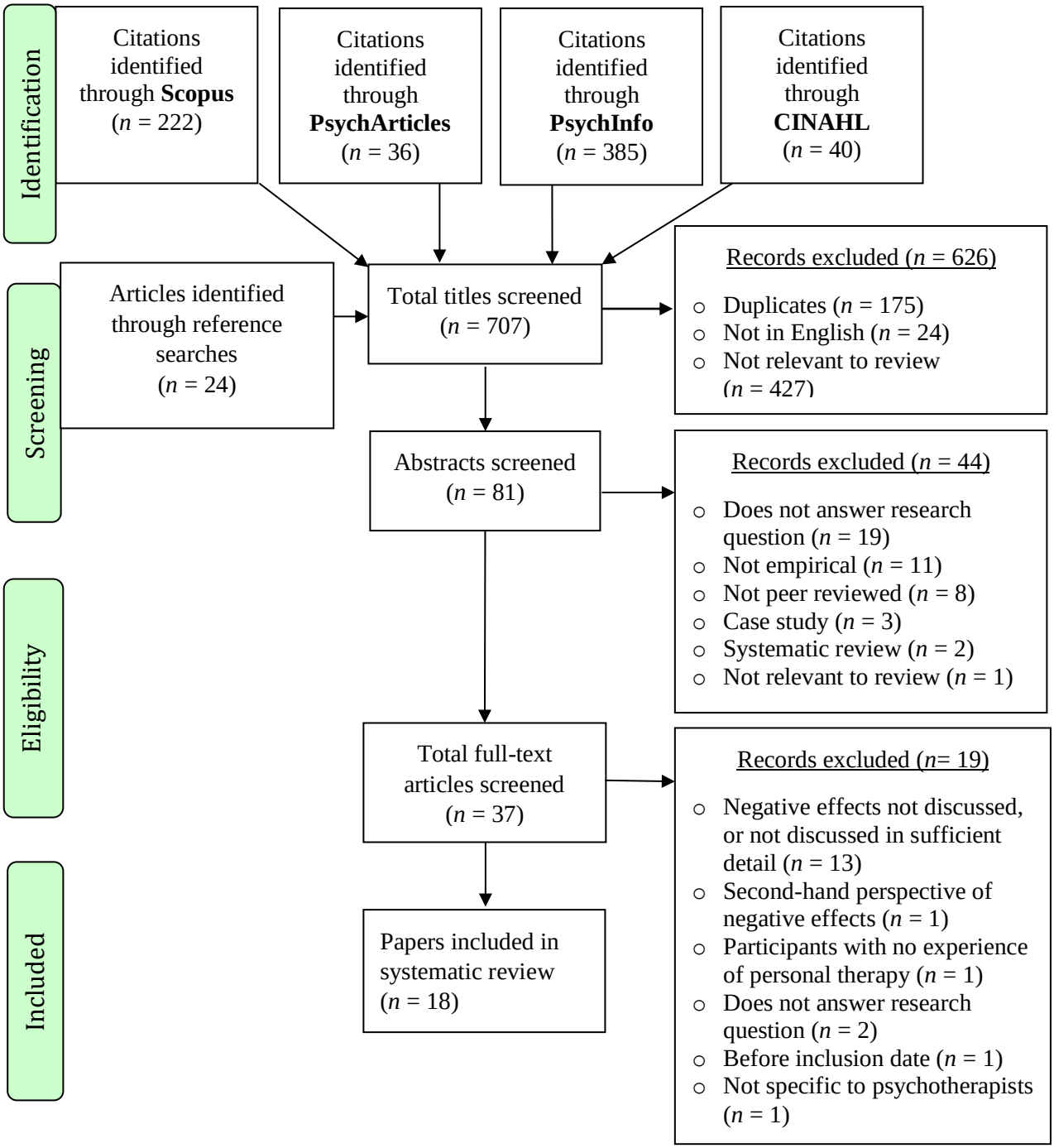

Figure 1. *Flowchart showing process of literature identification.*

1.2.3 Quality assessment.

The final selection of papers was critically appraised to assess their quality and thus internal and external validity (Booth et al., 2012). As the review included qualitative, quantitative and mixed methods research, three idiosyncratic quality assessment tools were developed, largely based upon quality checklists to ensure reproducible measurement. The Standard Quality Assessment Criteria for Evaluating Primary Research from a Variety of

Fields (QAC, Kmet, Lee, & Cook, 2004) formed the basis for the quantitative quality assessment tool, the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP QRP, Critical Appraisal Skills Programme, 2017) for qualitative research, and the Mixed Methods Appraisal Took (MMAT) for mixed methods studies (Pluye, et al., 2011).

Idiosyncratic items were added to the qualitative checklist to assess for reflexive consideration of whether researchers had biased the data analysis (Mays & Pope, 2000) and to check for inclusion of divergent data to show credibility as recommended by Silverman (2001).

Papers were not assigned a numerical quality score, as these do little to reduce subjectivity in the quality assessment process (Booth et al., 2012). They were instead categorised as methodologically weak, moderate or strong, based on the author's subjective rating, as detailed in Table 3.

1.2.4 Search validity.

To ensure reproducibility and transparency, an independent assessor reviewed and repeated elements of the literature selection process, including the search strategy and study selection process (against the eligibility criteria). They also repeated quality assessment for 13% of the review's final papers to ensure inter-rater reliability of quality ratings.

1.3 Data Extraction

Table 3 shows the aims, sample characteristics, design, measures, analysis and key findings that were extracted from each study included in the review. Many studies reported positive effects of personal therapy for psychotherapists however, to ensure data relevant to the research questions was included, only results pertaining to negative effects of personal therapy were extracted. Positive effects of personal therapy for therapists have already been reported extensively elsewhere within the literature.

1.3.1 Study characteristics.

Eight of the studies included in the review were qualitative, seven quantitative, and one a mixed method design. Of the quantitative studies, the majority were surveys (n = 4), two were experimental or quasi-experimental, and one was correlational.

Nine studies were conducted in the UK, compared to only four from North America, and one each from South Africa, Sweden and Israel. Most of the studies focus on psychotherapists' experiences of personal therapy (n = 13). Six studies specifically explored the experience and impact of personal therapy during professional training (with

some participants commenting retrospectively as qualified professionals), and five explored practitioners' experiences and perceived impact of personal therapy without specifying the context in which this was sought. One study sought to establish some of the variables associated with practitioners' experience of personal therapy, and a further study specifically explored personal therapy experiences which were perceived to be harmful. Two studies sought to establish whether therapists' personal therapy was related to client outcomes, and a final study explored the influence of personal therapy on the therapeutic relationship with clients.

Only 13 studies provided information regarding the gender of their participants, of which 12 had a female participant majority. Participants' ages were often omitted, but varied from younger than 25 to 65 years of age. Only three studies provided information regarding participant ethnicity, in which the majority of participants were Caucasian (67% to 88%).

Participant numbers varied widely from small scale qualitative studies (n = 5) to large scale surveys (n = 467). Participants were drawn from a range of psychotherapy professions, with some studies focussed on singular professions and others more broadly recruiting 'psychotherapists' with varied professional backgrounds. A number of professions were represented within the review, including clinical and counselling psychologists, psychiatrists, counsellors and social workers (directly providing therapy).

Theoretical orientation of participants included psychoanalytic/psychodynamic, Jungian, Gestalt, Humanistic, systemic, cognitive-behavioural and eclectic. Nine studies included therapists who were qualified at the time of participation, five specifically recruited trainee psychotherapists, and two did not specify. Eleven studies included participants for whom 100% of had engaged in personal therapy. Other studies included participants with varying personal therapy experience, ranging from 41 to 84% of the sample. Twelve studies omitted information regarding the orientation of personal therapy that participants had received. Psychodynamic/psychoanalytic was the dominating personal therapy orientation in the remaining studies, with 59% to 100% of participants describing this as the primary orientation of therapy in which they were a client.

Eight studies failed to provide information as to whether participants' personal therapy had been mandatory or voluntary. Personal therapy had been mandatory for 100% of participants in four of the studies, and was mandatory for between 13 to 84% of participants in the remaining four studies. Where data was available, the duration of

personal therapy participants received ranged from six months to 14 years, with the frequency of sessions and number of episodes varying widely.

1.3.2 Measures.

Garfield and Bergin (1971) used the Minnesota Multiphasic Personality Inventory (MMPI) as a measure of client and therapist pathology. Developed by Hathaway and McKinley (1942) for use in psychiatric settings, the MMPI is a broad test of personality and psychopathology containing ten subscales and three validity scales. Countless studies have demonstrated the external and internal validity of the measure over time (Butcher & Williams, 2009). Garfield and Bergin (1971) used the depression (D) and correction (K) subscales as measures of client change, and the D, Psychasthenia (Pt), Schizophrenia (Sc) and Barron's ego strength scale (Es) as estimates of therapist 'psychopathology'.

The Bulimic Investigatory Test, Edinburgh (BITE, Henderson & Freeman, 1987) measures attitudes towards food in clinical populations, and was used by Wheeler (1991) to ensure homogeneity of participants across multiple therapists. The measure originally showed satisfactory validity and reliability in two populations within it's original publication (Henderson & Freeman, 1987), and continues to demonstrate internal consistency and validity in more diverse, modern populations (Rueda-Jaimes, Camacho, & Rangel-Martínez-Villalba, 2008).

Wheeler (1991) used the Therapist Orientation Questionnaire to gather data regarding the theoretical orientation, qualifications and personal therapy experiences of therapist participants. As this measure was developed in an unpublished Master's project by Shapiro (1986), there is no available published data regarding it's reliability and validity, which Wheeler (1991) fails to acknowledge.

Wheeler (1991) also used the California Psychotherapeutic Alliance Scale (CALPAS, Marmar, Gaston, Gallagher & Thompson, 1987), which provides client and therapist measures of different dimensions of the therapeutic alliance to develop an overall estimate of it's strength. This was sourced by Wheeler (1991) as an unpublished document (as stated in the refererences). Although there is evidence to support the validity and reliability of a revised version of the measure, there is no available published data regarding the version Wheeler (1991) claimed to have used.

The General Symptom Index (GSI) of the Symptom Checklist-90 (SCL-90) was used by Sandell et al. (2006) to measure change in patients' distress across different stages of therapy. The SCL-90-R is a self-report scale that measures symptom severity across

nine subscales (Derogatis, Lipman, & Covi, 1973). GSI scores were shown to have good internal consistency within Sandell et al.'s (2006) study. Although it has been shown to have good internal consistency and descriminant validity, consensus has yet to be reached regarding the measure's underlying factor structure (Urban, Arrindell, Demetrovics, Unoka, & Timman, 2016).

Darongkamas et al. (1994) used the 28 item version of the self-report General Health Questionnaire (GHQ-28, Goldberg, 1978) as a measure of pschiatric difficulties (including subscales for depression, anxiety/insomnia, somatic symptoms and social dysfunction) (Sterling, 2011) amongst therapist participants. This version of the GHQ has undergone extensive testing of it's properties, and has consistently shown good validity in numerous settings and clinical populations (Sterling, 2011).

Participants in Wiseman and Shefler's (2001) study completed the Hebrew version of the Development of Psychotherapists Common Core Questionnaire (DPCCQ) as part of a separate project, and data was later made available to the authors. Developed by Orlinsky et al. (1999), the 370 item questionnaire explores psychotherapists' professional background, experience and elements of current practice. It was used by Wiseman and Shefler (2001) to capture participants' demographic information, work satisfaction and perceived therapist skill.

Rizq and Target (2010a & b) used the Adult Attachment Interview (AAI, Main & Goldwyn, 1998) and Reflective-Self Function Scale (RFS, Fonagy, Steele, Moran, Steele, & Higgitt, 1991). The AAI codes and categorises individuals' attachment function from discursive indicators within narrative accounts of childhood experiences (Jones-Mason, Allen, Hamilton, & Weiss, 2015), and has been shown to have good reliability and construct validity (George et al., 1996; cited in Jones-Mason et al., 2015). It is viewed as the "gold standard" (Jones-Mason et al., 2015, p. 429) of attachment assessment.

The RFS is used alongside the AAI to assess reflective function (RF); an individuals' ability to identify and understand mental states within others and themselves (Dimitrijević, Hanak, Dimitrijević, & Marjanović, 2017). This measure has also shown good reliability and validity across a number of studies (Fischer-Kern et al., 2010; cited in Dimitrijević et al., 2017). These measures were used by Rizq and Target (2010a & b) to explore how participants' AAI and RF classification influenced their experiences of personal therapy.

Table 3. *Data extracted from studies.*

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Darongkamas, Burton & Cushway, 1994 **Study 1**	Quantitative, survey. Research questions: 1) What percentage of therapists have had PT? 2) Are there any distinguishing characteristics for those with PT experience? 3) What are therapists' views of their PT experiences?	321 clinical psychologists. Recruited from district services departments. Random sampling. 60% female, 40% male. Mean age: 38.4 years. Clinical orientation: 41% CBT, 39% eclectic, 14% psychodynamic, 6% other. 41% had PT experience (of which 60% was past PT, 15% in PT for the first time, 15% in PT for a subsequent time). 1st PT episode: 16% pre-training, 30% during training, 54% post-training. 1st episode PT orientation: 64% psychodynamic, 2% CBT, 14% eclectic, 20% other. Experienced between 1-4 courses of PT. UK.	GHQ-28 and 2 idiosyncratic questionnaires which: 1) Captured information re work related factors; 2) Captured details and experience of PT (for pts with PT experience).	**Intervention:** N/A. **Analysis**: T-tests, correlations and multiple regression analysis. **Stress of PT:** 46% found PT moderately stressful, 26% a little stressful and 18% very stressful. Pts with PT experience reported sig. higher job stress than those with no PT, (t= 3.43, p <0.0007), more stress in doing psychotherapy (t= 2.82, p < 0.005), higher GHQ-28 scores (t= 3.76, p < 0.01), and approx. 3 times more sickness from work in the past 6 months (t= 2.78, p= <0.05). PT was a significant predictor of sickness days in multiple regression analysis with gender (F= 4.33, p <0.038), and marital status (F= 6.61, p < 0.011). **Timing of PT:** Pts having first time PT reported sig. more job stress than those without PT (Tukey HSD test, p < 0.001). Timing of PT was a significant predictor of GHQ-28 score (F= 7.72, p< 0.000). Pts having first time PT had significantly higher GHQ-28 scores than those whose without PT experience (Games-Howell, p< 0.01) and pts who's PT experience was in the past (Games-Howell, p< 0.05).	Large sample size aiding ecological validity. Incomplete analysis - 79% of pts had PT felt there was an interaction between PT and clinical work. This included "negative consequences" (p. 169), but these are not explored. Positive ways in which PT influenced clinical practice is discussed, demonstrating bias. **Quality**: Moderate.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Garfield & Bergin, 1971 **Study 2**	Quantitative, experimental. To explore PT of the therapist in relation to client outcome.	18 trainee psychotherapists (min. 1 year internship) treating 38 clients in a University clinic. Recruitment and sampling of participants not detailed. USA.	Therapist change score as measured by the: 1) MMPI D; 2) MMPI K; 3) Therapist Severity Rating Administered pre and post therapy. Measures of therapist psychopathology using the: 1) MMPI D, Pt, Sc and Es.	**Intervention:** IV= amount of PT of treating therapist, 3 levels; no PT experience (*n*=4), 80-175 hrs of PT (*n*=7), 200-450 hrs of PT (*n*=7). DV= patient change score. **Analysis**: Descriptive data of mean patient change as a function of therapists' PT, mean patient change as a function of therapist MMPI scores. **Results**: Clients treated by therapists with no prior PT showed greatest positive change across all outcome measures. Clients treated by therapists with 80-175 hours of PT showed greater patient change on two outcome measures (MMPI D and MMPI K) than clients treated by therapists with the most PT. Psychologically healthier therapists produce greater positive client change. No difference in amount of PT between therapists with more/less psychopathology.	Poorly defined rationale. Small sample, poor description of pt characteristics. No information re sampling/recruitment. Only 56% of therapists completed the MMPI. No tests of statistical significance or consideration of confounding variables. **Quality:** Poor.
Grunebaum, 1986 **Study 3**	Qualitative. To explore psychotherapists' experiences of harmful PT, and the features of this.	47 psychotherapists. 18 social workers, 14 psychologists, 10 psychiatrists, 5 'other'. 32 female, 15 male. Ages <25 to 50 years.	Idiosyncratic semi-structured interviews exploring subjective measure of harm.	**Intervention**: N/A. **Analysis**: Author and pt rated severity of harm: mild, moderate (duration of effects between 6-12 months) or severe (duration of effects >1 year) by. Anecdotal analysis of client accounts. **Results**: 49 harmful cases. No. of cases identified by the author/pts: None/mild harm (author= 4, pt= 10), moderate harm (author= 10, pt= 23), serious harm (author= 30, pt= 14), severe harm (author= 5, pt= 2).	Anecdotal; analysis lacks scientific rigour. Failure to explore all cases of pt harm.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Grunebaum, 1986 continued		Self-selecting sample (*n*=36) responding to adverts in professional newsletters looking to meet individuals with 'harmful psychotherapy' experiences. Identified following lectures delivered by the authors (*n*= 11). USA.		**Categories of harm:** *A) 18 Distant and rigid therapeutic relationships*: Ethical failures include breaches of confidentiality and consent. *B) 3 Explicitly sexual therapies*: Pts had been sexually intimate with their therapists (2 post-therapy). 1 pt paid for therapy with sex whilst acutely unwell. Therapists showed physical arousal in session. *D) 3 Multiple involvement in cults*: Pts engaged with their therapists as friends, lovers, colleagues and labourers. *E) 12 Residual cases:* Including unresolved financial disputes, therapist being demeaning of women and 'idiosyncratic problems'.	Author personally acquainted with 18 pts, introducing potential bias. **Quality**: Poor.
Ivey & Waldeck, 2014 **Study 4**	Qualitative. To explore how pts viewed and experienced mandatory PT; To explore pts' perceived impact of PT on their personal lives and professional development.	9 trainee clinical psychologists enrolled in a 2 year postgraduate degree. 7 female, 2 male. All pts had engaged in weekly mandatory PT for a min. of 1 year. Psychodynamic training orientation. Purposive sampling. South Africa.	Idiosyncratic semi-structured interview.	**Intervention**: N/A. **Analysis**: Inductive TA. **Results**: *Theme 'The ethical challenges of PT'*: Mandatory PT felt to breach professions' ethical code. Pts felt under-informed re the rationale for mandatory PT, and had insufficient opportunity to discuss their feelings around this, therefore felt their consent was not fully informed. *Subtheme 'A greater awareness of countertransference process'*: Preoccupation with own issues led to difficulty distinguishing between own and client's problems. *Subtheme 'Modelling'*: Pt felt inadequate compared to therapy. Therapist modelling contradicted students' training. *Theme 'Problematic aspects of mandatory PT concurrent with training'*: Pts described difficulty managing demands of PT and training, describing the experience as challenging and overwhelming.	Authors associated with the University from which pts were recruited. 1 author was a lecturer; potentially biasing participation and results. Authors show generally good reflexive awareness. Purposeful attempt to explore under-researched areas from previous studies. No information re recruitment. **Quality**: Moderate

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Kumari, 2011 **Study 5**	Qualitative. To explore trainee counselling psychologists' experiences of PT during training, opinions re mandatory PT, and perceived impact of PT on professional development and personal lives.	8 trainee UK counselling psychologists. 7 female, 1 male. 5 in their 2nd year of study, 3 in their 3rd year. 7 white British, 1 of Indian origin. All pts completed 40 hrs of mandatory PT, 2 completed additional hours of PT. Recruitment: 2nd and 3rd year trainees at University of Teesside emailed re study. Purposive sampling.	Semi-structured interviews.	**Intervention:** N/A. **Analysis**: IPA. **Results**: *Sub-theme 'Gaining first-hand experience of techniques and learning how not to do therapy'*: Pts discuss techniques they found unhelpful that they will not use in their own practice. *Major theme 'The stress of therapy'*: Pts describe PT as a source of stress. Includes subthemes *'Financial cost of therapy'*, *'The pressure of having to do 40 hours of therapy'*, *'The right time for therapy and going to therapy without specific problems'* and '*Therapy has the potential to disrupt clinical work'*.	Poor generalisability due to small, homogenous sample. Divergent cases not discussed. Do not discuss *how* themes were formed. Incomplete reflexivity; author doesn't consider the impact of conducting research with pts from the same training course and cohort. **Quality:** Moderate.
Macaskill & Macaskill, 1992 **Study 6**	Quantitative, survey. To explore whether US findings of PT experience are applicable to NHS UK trainee psychotherapists.	25 UK psychotherapy registrars. Recruitment: Questionnaires posted to all UK psychotherapy registrars. Total population purposive sampling. 22 courses psychanalytic in orientation, 2 eclectic, 1 Jungian. PT mandatory for 21 pts, optional for 4 pts. 16 pts in PT for >3 years, 8 pts in PT for 1.5-3 years, 1 pt in PT for <6 months.	Idiosyncratic questionnaire exploring pt views and experience of PT and location, duration and theoretical orientation of training institute.	**Intervention:** N/A, **Analysis**: Descriptive data of frequency and nature of negative effects of PT. **Results**: 38% reported PT to have a negative effect. 17% cited 2 or more negative effects. **Negative effects of PT**: 29% reported psychological distress, 13% marital/family distress, 13% reduced enthusiasm for PT and 8% avoidance of important life issues. 28.5% of pts studying at London training institutes report negative effects of PT, compared to 56% of trainees studying elsewhere in the UK. No statistical difference.	Addresses under-researched area of PT for UK psychotherapists. Descriptive only – no analysis. No tests of statistical significance. Small sample size and poor generalisability. Negative effects of PT described in discussion as "moderately low rate" (p.138) yet reported by 38% of sample. **Quality**: Moderate.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
McEwan & Duncan, 1993 **Study 7**	Quantitative, survey. To examine whether PT is being provided in an ethical manner by psychotherapist graduate training institutes, and to explore the clinicians' experiences of PT.	185 clinical and counselling psychologists. 47% in their forties. 56% male, 44% female. Doctoral qualification 66%. PT during training 41%, of which 46% was mandatory, 13 years mean experience. Purposive sampling of clinical and counselling psychologists from the Canadian College of Psychologists. Canada.	**Questionnaire**: Idiosyncratic questionnaire with 3 sections exploring: 1) Trainees' attitudes towards PT; 2) Ethical aspects of PT; 3) Demographic information. Items scored on 4 point Likert scale	**Intervention:** N/A. **Analysis:** Descriptive. **Results:** For pts who had PT during training*: 46% not given option to refuse PT, 62% had PT regardless of need, 41% not informed of benefits/risks of PT, 66% felt process not adequately monitored, 62% not screened for PT suitability, 80% had dual relationship with therapist, 48% no attention to dual relationships, 62% no follow-up care available. Frequency of perceived risks of PT**: Ethical problems (dual relationships 49, students' safety while in PT 33, effect on client from being forced into therapy 23, unnecessary therapy unwise 22), general risks of PT for any client (poor therapist 44, inappropriate/poorly conducted therapy 19, other 37), harmful to therapist development (stress 18, may drop out 17, poor role model indoctrination 8, over-generalisation of own experience as client 6).	Descriptive only – no analysis. Reports the 'most cited' perceived risks of PT, therefore lacks comprehensiveness. Many perceived risks of PT included ethical issues. Pts responses may have been biased by being asked to complete a questionnaire focussing on ethical aspects of PT. **Quality**: Moderate.
Pope & Tabachnick (1994) **Study 8**	Quantitative, survey. Aimed to: 1) Gather data re therapists' PT use and experiences; 2) Explore prevalence and perception of PT by therapists;	476 psychologists. Recruitment: Questionnaire posted to a random sample of APA Division 12, 17, 29 & 42 members. 52.3% female, 47.3% male, 17.2% aged <40, 42.6% aged 41-50, 34.2% aged >50. USA.	Idiosyncratic questionnaire.	**Intervention:** N/A. **Analysis:** ANOVA, factor analysis and MANOVA. **Results:** 20.1% of pts described PT as 'somewhat harmful' and 2.3% as 'very/exceptionally' harmful. 25 categories of harm and 144 causes of harm found. Top 5 causes and frequency of harm: therapists sexual/attempted sexual acts towards pts (16), therapist incompetence (13), emotionally abusive therapist (12), therapist failure to understand patient (11), dual relationships/boundary violations (10).	Adjusted fisher's criterion to 0.01 to account for heterogeneity and unequal sample sizes. Full description of client demographics. Robust statistical analysis from survey results. Large participant number. **Quality**: Strong.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Pope & Tabachnick (1994) continued	3) Explore therapists' opinions re mandatory PT, and benefits and harm from PT.	400 (84%) pts had experience of PT, 100 pts currently in PT. Median time in PT 4 years. Median age for starting PT 26 years. USA.		Pts who rated PT as harmful engaged in PT for longer (*M*= 6.7 years) than those who did not (*M*= 4.57), *F*(1, 386)= 20.33, n^2= .05. Factor analysis of PT experiences produced 3 factors: 1) "Therapist unkindness/error', 2) 'Therapist sexual material', 3) 'Patient sexual material'. Pts who found PT harmful were more likely to score on items related to all 3 factors. Pts in therapy for longer rated more therapist unkindness/error (*ft*= 0.278), *F*(l, 366)= 38.27, and more of their own sexual material in PT (0= 0.398), *F*(l, 366)= 78.45.	
Rake & Paley, 2009 **Study 9**	Qualitative. To explore how PT influences therapists' clinical practice.	8 therapists. 6 female, 2 male. Various professions. Mean experience since qualification 10.62 years. Clinical orientation: 3 psychodynamic, 3 Gestalt, 1 Humanistic, 1 systemic. Pts had between 2-5 episodes of PT, varying from 6 months to 10 years. 4 pts currently in PT. Purposive sampling. Recruited from an NHS psychological therapies service. UK.	Idiosyncratic semi-structured interview exploring: 1) Helpful and unhelpful aspects of PT; 2) Impact of PT on clinical practice; 3) Impact of the therapist in PT.	**Intervention**: N/A. **Analysis**: IPA. **Results**: *Master theme 'I know myself much better'*: Pts describe the distressing emotional impact of PT and destabilising experience of PT when working concurrently as a therapist. *Master theme 3 'A very dissolving process'*: Unhelpful experiences of PT included the therapists' challenging manner and approach. Some pts disagreed felt their therapist didn't understand their issues, and made ill-judged remarks producing a lingering emotional responses in pts. Pts described a 'destabilizing' effect of PT which was felt to be 'overly harmful'. PT during training was difficult and had a negative impact on pt relationships due to pts being preoccupied with their own issues.	Authors show intent to explore under-researched negative effects of PT. 1 researcher worked in the service from which pts were recruited, potentially biasing participation and accounts of PT. Do not provide details of number of pts for which PT was mandatory. Includes convergent and divergent cases. **Quality**: Strong.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Rizq & Target, 2008a and 2008b **Study 10**	Qualitative. To investigate how counselling psychologists view the significance of PT in their training and therapeutic practice.	9 experienced counselling psychologists. 6 female, 3 male. Aged 42-65. PT experience between 15 months to 14 years. Snowball purposive sampling, recruited by initial contact with 2 individuals from the Division of Counselling Psychology. UK.	Idiosyncratic semi-structured interview exploring: 1) Experience of training and pt background; 2) Views of PT during training; 3) Biographic information.	**Intervention**: N/A. **Analysis**: IPA. **Results**: *Subtheme 'Seeing the client in the self'*: Pts felt 'scrutinised' by their therapist, and found it hard to change from therapist to patient roles. *Subtheme 'Seeing the self in the client: distinguishing between self and client issues':* Increased ability to recognise aspects of themselves in their clients led to difficulties differentiating their own and their clients' problems for some pts. *Master theme 'PT provides an arena for intense self-experiences'*: Intense emotional experiences in PT were experienced as dangerous and overwhelming by some, lead to a sense of 'psychological danger' and a need to establish boundaries and psychological safety.	Authors claim there's a "dearth of negative views on personal therapy" (p.148, 2008a). Potentially biased interpretation. Inclusion of convergent and divergent cases. Thorough information regarding formation of themes, and inclusion of independent quality audit. **Quality**: Moderate.
Rizq & Target, 2010a and 2010b **Study 11**	Qualitatively driven mixed methods study. To explore how psychologists' attachment status and reflective function levels interconnect with the way in which they experience PT.	12 counselling psychologists. 3-7 years qualified experience. 9 female, 3 male. Aged 35-65 years. 10 white Caucasian, 1 Asian, 1 black Afro-Caribbean. 9 had PT prior to training, 3 had the minimum mandatory 40 hours of PT.	AAI, Reflective Self Function Scale, semi-structured interview: 1) Background information; 2) Training experiences; 3) PT experiences; 4) Influence of PT on clinical practice;	**Intervention**: N/A. **Analysis**: AAI coding of attachment classification. IPA and reflective function coding of semi-structured interviews. Integration of qualitative and quantitative data; IPA themes colour coded against attachment and reflective function status. **Results**: *Subtheme 'Acknowledging and identifying with the self in the client'*: Some pts experienced their therapist as 'intrusive' and 'pushy'. Authors suggest reluctance to fully disclose in PT is related to lower RF. *Subtheme 'Working with vs. avoiding process issues and difficulties'*: Evidence of over-generalisation of own experience. Pts with lower	Independent audit of initial analysis. Addresses important, under-researched area exploring factors associated with PT experience. At time of interviews researcher was blind to AAI results, reducing potential for bias. Consideration given to the way in which the researcher's own

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Rizq & Target, 2010a and 2010b continued		Orientations of PT: psychoanalytic, gestalt, CBT, existential. UK.	5) Views of PT during training.	reflective function were more likely to avoid difficult issues and thus gain less benefit from PT. *Subtheme 'Ensuring emotional safety'*: Pts held concerns about trust, safety and emotional control in PT. Insecurely attached pts demonstrated more caution. Pts felt anger and frustration at mandatory nature of PT. *Master theme 'Struggling with ambivalent feelings'*: Many felt a power imbalance and psychological threat from PT. *Subtheme 'Disappointment and disillusion'*: Pts felt disappointed with poorly skilled therapists, insecurely attached pts felt a more global sense of disappointment. *Subtheme 'Experiencing the therapist as parent':* Pts describe inappropriate therapist behaviour. Insecurely attached pts reported more anger and disappointment than securely attached pts.	RF and attachment status influenced interviews and ultimate data collected. No statistical analysis of difference in securely and insecurely attached pts account of PT. Conclusions based on face valid trends. **Quality**: Strong.
Sandell et al., 2006 **Study 12**	Quantitative, quasi-experimental. To explore the relationship between training PT and clients' benefits from psychoanalytic therapy.	167 Swedish therapists (reduced to 143). 76% female, mean age 54.2 years. 77% psychologists, 10% social workers. 10 years mean experience. Mean duration of training PT 10 years. PT orientation: 59% psychoanalysis, 33% psychotherapy, 4% group. 327 patients (reduced to 264): 77% female, 23% male. Mean age 38.9 years. Recruited by posting questionnaires to clients accessing subsidized treatment. Purposive sampling.	GSI of the SCL-90 as a measure of patient change.	**Intervention:** 3 treatment groups (pre-treatment, peri-treatment, post-treatment) and 3 panels, producing 9 groups on a stage scale (reduced to 8 due to attrition). **Analysis**: Nonparametric latent class analysis to cluster therapists on the basis of patients' repeated self-ratings across each level of the stage scale. **Results**: Patient change was highest among cases with therapists who had training therapies of 7 or 8 years duration (b= -0.081) and lowest among cases with therapists with training therapy durations of 13 or 14 years (b= 0.009). The relationship between therapists training therapy duration and patient outcome was curvilinear.	No demographic data for final pt number. Accounted for confounding variables in analysis. Therapist training therapy accounted for only 5% in therapist variance. Poor generalisation - over-representation of psychoanalysts. Repeated analysis; increased likelihood of Type 1 error. **Quality**: Moderate.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Von Haenisch, 2011 **Study 13**	Qualitative. To explore the influence of PT on the personal and professional development of trainee counsellors at Diploma level.	6 qualified UK counsellors. 4 female, aged 40-55 years. 4 white British, 1 white European/Continental, 1 British-Indian. 5 humanistic training, 1 integrative. 1-6 years post qualification experience. Purposive sampling. Recruited through discussion and letters.	Semi-structured interview.	**Intervention**: N/A. **Analysis**: IPA. **Results**: *Domain 1 'The impact of the compulsory nature of PT during training'*: Negative aspects included 1) Previous PT hours ignored, 2) PT feels repetitive 3) Pressure (feeling coerced into PT, financial and time management pressures). *Domain 2 The influence of PT on personal development'*: Pts describe the process of PT emotionally challenging painful feelings.	All pts knew the researcher personally, introducing potential bias. Author doesn't discuss this. Author lacks experience in conducting research. Small sample size; limited generalisability. **Quality**: Poor.
Wheeler, 1991 **Study 14**	Quantitative, correlational. To explore the relationship between counsellor orientation and therapeutic alliance with clients with EDs.	25 student counsellors. Clinical orientation: Predominately psychodynamic; psychodynamic and humanistic, or humanistic. Purposive sampling. Questionnaires posted to BASC members. UK.	Therapist Orientation Questionnaire, B.I.T.E, CALPAS.	**Intervention:** N/A, **Analysis**: Correlation. **Results**: Therapist PT correlated negatively with therapist measure of therapeutic alliance (-0.609), and clients' measure of the therapeutic alliance (-0.321).	Poor explanation of study rationale; Lacks descriptive information. Incomplete statistical reporting (*p* values not reported) Use of non-validated measures. Incomplete detail re sampling method and poor response rate. **Quality**: Poor.
Wilson, Weatherhead & Davies, 2015	Qualitative. To explore pts' experiences of PT during training, and its perceived impact on personal and professional development.	10 clinical psychologists. 100% female, mean time since qualification: 2.85 years. Mean PT sessions: 82. PT orientation: 3 integrative, 1 CAT, 6 psychodynamic.	Idiosyncratic interview.	**Intervention:** N/A. **Analysis**: Narrative analysis. **Results**: *Chapter 1 'Being a trainee'*: Pts report anger at mandatory nature of PT and the difficult cost of PT. *Chapter 2 'Stigma of therapy'*: Pts felt PT indicated weakness, feared judgement from others and felt their professional competence may be questioned. Pts felt that they shouldn't need PT due to their profession.	Addresses under researched area. Good awareness of reflexivity. All female sample, therefore limited generalisability.

Author and date	Study design and aims	Sample characteristics and recruitment	Measures and questionnaires	Intervention, analysis and key findings	Quality, strengths and weaknesses
Study 15 Wilson, Weatherhead & Davies continued		Recruitment: UK training institutions requested to forward study information to former trainees from 2002 onwards. Purposive sampling. UK.		*Chapter 3 'The therapy process - Scary but exciting'*: Pts felt difficult emotions during PT, and felt 'open and vulnerable'. Difficult aspects included problems with their therapist, fear of being judged for their thoughts, needing to be a good client, deterioration in sleep, mood and anxiety, and dangers of incomplete therapy. *Chapter 4 'Impact of therapy'*: Most pts discussed changing their clinical practice to replicate what worked for them in PT.	Does not explore divergent cases. **Quality**: Strong
Wiseman & Shefler, 2001 **Study 16**	Qualitative. To explore how psychoanalytical therapists experience and describe their PT, and the impact of PT on personal and professional development.	5 experienced psychoanalytically orientated therapists. 3 female, 2 male. 4 clinical psychologists, 1 psychiatrist. Personal psychoanalysis was mandatory for 80% of pts. 100% of pts had been in PT; 3 were currently in PT. Aged 40-50 years. Mean post-qualification experience 17.2 years. Purposive sampling, Israel.	DPCCQ (Hebrew version)	**Intervention**: N/A. **Analysis**: Narrative analysis, producing domains. **Results**: *Subcategory 'Shifting from the patient role to the therapist role'*: 1 pt discusses difficulty shifting from role as patient to therapist. They feel preoccupied with their own material, which makes it harder to attend to their clients and describes having to "pretend to listen" (p. 135).	Sampling method (selecting pts by reputation) introduces potential bias. No information re recruitment. Biased interpretation: Authors dismiss significance of a pt needing to 'pretend to listen' to their client due to preoccupation with own PT. **Quality**: Moderate.

**Whilst eligibility criteria required the nature of negative effects of personal therapy to be fully detailed for inclusion, this study was an exception. The authors coded the most commonly reported perceived risks of personal therapy for future therapists (thus not giving an exhaustive list of negative effects). This was deemed suitable for inclusion as the authors give equal attention to reporting the positive and negative effects of personal therapy. **Although the authors present results of the perceived risks of participating in future therapy combined for participants who had and had not undergone personal therapy during training, chi-square analyses on the four most commonly cited perceived risks for each of these subgroups (those who had received personal therapy during training and those who had not) concluded both groups most frequently cited the same four risks. The authors therefore conclude that perceived risks of personal therapy were not influenced by participants' experience of personal therapy.*

*Abbreviations: **Study Aims:** EDs = Eating disorders. **Sample characteristics**: APA = American Psychological Society, APA Division 12 = Division of Clinical Psychology, APA Division 17 = Division of Counselling Psychology, APA Division 29 = Division of Psychotherapy, APA Division 42 = Division of Psychologists in Independent Practice), BASC = British Association of Student Counsellors. CAT = Cognitive Analytic Therapy, CBT = cognitive behavioural therapy, PT = personal therapy, pt/s = participant/s. **Intervention**: DV = Dependent Variable, IV = Independent Variable, N/A = Not Applicable, RF = Reflective Function. **Measures**: AAI = Adult Attachment Interview, B.I.T.E = Bulimic Investigatory Test Edinburgh, CALPAS = California Psychotherapeutic Alliance Scale, DQCCP = Development of Psychotherapists Common Core Questionnaire, GHQ-28 = General Health Questionnaire, GSI = General Symptom Index, MMPI D = Depression scale of the Minnesota Multiphasic Personality Scale, MMPI Es = Barron ego strength scale of the Minnesota Multiphasic Personality Scale, MMPI K = Correction scale of the Minnesota Multiphasic Personality Scale, MMPI Pt = Psychasthenia scale of the Minnesota Multiphasic Personality Scale, MMPI Sc = Schizophrenia subscale of the Minnesota Multiphasic Personality Scale, SCL-90 = The Symptom Checklist-90. **Analysis and key findings**: IPA = Interpretative Phenomenological Analysis, RF = Reflective function, TA = Thematic analysis.*

1.4 Discussion

1.4.1 Interpretation of themes from the data.

Data was synthesised using a traditional narrative approach, and superordinate themes were created on the basis of their semantic similarity. Given the unexpectedly large volume of data, only the most salient findings could be presented. Data was included on the basis of frequency of occurrence within the literature, its significance to the research question (and ultimately the profession) and the quality of the study from which it was extracted.

The main findings have been categorised into two superordinate themes '*Negative effects of personal therapy for psychotherapists*' and '*Variables associated with negative effects of personal therapy for psychotherapists*'.

1.4.2 Negative effects of personal therapy for psychotherapists.

1.4.2.1 Emotional and psychological burden.

Despite claims that personal therapy eases stress in the therapist role (Macran & Shapiro, 1998), stress featured as a negative effect of personal therapy in seven papers (1, 4, 5, 6, 7, 13 & 15).

Twenty six percent of qualified clinical psychologists from Darongkamas' (2014) study found personal therapy to be 'a little' stressful, 46% found it 'moderately' stressful and 16% 'very' stressful. Only 8% of participants reported no stress from the process. Stress was perceived as a risk of therapy by 10% of 184 trainee clinical and counselling psychologists in McEwan & Duncan's (1994) study, which the authors related to the trainees' student role. Participants from Ivey and Waldeck's (2014) qualitative study described managing simultaneous training and therapy demands as 'stressful', 'demanding' and overwhelming.

The financial cost of personal therapy and time pressures that it imposes were cited as causes of stress in five studies (4, 5, 7, 13 & 15), and comprised separate themes within Kumari's (2011) study of mandatory personal therapy amongst trainee counselling psychologists. Financial and time pressures may be exacerbated by many trainees' need to work additional hours to supplement the cost of mandatory therapy (Kumari, 2011), and by refusal of many training institutes to acknowledge therapy hours accrued prior to professional training (Von Haenisch, 2011). In the wider literature, Mearns, Dryden, McLeod, and Thorne (1998) described the requirement for mandatory personal therapy to be financed by trainees as a 'financial scam'.

Psychological distress from personal therapy was reported by many studies within the review, which is perhaps unsurprising given the often difficult content processed. In two papers however (6 & 8), the nature and extent of distress was perceived to be excessive. Fifty one percent of Macaskill and Macaskill's (1992) psychotherapy trainees experienced psychological distress from personal therapy. Twenty nine percent considered this to be a negative effect from therapy; culminating into periods of depression for some trainees. Two psychologists in Pope and Tabachnick's (1994) study reported that the most harmful aspect of their therapy was the "undue and nontherapeutic emotional turmoil" (p. 250) created by their therapist.

The exposing and intense experience of personal therapy produced a visceral sense of psychological danger/threat for participants in two studies (10 & 11). Rizq and Target (2010b) described a need for participants to establish emotional control and safety in the therapy process. As this theme arose from work by the same authors, there may be potential for biased interpretation to recreate findings across studies. However there is support for this subtheme in wider research in Moller, Timms and Alilovic's (2009) study, in which trainee clinical and counselling psychologists likened the ominous anticipation at engaging in personal therapy to "opening Pandora's box" (p. 379).

The majority of participants in Wilson et al.'s (2015) study felt stigma and shame at accessing personal therapy. They held concerns that it signified weakness, reflected poorly on their professional competence and feared judgement from their training faculty and therapist.

Personal therapy produced a sense of personal failure for participants in three papers (3, 4 & 11). Grunebaum's (1986) study of 47 psychotherapists' harmful psychotherapy experiences found some therapists blamed themselves for perceived failures. Others' sense of failure emanated from feeling incompetent compared to their therapist (Ivey & Waldeck, 2014). Feeling competitive with ones' therapist was found to significantly correlate to participants' experience of harmful personal therapy in a study by Buckley et al (1981), not included within this review.

1.4.2.2 Negative impact on therapists' personal relationships.

Personal therapy negatively impacted psychotherapists' personal relationships in five papers (3, 4, 5, 6 & 9). 13% of participants in Macaskill and Macaskill's (1992) study reported significant family or marital distress from personal therapy. For some, interpersonal difficulties arose as a result of working additional hours to fund therapy (Kumari, 2011).

Others described how increased self-refection and personal change as a result of therapy placed pressure on relationships. Participants described how preoccupation with their own difficulties throughout the process impacted on relationships (Macaskill & Macaskill, 1992; Rake & Paley, 2009), and led some to avoid important personal issues. In an extreme example of harm, one participant from Grunebaum's (1986) study reported impaired relationships with men following a sexual relationship with her therapist. Outside of this review, Buckley et al. (1981) also found that personal therapy had a deleterious effect on psychotherapists' personal relationships.

1.4.2.3 Disruption to the process and outcomes of clinical practice.

Participants from four papers felt that the emotionally destabilising process of personal therapy led to preoccupation with their own difficulties and disrupted their ability to attend to their clients (4, 5, 9 & 16). Participants described having to pretend to listen to their patients (Wiseman & Shefler, 2001), feeling that their judgement was impaired (Rake & Paley, 2009), and being "emotionally unavailable" to clients (Kumari, 2011, p. 226). The moderate to strong quality of these studies adds credence to their findings.

Three of these studies involved trainee therapists (4, 5 & 16). Previous reviews have concluded that personal therapy may have a detrimental impact on client work for *inexperienced* therapists due to aforementioned difficulties with preoccupation (Macaskill, 1988; Macran & Shapiro, 1998). Given the prevalence of mandated therapy whilst training, the effect of such destabilisation could be vast. Ivey and Waldeck (2014) suggested that trainee therapists' personal therapy is complicated by the additional dimension of learning about the therapy process whilst exploring personal issues. Rake and Paley's (2009) study of *qualified* therapists however, suggested there is potential for similar difficulties to be found amongst more experienced therapists.

Reviews have previously concluded that personal therapy cultivates therapists' ability to develop therapeutic relationships (Macran & Shapiro, 1998). However Wheeler (1991) found trainee counsellors' personal therapy significantly, negatively correlated with practitioners' measures of the therapeutic alliance, and clients' measures also, although the author failed to confirm whether the latter relationship was significant. Wheeler (1991) suggested that therapists with more personal therapy hold higher expectations of the therapeutic relationship, and are therefore inclined to underestimate their own. The poor quality of this study (reflected through incomplete statistical reporting and use of measures of unknown validity and reliability) limits the significance of these findings. In research outside of this review Strupp (1958) found empathy ratings to be lower amongst analysed

than non-analysed therapists in a mock interview. Given the importance of empathy in the development of the therapeutic alliance and the significance of the therapeutic relationship in predicting therapy outcome (Lambert & Barley, 2001), these findings are interesting.

Two studies (2 & 12) found psychotherapist personal therapy negatively related to client outcome. This is perhaps unsurprising, given that personal therapy has been shown to limit therapists' ability to attend to clients and engender a positive therapeutic alliance.

Garfield and Bergin's (1971) study found patients treated by trainee therapists with no prior personal therapy showed the greatest therapeutic change across three outcomes. Longer duration of personal therapy was *not* related to increased psychological 'disturbance' of the therapist, therefore poorer client outcomes amongst this therapist group could not be attributed to therapist 'pathology'. The study's methodological flaws and omission of statistical tests of significance limit the significance of its findings.

Sandell et al. (2006) found a curvilinear relationship between client change in long-term psychoanalysis or psychotherapy and therapists' length of training therapy. Positive improvement was greatest amongst clients of therapists with seven to eight years of personal therapy experience, and poorest amongst clients of therapists who had the longest personal therapy (13-14 years), with these clients even showing non-significant deterioration. As the latter class of therapists mainly consisted of therapists whose training therapy had been psychoanalysis, the authors suggested that longer personal analysis strengthens the therapists' identification with the psychoanalytic *approach,* producing negative transfer. The therapist thereby adopts psychoanalytic approaches when using different theoretical models; impairing clinical effectiveness (Sandell et al., 2006).

Additionally, three studies found personal therapy led to therapists having difficulty differentiating between their own and their clients' problems by improving their capacity to recognise aspects of themselves within their clients. (4, 10 & 11). This led to confusion (Ivey & Waldeck, 2014) and over-identification with clients' difficulties (Rizq & Target, 2008a) for some. This suggests previous conclusions by Macran et al. (1999) that personal therapy supports therapists in distinguishing their own versus their clients' psychological material is incomplete.

1.4.2.4 Negative impact on therapist development.

Although learning from the modelling of their therapist is a proposed benefit from personal therapy (Macran & Shapiro, 1998), evidence from two studies suggests personal therapy could lead to poor role model indoctrination (4 & 7). Participants who observed

their therapist deviating from protocol felt it granted them "permission to try little things that didn't adhere to the frame" (Ivey & Waldeck, 2014, p. 92). Macran et al. (1999) reported that it is potentially unhelpful for trainees' therapists to deviate from trainees' academic training; potentially disrupting trainees' understanding of treatment fidelity.[4]

Five studies suggested that therapists over-generalise their own therapy experiences, and make changes to their practice to replicate or avoid helpful/unhelpful elements (5, 7, 9, 11 & 15). This indicates failure to work in a person-centred way and mistakenly assumes that their clients would have similar reactions to these experiences (Wilson et al., 2015); potentially depriving clients of valuable therapeutic techniques. In a particularly alarming example, one trainee therapist generalised his own experiences of therapy to conclude that the therapeutic relationship is of little importance (Rizq & Target, 2010b).

Four papers described therapists being disappointed and disillusioned with the therapy process after their own personal therapy (3, 6, 10 & 11). This may have implications for therapists' future practice, as Macaskill and Macaskill (1992) found four participants felt a decrease in enthusiasm for therapy after engaging in personal therapy. The therapeutic relationship is crucial in supporting clients to trust the therapy process (Bordin, 1979; cited in Ardito & Rabellino, 2011). Therapists' reduced faith in therapy may therefore limit their clients' investment in the therapy process. Ironically, strengthened belief in the value of personal therapy is often advocated as a positive outcome of personal therapy for psychotherapists (Macran & Shapiro, 1998).

1.4.2.5 Negative experiences or harm arising from ethical violations.

Three papers found evidence of dual relationships in therapists' personal therapy (3, 7 & 8) despite this being actively discouraged in ethical guidance from the American Psychological Association (APA, 2002). For some, this included having a therapist who was also a member of their academic faculty or even a fellow student (McEwan & Duncan, 1993). In cases where the therapist belonged to the academic faculty in McEwan and Duncan's (1993) study, no attempts were made to manage issues arising from the dual relationship in 48% of cases. Grunebaum (1986) identified three participants that became involved with their therapist as friends, lovers and supervisees, after which they reported relational difficulties and being fearful of future personal therapy. Given the potential for

[4] For review of the importance of treatment fidelity within psychological interventions, interested readers are directed to a systematic review by Prowse and Nagel (2015).

dual relationships to be exploitative and impair clinical judgment (Borys & Pope, 1989), such widespread occurrence is worrying.

There was a narrative within five studies which suggested that participants felt compelled or coerced into therapy (4, 7, 11, 13 &15).

Some trainees experienced negative treatment if they did not engage in therapy, with some faculty members refusing to speak to them (McEwan & Duncan, 1993). Mandatory therapy was elsewhere felt to be a violation or attack (Ivey & Waldeck, 2014), and a demonstration of the faculty's power (Rizq & Target, 2010b, p. 352); leading some to feel that their autonomy had been defiled (Rizq & Target, 2010b). These findings are consistent in studies occurring across time, country and culture (Canada, South Africa and the UK respectively). This theme emerged from studies in which many participants had experienced mandatory personal therapy, but also from those including participants who had voluntary or mandatory therapy.

Three papers found evidence that therapists were not adequately informed of the risks/benefits of undertaking personal therapy (4, 7 & 11), leading one to question whether participants' consent to engage in personal therapy was truly informed. Evidence of informed consent being violated was found in two studies (3 & 8). This includes one therapist quoting a client within their published work without the client's consent, causing subsequent relational difficulties when the material was read by the client's spouse (Grunebaum, 1986).

Three papers evidenced participant concerns over breaches of confidentiality in personal therapy (7, 8 & 11). Of the participants who had personal therapy experience in Pope and Tabachnick's (1994) study, 10.3% reported that their rights to confidentiality had been violated. Trainee therapists from Rizq and Target's (2010b) study reported concerns over details of their therapy being relayed back to their training institution, although there was no evidence to suggest this had occurred.

1.4.2.6 Negative experiences or harm arising from therapist factors.

Shocking ethical violations by psychotherapists' therapists were reported in two papers (3 & 8). An array of inappropriate sexual behaviour was documented within Pope and Tabachnick's (1994) study exploring psychologists' experiences of therapy, including therapists showing arousal in session, disclosing their attraction to clients, discussing sexual issues in an inappropriate way, and touching clients in a sexual manner. Sexual acts or attempted sexual acts were cited as the most serious cause of harm to clients in therapy.

Sexually inappropriate contact between psychotherapists and their therapist was again common in Grunebaum's (1986) study. One vulnerable and acutely unwell therapist paid for her therapy through sex with her therapist, and three other participants engaged in sexual relationships with their therapist (two post-therapy termination). The leading therapists' abuse of power within these relationships is clear, as one participant felt like a "puppet" (p. 172) when her therapist initiated intimacy. The poor quality of Grunebaum's (1986) largely anecdotal study limits the generalisability of this work. However findings from this study are corroborated by data from Pope and Tabachnick's (1994) high quality study, adding credence to their significance.

Three papers found evidence of therapists pressuring clients to discuss issues that the clients did not feel ready to explore (8, 10 & 11). Therapists in these instances were interpreted as being forceful and intrusive by some participants (Rizq & Target, 2010a & b).

Five studies found psychotherapists perceived their therapist to have made errors or shown incompetence (7, 8, 9, 11 & 15), with the nature of perceived failures varied. Therapist incompetence was reported as the second most common cause of harm from psychotherapists' personal therapy experiences in Pope and Tabachnick's (1994) study, in addition to "mishandling of marital issues" and "poorly handled termination" (p. 250). Others felt that their therapist failed to understand them (Rizq & Target, 2010b), or had overlooked important factors in their case, such as abuse or medical issues (Pope & Tabachnick, 1994). Seventy eight percent of participants from Pope and Tabachnick's (1994) study reported cases of therapist clinical or therapeutic error. As participants across these studies were themselves therapists, they may have been better equipped to identify poor therapeutic practice.

Participants from four papers experienced their therapists as cold, insensitive and lacking human relatability (3, 8, 9 & 11). Almost 50% of participants from Pope and Tabachnick's (1994) study felt that, at some time, their therapist didn't care about them. Therapists were seen to make insensitive, sharp comments which often stirred emotional responses in their clients long after therapy had terminated.

Three papers found evidence of therapists behaving in a narcissistic, self-centred and superior manner (3, 8 & 15). One participant resentfully described her therapist as "self-satisfied" (Wilson et al., 2015, p. 39), and another as being "invested with all the sort of authority of God" (Rizq & Target, 2010b, p. 357).

1.4.3 Variables associated with negative effects of personal therapy for psychotherapists.

Data was considered to be a variable associated with negative effects of personal therapy for psychotherapists if it was not explicitly discussed as an effect of personal therapy, but was found to relate to or be associated with a negative effect. To date, few studies have explored the factors associated with negative therapy experiences in this population. There is some inevitable overlap in what could be interpreted as a negative effect of therapy or a variable relating to a negative effect. This was subject to the review author's interpretation, and guided by the presentation of data within the original research.

1.4.3.1 Therapist variables.

One study identified variables associated with the therapist to be associated with negative effects of therapy for psychotherapists (8). Pope and Tabachnick's (1994) statistical analysis concluded that participants who had experienced personal therapy as having been at least somewhat harmful were more likely to score highly on items assessing for sexualised behaviour or material of their therapist and items measuring therapist unkindness or error. This reinforces findings of negative effects emanating from the therapists' inappropriate sexual behaviour and abusive behaviour discussed above.

1.4.3.2 Client variables.

Three papers found client variables (who were themselves therapists) to be associated with negative effects of personal therapy (8, 10 & 11). By analysing participant narratives of their personal therapy experience alongside attachment and reflective function status, Rizq and Target (2010a & b) concluded that early experiences and subsequent attachment status of counselling psychologists influenced their interpretation and experiences within personal therapy. The authors suggested that insecurely attached participants were more sensitive to power dynamics within therapy, were resistant to developing trust within the therapeutic relationship, experienced greater psychological threat from personal therapy, and greater dissatisfaction and frustration with their therapist and overall therapy experience than securely attached therapists.

Rizq and Target (2010a & b) also suggested that clients with lower RF experienced increased discomfort with discussion of difficult psychological experiences within personal therapy and subsequently experienced their therapists as intrusive. Authors proposed that this reluctance to address sensitive issues results in difficulties remaining unresolved. As therapists with lower RF are proposed to have a decreased ability to mentalize their clients' psychological experiences, this is hypothesised to then make it harder for these therapists

to distinguish between their own and their clients' problems when they are themselves in the therapist position.

The authors do not however carry out statistical analysis to determine whether particular behaviours and emotional responses were more likely to occur in participants with greater RF and AAI status, and results are merely suggestive of trends. Therefore whilst advocates of personal therapy boast that it improves awareness of interpersonal processes in the therapeutic alliance, this may not be the case for all therapists who undertake it.

Finally, Pope and Tabachnick (1994) identified that participants who felt that their personal therapy was at least somewhat harmful were more likely to report patient sexual behaviour and material, such as being sexually attracted to or fantasising about their therapist. Outside of this review, Buckley et al. (1981) found therapists' preoccupation with their own therapist (operationalised through behaviours such as thinking and dreaming about the therapist) significantly correlated with therapists' experience of harm from personal therapy.

1.4.3.3 Therapy process.

Five papers identified aspects of the therapy process that were associated with harm from personal therapy (1, 6, 8, 12 & 14). Firstly, Darongkamas (2014) found qualified therapists who were in therapy for the first time experienced significantly greater stress in their job than those who hadn't had personal therapy or who had previously been in personal therapy. The authors suggested that the timing of therapy is key, and proposed that these individuals are most likely to be newly qualified, and thus subsuming the majority of clinical work within their service. This supports findings from previous reviews which have suggested that personal therapy may produce negative effects on the clinical work of less experienced therapists (Macran & Shapiro, 1998).

The duration of therapy may also be related to negative effects of psychotherapy. Pope and Tabachnick (1994) found there was a main effect of duration of therapy and how harmful participants reported their therapy to be. Therapists who were in personal therapy for longer reported increased levels of their own sexual material (towards their therapist) and greater incidence of therapist unkindness or error. Participants who found therapy to be at least somewhat harmful were in therapy for an average of 2 years longer than those who didn't find it harmful. Interestingly however, participants who found therapy helpful were in therapy for 1 year longer than those who didn't find it to be helpful (3.5 and 4.5 years

respectively). This suggests that the potential relationship between time in therapy and harm may be complex, and requires further exploration.

Furthermore, Wheeler (1991) found a negative correlation between the amount of therapists' personal therapy and therapist and client ratings of the therapeutic alliance, and Sandell et al. (2006) found client change to be poorest amongst therapists with the longest duration of personal therapy. Wheeler (1991) proposed that practitioners with a long period of personal therapy may become "too stylised" (p. 200) in their clinical work, whilst Sandell suggested therapists with longer therapies over-identify with their own personal therapy approach. Critical review.

A number of methodological variants and failures across the studies limit the generalisability of the current review.

Although the majority of studies were of moderate to strong quality; four were classified as poor quality (2, 3, 13 & 14) which limits the significance and generalisability of their findings, and subsequent generalisability of this review. Sample size varied widely from five to 476 participants, which reflects the inclusion of both qualitative and quantitative designs; limiting the ability to draw comparisons across the research.

The studies employed a variety of sampling and recruitment strategies. Many used purposive sampling to identify appropriate therapist participants best able to contribute to the research questions, yet this non-random method of sampling can introduce bias in the sample and ultimately the data. Wiseman and Shefler (2001) for instance specifically recruited therapists with a good professional reputation, who may have been known to highly value personal therapy and therefore be less likely to identify negative effects. Furthermore, some of the researchers were personally acquainted with their participants, or were associated with the institutes from which participants were recruited. For instance Grunebaum (1986) knew 18 of his 47 participants personally, and Kumari (2011) interviewed participants from their own training cohort, potentially biasing participants' accounts. Some studies omitted important information about sampling and recruitment, making it difficult to assess for bias.

Even though all of the studies within this review were focussed on personal therapy for *psychotherapists*, this umbrella term includes individuals from a wide range of professions. This introduced difference in terms of professional identities, training requirements and theoretical orientations which makes it harder to draw comparisons between the studies, thus impairing both the internal and external validity of the review.

Where information was available, all but one study had a majority female sample. Yet this may be representative of the therapist population; with females representing 80% of registered psychologists in the UK Health and Care Professions Council (HCPC) (Farndon, 2016). Several studies failed to fully document participant characteristics, and only three provided information regarding participant ethnicity. There was also an over-representation of therapists who have undertaken psychoanalysis as their mode of personal therapy; limiting applicability of results to therapists who have engaged in other therapeutic models. Omission of key demographic and contextualising information (i.e. therapeutic model of personal therapy, reasons for seeking therapy) from several studies limits the ecological validity of the review.

Although only three studies were conducted outside of North America and the UK, many findings and themes occurred across geographic regions and appeared more globally within the literature (e.g. the stress of personal therapy, impact on personal relationships). Findings specifically regarding sexualised behaviour of therapists and clients however emerged from research from the US. This suggests that some findings from the review may be more applicable for therapists practicing in some geographical areas than others.

There was an over-representation of quantitative survey-based studies within the review that enable exploration of attitudes, behaviours and trends (Ivey & Waldeck, 2014), but few experimental studies employing objective measures of negative effects. However this is likely to reflect the trend in the literature to move away from quantitative studies attempting to isolate outcomes associated with personal therapy towards contextual understanding of experience.

The bias within the wider literature to report only positive effects of personal therapy for psychotherapists was evident in Wiseman and Shefler's (2001) study, when one participant described feeling unable to attend to clients due to preoccupation with their own issues arising from therapy. Although authors acknowledged that this is a "hazard" (p.139) for junior therapists, they dismissed the gravity of this issue by claiming that more experienced therapists are able to manage such difficulties with ease, yet they provided no evidence to support this claim. Elsewhere within qualitative studies in the review, many researchers showed awareness of reflexivity by acknowledging their own opinions regarding personal therapy for therapists, yet many failed to acknowledge how their own assumptions influenced data interpretation and how they aimed to limit this bias.

Participants from some studies retrospectively commented on their experiences of personal therapy, in some cases several years after its completion. Delayed self-report

introduces bias and reduces the reliability of participants' accounts (Schwarz, 2007), and impairs the reliability of some results within the review. Missing from all of the studies was the voice and opinion of the treating therapist, which would contextualise participants' experience of negative effects from personal therapy to produce a more balanced understanding.

Due to the aforementioned bias within the research to under-report negative effects of personal therapy, what was considered to constitute a negative effect was decided by the review author. Furthermore, due to the abundant, rich data extracted from the research, it was again the decision of the review author to determine which data to present within the review. This subjective interpretation again introduced potential for bias within the review, which may have benefited from inter-rater review. Ten studies were identified through reference searches. Although these papers were subject to the same rigorous selection process, this limits the replicability of the review. Although exhaustive reference searches were conducted, some studies may have been missed from this process that may have added important information to the review.

The synthesis of qualitative and quantitative data was a strength within the review, as data from both designs was often found to support findings of the other. The review may have been strengthened by specifically investigating negative effects of personal therapy for trainee or qualified therapists; with each population experiencing distinct challenges and stressors. Exploring negative effects of personal therapy at different stages of professional developmental may produce a more nuanced understanding of the conditions conducive to producing negative effects at each stage to enable subsequent intervention.

1.4.4 Implications.

Findings of this review carry many implications for therapist training institutes and wider therapy professions.

As suggested by Kumari (2011), professional bodies and training institutions need a heightened awareness of negative effects of personal therapy for psychotherapists. By turning towards negative effects to develop our understanding of why they occur, institutes and researchers can take steps to minimise potential harm produced by this process; ensuring the safety of practitioners and clients.

Where personal therapy occurs alongside professional training, training institutes should ensure they are abiding by the ethical principles of their profession. Dual relationships should be avoided through provision of external practitioners (McEwan &

Duncan, 1993; Wilson et al., 2015). Students should be given clear rationale for engaging in personal therapy (Kumari, 2011) and be informed of potential risks and benefits to ensure their consent to participate is informed (Ivey & Waldeck, 2014). Training institutes should then support trainees to consider strategies to manage difficult experiences in therapy to minimise the impact on trainees and their clinical practice (Ivey & Waldeck, 2014; Kumari, 2011). Given the stress caused by the therapy process, trainees would also benefit from increased support for issues raised from therapy by their training institute. Opportunities for reflection would grant trainees space to consider their therapy experiences, and how this may influence their clinical practice.

With research suggesting client variables (such as attachment status and RF) influence how personal therapy is experienced, training institutes should consider screening trainees for suitability for personal therapy. Increased flexibility within training institutes to ensure personal therapy is timely and appropriate may attenuate the stress trainees report from this process. Training institutes should provide an achievable time frame within which to complete mandated therapy to alleviate time pressures (Kumari, 2011).

Timing of therapy should also be a consideration for qualified therapists. Darongkamas et al. (1994) suggest services should be sensitive to the stress *newly qualified* therapists experience from their first personal therapy experience, and make reasonable adjustments to practitioners' workload.

1.4.4.1 Future research.

Much of the research exploring personal therapy for psychotherapists is dated, lacks scientific scrutiny, and suffers from biased interpretation. More research is therefore needed to extend ideas presented in this review, specifically exploring the negative effects of personal therapy in this population to balance biased conclusions from previous research.

An improved understanding of the processes by which negative effects are produced would improve the professions' ability to intervene to minimise the occurrence of such effects. The current review highlights many areas for further research.

Extending on work by Rizq and Target (2010a & b) more research is needed to explore how therapist variables influence the experience of personal therapy, which may also develop our understanding of therapy experiences in the general public. Further research is also needed exploring mechanisms by which stigma of accessing personal

therapy manifests amongst therapists, to advance our understanding of how to reduce the psychological burden of accessing therapy. Bearse et al. (2009) argue for further research into the timing of personal therapy for psychotherapists to maximise the potential benefit of this process throughout therapists' careers. Finally, as many authors refer to some negative effects of personal therapy as being expected or transient, further research evidencing such effects and differentiating them from other, more harmful effects of personal therapy is needed.

1.5 Conclusion

To the author's knowledge, this is the first systematic review exploring negative effects of personal therapy for psychotherapists and variables associated with them. Although the literature shows that personal therapy produces a plethora of benefits for the wellbeing and professional development of the majority of psychotherapists, data from this review suggests engaging in personal therapy (as a client) whilst simultaneously delivering therapy (as the therapist) can also produce a spectrum of negative effects for trainee and qualified therapists, some of which have the potential to cause significant harm.

Of particular concern is the finding that psychotherapist personal therapy can disrupt clinical work; reducing therapists' ability to attend to often acutely distressed clients presenting with high levels of risk. Also alarming is the potential for personal therapy to negatively impact therapist development and reduce practitioners' enthusiasm for therapy. The review also highlights evidence of shocking boundary violations compromising the therapeutic integrity of the practitioners and training institutions in question.

This review concludes that the literature on personal therapy for psychotherapists to date has produced a biased and incomplete account of its value and role in therapist development. More robust scientific scrutiny from future research is needed to balance and improve our understanding of the mechanisms and variables responsible for these effects. Findings of this review calls for training institutes and professional bodies to acknowledge the potential negative effects of this process, and take steps to minimise potential harm to therapists and their clients.

2 Trainee Clinical Psychologists' Attitudes toward Seeking Psychotherapy: The Influence of Interpersonal Perfectionism and Perceived Attitudes of Others

2.1 Introduction

2.1.1 Lived experience of mental health difficulties amongst psychologists and trainees.

Research has consistently shown that psychologists are vulnerable to mental health difficulties (Good, Khairallah, & Mintz, 2009), but the prevalence of reported difficulties within the literature varies. Pope and Tabachnick's (1994) survey of US psychologists found 61% of 400 therapists had experienced one of more episodes of depression, 29% had felt suicidal, and 4% had attempted suicide. More recently, Nachshoni et al.'s (2008) study exploring psychologists and social workers self-report of DSM-IV diagnoses showed 81.2% identified as having what was then recognised as Axis-I traits (57% mood difficulties, 50% OCD and 34% eating disorders) and 73.4% reported Axis-2 traits (49% narcissistic, 37% avoidant, and 27% obsessive-compulsive personality traits) of which the majority were of minor severity.

Similar difficulties have been identified amongst trainee psychologists. Wood et al. (1985) found 32.3% of US trainee psychologists experienced depression, whereas Cushway (1992) identified 59% of 281 UK trainee clinical psychologists experienced clinically significant levels of psychological distress. A recent survey of 348 UK trainee clinical psychologists by Grice, Alcock and Scior (2018) found 67% to have experienced a significant mental health difficulty, with 29% experiencing a mental health difficulty at the time of participation. UK trainee clinical psychologists have also been found to experience high levels of substance abuse, self-esteem difficulties, anxiety and depression (Brooks, Holttum & Lavender, 2002).

Research specifically looking into mental health difficulties amongst *clinical* psychologists is however scarce, dated, and suffers from low response rates and bias through self-report (Nachshoni et al., 2008).

2.1.2 Psychologist distress, burnout and impairment.

Distress can be defined as "an experience of intense stress that is not readily resolved, affecting well-being and functioning, or disruption of thinking, mood and other health problems that intrude on professional functioning" (Munsey, 2006a, p.35). Distress

can emerge from occupational factors such as ‘burnout’ (negative reactions to work related demands and stresses), vicarious traumatisation, and non-occupation factors such as practitioner mental health difficulties, substance misuse, financial and relationship strains and experience of trauma (APA, 2006).

Distress can be an early indicator of- and can lead to psychologist impairment (Baker, 2003; Smith et al, 2009); “a condition that compromises psychologists’ professional functioning to a degree that may harm the client or make services ineffective” (Munsey, 2006, p. 35).

Psychologist impairment has been identified within the literature. Wood et al. (1985) found 32% of participants in APA approved programmes reported levels of depression that interrupted their ability to do their work. Guy, Poelstra and Stark (1989) found psychologists reported that their own psychological distress interfered with their delivery of care. A qualitative study of psychologists found lived experience of mental health difficulties led to difficulties being ‘present’ with their clients (Cain, 2000). Finally, a survey by Pope, Tabachnick, and Keith-Spiegel (1987) found a staggering 59% of psychologists saw clients when they felt too distressed to be clinically effective.

Impairment is not an inevitable product of distress (Barnett, Baker, Elman & Shoener, 2007). Lived experience of mental health difficulties can enrich therapists’ practice through improved empathy, insight, confidence and shared understanding with clients (Cain, 2000; Charlemagne-Odle, Harmon, & Maltby, 2014; Zerubavel & O’Dougherty Wright, 2012). Lived experience is increasingly valued within services; reflected in the growing employment of peer support workers whose role is to use their lived experience in the support of others (Repper et al., 2013). However impairment is more likely to manifest if distress is not appropriately addressed (Barnett et al., 2007).

2.1.3 Profession specific risk factors for psychologist distress.

Although not unique to psychologists, it has been suggested that repeated exposure to clients’ suicidal ideation may lead to cognitive biases highlighting practitioners’ own negative thoughts (Ramberg & Wasserman, 2000). Pope and Tabachnick (1994) suggested dangers inherent in the therapist role, such as compassion fatigue, vicarious traumatisation and stress burnout, also contribute to the development or exacerbation of psychologists’ mental health difficulties. Early work by Farber and Heifetz (1982) found therapists can also experience stress from adopting a therapeutic role outside of work.

2.1.4 Importance of practitioner self-care.

Self-care refers to a variety of activities to support practitioner wellbeing; protecting against burnout and other occupational difficulties (Benedetto & Swadling, 2014). This includes idiosyncratic activities in one's work and private life (such as ensuring a positive work-life balance, taking regular breaks) (Stevanovic & Rupert, 2004) and more formal processes (such as engaging in personal therapy, maintaining an awareness of one's own needs and engaging in supervision and reflective practice) (Barnet et al., 2007, Evans, 2015; Good et al., 2009). Lack of self-care may contribute to the emergence of psychologist impairment, therefore self-care is essential to protect the clinician, their clinical practice and the profession itself (Bamonti et al., 2014; Barnett et al., 2007).

The need to address personal distress has long been discussed in the literature. Whitehorn's (1959) model of resilience proposed practitioners' distress must be addressed to achieve effective practice, and Gelso and Hayes (2007) stressed the need for therapists to process their 'wounds' to avoid countertransference in therapeutic relationships.

Furthermore, the APA's Ethical code of Conduct (2016) states psychologists bear an ethical responsibility to be aware of personal problems impacting upon professional practice, and to "take appropriate measures, such as obtaining professional consultation or assistance" when required.

It can be surmised therefore that, whilst lived experience of mental health difficulties can be valuable to practice, self-care (including seeking professional psychological support if needed) is essential to help psychologists stay well and minimise impairment.

2.1.5 Inadequate help-seeking amongst psychologists and trainees.

Research has shown that 41% to 86% of UK and US psychologists have participated in personal therapy; some to meet training needs, but many to seek help for psychological, interpersonal, or substance abuse problems (Bearse, McMinn, Seegobin & Free, 2013; Darongkamas et al,1994; Fortune, McCarthy, & Abramson, 2001; Norcross et al, 1988a).

Psychologists report predominately positive outcomes from personal therapy, including symptom reduction and improvement in professional functioning (Buckley et al., 1981), but are often reluctant to pursue psychotherapy, and access inadequate support for their mental health (Deutsch, 1985; Farber, 2000; Mahoney, 1997). Bearse et al. (2013) showed that, although 86% of 258 US psychologists had engaged in psychotherapy at

some time, 59% had experienced a time in which they were in need of professional psychological suport but did not seek it.

Research specifically exploring help-seeking amongst *traniee* counselling psychologists found trainees hesitated to seek professional help, with this seen as a "last resort" (Farber, 1999). Of particular concern is Farber's (1999) finding that less than half of trainees felt confident they would access professional support for mental health difficulties once qualified. This is again in spite of sizeable benefits from accessing professional help reported amongst trainees, including improved wellbing, reduced experience of distress and even improvement in perceived progression throughout clinical training (Colman, et al., 2016; Zahniser, Rupert, & Dorociak, 2017).

2.1.6 Factors influencing help-seeking attitudes and behaviour of psychologists and trainees.

2.1.6.1 Barriers to psychological help-seeking.

In a survey of 260 US psychologists, Bearse et al. (2013) found the most frequent barrier to seeking professional psychological help for distress was difficulty finding a therapist, with challenges of dual relationships and perceived therapist incompetence. Deutsch (1985) and Farber (1999) also highlighted psychologists' confidentiality concerns and difficulty finding appropriate therapists as obstacles to seeking help. The financial strain of therapy and having insufficient time for therapy are also significant barriers for trainee and qualified psychologists (Bearse et al. 2013; Farber, 1999; Mahoney, 1997).

These barriers are arguably more prominent for trainee psychologists, who manage additional academic demands (Dearing, Maddux & Tangney, 2005), and may feel pressure to present as being 'well' to be deemed 'stable' enough for work in this area.

A full review of factors influencing help-seeking amongst trainee psychologists is beyond the scope of this review, however key factors relevant to the current research are discussed.

2.1.6.2 Influence of the wider profession.

Empirical data demonstrates that help-seeking amongst trainee psychologists is influenced by perceived attitudes and behaviours of those within their profession.

Farber (1999) found trainee counselling psychologists were more inclined to seek personal therapy if they felt it was considered to be important and valued by their teaching staff. A subsequent study of clinical and counselling psychology graduate students' by Dearing et al. (2005) found perceiving academic faculty to view student engagement in

therapy to represent growth (instead of weakness) was associated with students themselves holding positive attitudes towards therapy. Students' help-seeking attitudes partially mediated the relationship between perceived faculty attitudes and prevalence of help-seeking amongst students. This suggests that perception of faculty attitudes towards help-seeking influences student's attitudes regarding accessing therapy, which in turn influences their help-seeking behaviour (Dearing et al., 2005). Dearing et al. (2005) predict that perceived attitudes of doctoral faculty mentors and supervisors would have a similar impact on students' help-seeking attitudes and behaviours.

Farber (1999) concluded that help-seeking was higher amongst trainees who perceived it to be normative amongst their peers. This is reinforced by McClure's (2014) study of 318 doctoral psychology students, who found that knowledge of a fellow student or member of the training program who has sought help significantly predicted students' openness to seeking help for psychological difficulties. Results of this study also showed that knowing a professor or supervisor who had accessed therapy was related to students' increased belief in the importance of personal therapy for professional growth and effectiveness', and trainees holding fewer concerns about confidentiality of attending therapy. Finally, knowing a fellow student, professor or supervisor that had accessed therapy was also related to fewer concerns regarding professional credibility and being perceived to be incompetent by other psychologists due to accessing therapy.

These results are perhaps to be expected, as individuals' attitudes towards seeking help for distress is proposed to be influenced by attitudes held by those within their social network (Vogel et al., 2007).

2.1.6.2.1 Social Identity Theory (SIT).

The influence of the wider profession on psychologists' and trainees' help-seeking attitudes can be understood from a Social Identity Theory (SIT) perspective. Within this theory, an individuals' concept of self is defined by their *personal* identity (idiosyncratic psychological and physical qualities) and their social identity (ones' membership within a number of groups) (Ashforth & Mael, 1989). Group membership arises through a process of self-categorisation, in which the individual and group undergo a mutual process of assessment to ensure compatibility (Korte, 2007).

Group membership influences behaviour by providing a guide for appropriate, representative and archetypal behaviours associated with that group identity (Sindic & Condor, 2014). Upon joining the psychology profession, trainees would hypothetically conform to the expectations of this group. Dearing et al. (2005) similarly describe a

"socialisation process" (p. 324), in which graduate psychology students are influenced by the attitudes of their supervisors and faculty towards help-seeking. Perceiving help-seeking to be normative within the group identity of the psychology profession may increase trainees' and qualified therapists' likelihood of engaging in this same behaviour.

2.1.6.3 Perfectionism.

Perfectionism is broadly defined as a multifaceted personality trait, and has been conceptualised in terms of it's content, expression and interpersonal manifestation (Hewitt, et al., 2003). As there is a stark lack of research exploring the role of perfectionism in help-seeking amongst trainee or qualified psychologists, we are guided by research pertaining to the general population. The construct 'perfectionistic self-presentation' (PSP) is considered here, as it is theorised to influence inidividuals' ability to recognise their distress, and to predict difficulties seeking professional psychological help (Hewitt, Habke, Lee–Baggley, Sherry, & Flett, 2008).

PSP describes the relational expression of perfectionism and the wish to appear perfect to others (Hewitt, et al., 2003; Hewitt, Besser, Sherry, & Cassels, 2011). In a study of 184 adults, higher levels of PSP was associated with more negative attitudes towards help-seeking (Hewit et al. 2007; cited in Hewitt et al., 2008), and greater self-reported discomfort at seeking help (Hewit et al. 2006; cited in Hewitt et al., 2008).

Although the above research is not specific to psychologists, Grice et al. (2018) highlight the potential relevance of perfectionism within the demanding and competitive clinical psychology profession. In their study exploring factors related to disclosure of hypothetical mental health difficulties amongst 348 UK trainee clinical psychologists, Maladaptive perfectionism (a need to conceal flaws, appear perfect to others and thus avoid negative judgement from others), was found to consistently predict likelihood of disclosing psychological distress (Grice et al., 2018).

The relationship between perfectionism and help-seeking can again be considered from a SIT perspective. People with high levels of PSP are proposed to have a preoccupation with social evaluation and other peoples' expectations of them, and have been shown to have reduced tolerance to stigma associated with help-seeking (Hewitt et al., 2003; Hewit et al., 2016, cited in Stoeber, 2018). People with high levels of PSP are also proposed to have a hyperawareness of their own perceived failures in fulfilling expectations of others, resulting in a tendancy to interpret interpersonal exchanges as threatening (Hewitt et al., 2003). Two submeasures of PSP, non-disclosure of imperfection (individuals' desire to avoid verbal disclosure of imperfection) and non-display of

imperfection (avoidance of behavioural demonstration of imperfection), are therefore considered protective aspects of self-presentation (Hewitt et al., 2008).

Perfectionists may therefore be more aware of and sensitive to the behavioural norms and expectations within their group identity. Individuals with experience of a stigmatising mental health difficulty may feel they are in violation of group norms and fear negative appraisal; reducing their normative fit within the group (Kearns, Muldoon, Msetfi, & Surgenor, 2015). This, in turn, means receiving support from sources within the 'in-group' for their difficulties (i.e. other psychologists) exposes their violation of group norms (Kearns et al. 2015). This suggests that individuals' perception of the acceptability and normality of a behaviour or quality is key.

Research suggests that psychologists and trainees do not perceive experience of mental health difficulties to be acceptable within the clinical psychology profession. In Wilson et al.'s (2015) study of trainee clinical psychologists, participants felt accessing therapy during clinical training indicated weakness or professional incompetence, and feared being judged by their therapist, training institute and peers. The authors concluded that there's a professional narrative that experience of mental health difficulties is "unacceptable, even shameful" (p. 41), and that this negatively impacts upon their likelihood of seeking help for their difficulties. A phenomenological study by Charlemagne-Odle, Harmon and Maltby (2014) of 11 UK clinical psychologists with experience of high levels of psychological distress found five participants reported "fear and shame" (p. 244) around disclosure of difficulties.

Deutsch (1985) suggested psychologists show reluctance to seek professional support for their mental health difficulties due to fear of disapproval within their profession. Nadler (1987) argued that psychologists feel too threatened to seek help for difficulties that they are themselves proficient in treating, as this may shatter their image of competence. Trainee psychologists in particular may anticipate negative effects of engaging in personal therapy, including impaired professional integrity and career prospects (Farber, 2000).

The literature as a whole suggests that there is a culture of "secrecy, self-stigma and shame" (Zerubavel & O'Dougherty Wright, 2012, p. 483) around psychologist distress within the profession (Pope, 1994).

2.1.6.4 Year of study.

Dearing et al.'s (2005) study of predictors of psychological help-seeking amongst psychology graduate students found that being further progressed in the programme was

associated with an increased likelihood of accessing psychological support whilst studying. The authors do not offer explanation for this relationship, however this may relate to increased psychological distress with growing stress of study, or simply increased likelihood of experiencing difficulties over longer periods of time.

2.1.6.5 Gender.

Research by Pope and Tabachnick (1994) found female psychologists were more likely to have engaged in personal psychotherapy than men, with 89.6% participation compared to 79.7% respectively. Furthermore, there is a vast array of literature pertaining to the general population demonstrating an increased tendency for women to seek professional psychological support over men. A study by Mackenzie, Gekoski and Knox (2006) showed that women held more positive attitudes towards help-seeking relative to men, and subsequent positive intentions to seek professional support if needed. The authors argued that mens' reduced psychological openness and poorer attitudes towards seeking pscyhological help compared to women are key in explaining their lower enagement with psychological services.

2.1.6.6 Experience of mental health difficulties and previous help-seeking experiences.

Experience of mental health difficulties and help-seeking are related, with the former often necessitating the latter. Dearing et al. (2005) found psychology graduate students' previous experience of accessing therapy was associated to more positive attitudes towards seeking professional help. Trainee counselling psychologists have also been found to be more likely to seek future help if they have previous positive therapy experiences (Farber, 1999).

This relationship has also been found in the general population, as a systematic review of barriers and facilitators of help-seeking amongst young adults found past positive experiences of seeking professional help facilitated future help-seeking (Gulliver, Griffiths, & Christensen, 2010). Authors suggest previous experiences of accessing support increases likelihood of future help-seeking by improving individuals' mental health literacy.

2.1.7 Current study.

Trainee clinical psychologists[5] often fail to seek help for psychological difficulties, with potentially dangerous consequences for their wellbeing and that of their clients.

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[5] Henceforth referred to as 'trainees'.

Developing our understanding of factors influencing their attitudes toward seeking psychotherapy is essential, as attitudes towards help-seeking can predict future help-seeking behaviour (Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016).

The current research aimed to further our understanding of the role of a number of variables in influencing trainees' attitudes towards seeking psychotherapy. Variables explored included factors previously shown to influence help-seeking in similar populations (gender, year of study, history of accessing psychological help and lived experience of mental health difficulties), and novel, theoretically salient variables.

Continuing on from work by Dearing et al. (2005), the current project aimed to develop a more nuanced understanding of which figures within trainees' professional sphere influence their attitudes towards help-seeking. Further variables explored therefore included perceived attitudes of others (cohort peers, doctoral faculty, clinical supervisors and other qualified clinical psychologists) toward the acceptability of clinical psychologists having lived experience of mental health difficulties and accessing professional psychological help for their difficulties. The research focussed on perceived attitudes of others regarding behaviour and experience of *qualified* clinical psychologists, as trainees are soon to adopt the same professional identity. This aimed to highlight trainees' expectations or norms within their new group identity.

Finally, with research showing that increased interpersonal perfectionism is associated with negative attitudes towards help-seeking (Hewitt et al. 2008), a measure of perfectionistic self-promotion (PSP) was also explored. The role and relative importance of each variable in influencing trainees' help-seeking attitudes was explored using correlation and regression analysis.

As individuals high in PSP are proposed to be more sensitive to feedback within their social surroundings, the study also explored whether the possible relationship between trainees' PSP and help-seeking attitudes was mediated by perceived attitudes of others, specifically regarding the acceptability of seeking help for mental health difficulties.

Finally, the research aimed to improve our understanding of which figures within trainees' professional group have the greatest influence on their perceptions of the normative and appropriate attitudes and behaviours of clinical psychologists (cohort peers, doctoral faculty, clinical supervisors or other qualified clinical psychologists).

The current study therefore extends ideas from previous research whilst incorporating more exploratory, novel elements.

2.1.7.1 Research Questions.

R1: Which members of their professional group identity (cohort peers, doctoral faculty, clinical supervisors or other qualified psychologists) do UK trainee clinical psychologists look to *most* to influence their understanding of the expected qualities and behaviours of a clinical psychologist?

R2: What is the ability of a regression model (consisting of previously researched and novel variables) to predict UK trainee clinical psychologists' attitudes towards seeking psychotherapy? And how much relative variance in attitudes towards seeking psychotherapy can be explained by each variable?

2.1.7.2 Hypothesis.

H1: The relationship between trainees' interpersonal perfectionism and attitudes towards seeking psychotherapy will be mediated by their perceived attitudes of others within their profession towards the acceptability of clinical psychologists accessing professional psychological help for their difficulties.

2.2 Method

2.2.1 Design.

The research employed a correlational, cross sectional design. Bivariate correlations and multiple linear regression was used to explore the research questions, and mediation analysis to test hypothesis 1 (see 'Analysis strategy' for analysis overview).

Predictor variables included trainees':

1. Gender;
2. Year of doctoral study (1, 2 or 3);
3. Previous experience of help-seeking for mental health difficulties (has sought previous help/is currently seeking help, no previous help-seeking, not applicable);
4. Lived experience of significant mental health difficulty/difficulties[6] (currently experiencing a significant mental health difficulty, not currently

[6] A significant mental health difficulty was defined as psychological and behavioural difficulties that cause significant distress and/or impairment in one or more important areas of functioning. This includes mental health difficulties detailed by DSM and ICD, however a formal diagnosis was not necessary (adapted from definitions suggested by Grice et al. 2018 and Stein et al. 2010).

experiencing a significant mental health difficulty but have previously experienced a significant mental health difficulty, not currently experiencing a significant mental health difficulty and have never experienced a significant mental health difficulty, prefer not to disclose);

5. Perfectionistic self-presentation (measured using the 'non-disclosure of imperfection' subscale of the PSPS);
6. Perceived attitudes of others (cohort peers, doctoral faculty, clinical supervisor and other qualified psychologists) regarding the acceptability of clinical psychologists having lived experience of mental health difficulties and acceptability of clinical psychologists accessing professional psychological help for mental health difficulties. Only perceived attitudes of others regarding the acceptability of clinical psychologists seeking help for their difficulties will be included in mediation analysis.

The outcome variable was trainees' attitudes towards seeking professional psychological help, operationalised using the Trainees' Attitudes Toward Seeking Psychotherapy Scale (TATSPS, Farber, 2000).

2.2.2 Measures.

Participants completed two standardised measures and an idiosyncratic survey. The measures were available online survey via Southampton University's online survey system, iSurvey, and was piloted by 4 trainee clinical psychologists to ensure acceptability.

2.2.2.1 Idiosyncratic questionnaire.

To explore R1, participants were asked to rank from 1 to 4 whom they perceived to have the greatest influence on their ideas about what a clinical psychologist should be like, between their cohort peers, doctoral faculty, clinical supervisor and other qualified psychologists (1 representing the most influential, and 4 the least). Participants rated their perceived attitudes of others regarding the acceptability of clinical psychologists having lived experience of mental health difficulties and of accessing professional psychological help on a seven point Likert scale (from 1-extremely unacceptable, to 7-extremely acceptable). Participants selected their theoretical orientation from a selection of options. Additional information was gathered exploring whether trainees' had experienced a time

during training in which they felt they needed professional psychological support but did not seek it.[7]

2.2.2.2 Trainees' Attitudes Toward Seeking Psychotherapy Scale (TATSPS)[8].

Trainees' attitudes towards seeking professional psychological help for emotional difficulties was measured using the TATSPS. This 26[9] item measure was developed by Farber (2000) to measure trainee psychotherapists' attitudes towards seeking psychotherapy. The TATSPS was deemed particularly appropriate, as it was validated and standardised using a population of US masters and doctoral counselling and clinical psychology students, where it was shown to have good concurrent validity and construct reliability (Farber, 2000).

The four TATSPS subscales capture different concerns with seeking psychotherapy, including 'important for professional growth/effectiveness' (the degree to which engaging in psychotherapy is felt to improve professional effectiveness), 'concern with professional credibility' (concern with being viewed by others as incompetent due to accessing psychotherapy), 'concern about confidentiality' (concern with others knowing they are seeking psychotherapy) and 'need for self-sufficiency' (belief that psychologists should manage their own difficulties). The TATSPS total score was used in regression and mediation analysis to represent trainees' overall attitudes towards seeking psychotherapy.

2.2.2.3 The Perfectionistic Self–Presentation Scale, 27 Item Version (PSPS)[10].

Perfectionistic self-presentation (PSP) is conceptualised as a maladaptive expression of perfection within interpersonal contexts (Hewitt et al. 2003). Developed by Hewitt et al. (2003), the PSPS comprises three subscales; 'perfectionistic self-promotion' (concern with portraying oneself in a flawless manner), 'non-display of imperfection' (concern with behaving in an imperfect manner) and 'non-disclosure of imperfection' (concern with verbal disclosure of imperfection) (Hewitt et al., 2003).

Only subscale 'non-disclosure of imperfection' was used as a predictor variable. This was considered most theoretically relevant to help-seeking attitudes; as seeking psychotherapy will inevitably involve verbal disclosure of mental health difficulties and thus admission of a need for support, which trainees' may interpret as a failure.

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[7] See Appendix E for a copy of the idiosyncratic questionnaire.
[8] Permission to use the TATSPS was granted verbally and in writing by Dr Nancy Farber.
[9] Only 22 items are included in the scoring of the measure, as four items were under the loading criteria threshold.
[10] The PSPS is freely available online provided by the authors.

Hewitt et al. (2003) conducted a series of studies confirming the underlying factor structure of the measure, and demonstrating its strong validity and reliability across clinical and student samples.

2.2.3 Recruitment and inclusion criteria.

An a priori power calculation using G-Power (Version 3.1) indicated a sample size of 207 participants was required for adequate statistical power for a multiple linear regression model using input parameters of a medium predicted effect size ($f^2 = .15$), an alpha error probability of 0.01, anticipated power of 0.80 (1-β) and 20 predictors.

A purposive sample of trainee clinical psychologists was recruited between January-March 2018 through their doctoral training institutes and via online posts on social media. Training institutes were approached via email and asked to disseminate a recruitment email to their trainees, which 23 training courses agreed to. Participants were recruited from multiple courses to prevent bias from differences in theoretical orientations and values/culture between courses. Participants were given the option to enter a prize draw to win a £100 Amazon voucher to thank them for their time.

Participants were required to be current trainee clinical psychologists studying at UK BPS accredited doctoral training programmes. Only participants from the lead researcher's doctoral cohort were excluded from participation, as their prior knowledge of the study may have biased data. No other exclusion criteria applied.

2.2.4 Procedure.

Clinical psychology doctoral programmes were approached about the study via email and asked to disseminate an email advertising the current study to all trainees in their programme. The advertising email contained a link to the study information sheet and consent form required to be completed before participants could access the online survey. The last item of the survey offered participants the opportunity to submit their email address to be entered into the prize draw. Upon completing the survey, participants were shown a study debrief sheet providing a more detailed explanation of the study.

2.2.5 Ethical considerations.

The project received ethical approval from the Southampton University ethics committee via ERGO in January 2018. Participants were informed of any potential risks from participation and of their right to withdraw from the study in the study information sheet. Participants were required to complete an online item indicating their informed

consent to participate. Participants were provided with details of appropriate support to access in case they felt distressed following participation.

Participants can only be linked to their data through email addresses provided for prize draw entry, and were made aware of this at the time. Only the primary researcher and research supervisor have access to participant data. No identifiable information has been included in this report.

2.3 Results

2.3.1 Analysis strategy.

Due to the exploratory elements of the study, analysis proceeded in a staged, funnel like approach. To answer research R2, initial exploratory bivariate correlations were first run to investigate the relationships between all variables. Predictor variables that significantly correlated with the TATSPS total score were then entered into a multiple linear regression model to further refine and narrow the focus of the research to explore the ability of the model to predict change in the outcome variable. Theoretically relevant variables (guided by the literature) of perceived attitudes of others towards the acceptability of help-seeking, interpersonal perfectionism and TATSPS total score were then entered into mediation analysis to test Hypothesis 1. Analysis was therefore guided by top-down and bottom-up approaches.

Data was analysed using computing programme Statistical Package for the Social Sciences (SPSS), version 24. R1 was explored by summing participants' ranked scores assigned to figures within their profession, and analysing for statistical difference between these scores using Friedman's test.

2.3.2 Participant demographics and descriptive statistics.

A total of 960 individuals accessed the online survey, with 204 trainees completing. The mean participant age was 29 years (SD = 3.62) and, as demonstrated in Table 4, the majority of participants were female (N = 175), and in their second year of doctoral study (N = 87). Participants were predominantly of eclectic/integrative theoretical orientation (N=100).

The study found that 10.3% of trainees described themselves as currently experiencing a significant mental health difficulty (N = 21), however the majority, 51.5%, stated they were not currently experiencing difficulties, but that they had previously experienced a significant mental health difficulty (N = 105). The data also showed that 48.5% of trainees had sought professional psychological help for their mental health

difficulties (*N* = 99), but 29.9% disclosed that there had been a time during training in which they were in need of professional psychological help but had not sought it (*N* = 61).

Table 4. *Participant demographic variables.*

Variable	**Subcategory**	***N* (%)**
Gender	Male	28 (14.0%)
	Female	175 (86.0%)
Year of Study	1	59 (29.0%)
	2	87 (43.0%)
	3	58 (28.0%)
Theoretical orientation	Eclectic/Integrative	100 (49.0%)
	Systemic	24 (11.8%)
	Cognitive-behavioural	60 (29.4%)
	Psychodynamic/analytic	15 (7.4%)
	Other	5 (2.4%)
Lived experience of MH difficulties	Currently experiencing a sig. MH difficulty	21 (10.3%)
	Not currently experiencing a sig. MH difficulty, but have previously experienced	105 (51.5%)
	Not currently experiencing a sig. MH difficulty, and have never experienced	74 (36.3%)
	Prefer not to disclose	4 (1.9%)
Experience of accessing psychological support	Yes	99 (48.5%)
	No	43 (21.1%)
	Not applicable	62 (30.4%)
Time during training when in need of help but didn't seek?	Yes	61 (29.9%)
	No	142 (69.6%)
	Prefer not to disclose	1 (0.50%)

Abbreviations: MH = Mental health, sig. = significant.

Table 5 shows that most participants perceived their cohort peers, clinical supervisors and other qualified psychologists to view lived experience of mental health difficulties amongst clinical psychologists as 'very acceptable'. Interestingly, trainees perceived their doctoral faculty to view experience of mental health difficulties as less acceptable than other figures within their profession, at 'somewhat acceptable'. Mean scores show trainees perceived their cohort peers to view lived experience of mental health difficulties amongst clinical psychologists as most acceptable (*M* = 5.65, *SD* = 1.13),

followed by their clinical supervisor (M = 5.40, SD = 1.25), other qualified psychologists (M = 5.25, SD = 1.16) and their doctoral faculty (M = 5.13, SD = 1.36)[11].

A repeated measures ANOVA concluded that there was a significant difference in trainees' perception of the attitudes of others within their profession (cohort peers, doctoral faculty, clinical supervisor and other qualified psychologists) regarding the acceptability of clinical psychologists having lived experience of mental health difficulties, F (3, 609) = 14.36, $p < .001$. Mauchly's test of sphericity indicated that the assumption of sphericity had been met. Repeated contrast analyses showed that there was a significant difference in perceived attitudes between cohort peers and doctoral faculty ($p < .001$), and doctoral faculty and clinical supervisors ($p < .01$). There was not a significant difference in perceived acceptability between clinical supervisors and other qualified clinical psychologists ($p > .05$)

Table 5. *Frequency of trainees' perceived attitudes of others regarding the acceptability of lived experience of mental health difficulties amongst clinical psychologists.*

Perceived acceptability	**Cohort peers**	**Doctoral faculty**	**Clinical supervisor**	**Other qualified psychologists**
Extremely Unacceptable	1	2	2	1
Very Unacceptable	2	9	2	3
Somewhat unacceptable	14	19	16	12
Neutral	5	17	16	30
Somewhat acceptable	44	68	62	63
Very acceptable	100	62	69	71
Extremely Acceptable	38	27	37	24

Shaded areas highlight the mode response.

Table 6 shows that trainees most commonly perceived their cohort peers, doctoral faculty, clinical supervisors and other qualified psychologists to view clinical psychologists accessing professional psychological support for their difficulties as 'very acceptable'. Mean scores show that trainees once again perceived their cohort peers to view help-seeking as most acceptable of all of the figures (M = 6.06, SD = 1.00), followed

[11] Higher scores represent lived experience of mental health difficulties amongst psychologists to be seem as more acceptable.

by doctoral faculty (*M* = 5.87, *SD* = 1.16), clinical supervisors (*M* = 5.81, *SD* = 1.11) and other qualified psychologists (*M* = 5.7, *SD* = 1.06). Mean scores show participants perceived all key figures to view help-seeking amongst clinical psychologists to be more acceptable than having lived experience of mental health difficulties.

A repeated measures ANOVA was again conducted to determine whether there was a significant difference in perceived attitudes of others within trainees' profession towards the acceptability of clinical psychologists accessing professional psychological help for their mental health difficulties. Mauchly's test of sphericity indicated that the assumption of sphericity had been violated, therefore a Greenhouse-Geisser correction was used. Analysis concluded that there was a significant difference between perceived acceptability of help seeking, F (2.89, 575.85) = 9.39, $p < .001$. Repeated contrast analyses showed that there was a significant difference in perceived attitudes between cohort peers and doctoral faculty ($p < .01$). However there was no significant difference in perceived acceptability between doctoral faculty and clinical supervisors ($p > .05$), and clinical supervisors and other qualified clinical psychologists ($p > .05$).

Table 6. *Frequency of trainees' perceived attitudes of others' regarding the acceptability of clinical psychologists accessing professional psychological help for their mental health difficulties.*

Perceived acceptability	Cohort	Doctoral faculty	Clinical supervisor	Other qualified psychologists
Extremely Unacceptable	1	2	1	0
Very Unacceptable	1	2	0	1
Somewhat unacceptable	4	7	9	6
Neutral	3	7	14	20
Somewhat acceptable	38	38	36	48
Very acceptable	79	84	86	80
Extremely Acceptable	78	64	58	49

Shaded areas highlight the mode response.

2.3.2.1 Trainees' attitudes toward seeking psychotherapy.

As higher mean item scores demonstrate more positive attitudes towards seeking psychotherapy, Table 7 shows participants' had fewest concerns with being perceived as incompetent by others for accessing psychotherapy (*M* = 4.35, *SD* = 0.86). Lowest mean

item score was for subscale 'need for self-sufficiency', suggesting participants were more inclined to feel that they should be able to solve their own difficulties (*M* = 3.27, *SD* = 1.09).

The total mean score across all participants (*M* = 83.04, *SD* = 10.82), is considerably lower than the mean scores generated during the measure's standardisation (*M* = 103.68, *SD* = 15.26)[12], suggesting participants within the current study had less adaptive attitudes towards seeking psychotherapy than the standardisation sample.

Table 7. *TATSPS descriptive statistics, N = 204.*

TATSPS Subscale	**Mean Total**	**Mean Total SD**	**Mean item score**	**Mean Item Score SD**
Important for professional growth	30.61	5.39	3.83	1.00
Concern with professional credibility	26.11	3.37	4.35	0.86
Concerns about confidentiality	13.24	3.88	3.31	1.36
Need for self-sufficiency	13.08	2.84	3.27	1.09
Total Score	83.04	10.82	3.77	1.14

Abbreviations: SD = Standard Deviation.

2.3.2.2 Measure of trainees' perfectionistic self-presentation (PSP).

As lower scores indicate lower levels of PSP, mean item scores from Table 8 indicate that, on average, participants show highest levels of PSP within subscale 'non-display of imperfection' (*M* = 4.57, *SD* = 1.64), and lowest within subscale 'non-disclosure of imperfection' (*M* = 3.03, *SD* = 1.52).

Participant total mean subscale scores were compared with normative data generated from a pool of 2,014 psychology university students in the measure's standardisation (Hewitt et al., 2003). This shows participants from the current study scored

[12] This represents the mean and standard deviation from individuals within the standardisation sample aged between the ages of 26-30. This age range was chosen as it was closest to the average age of participant within the current study, 29 years old.

lower on PSP subscales 'perfectionistic self-promotion' and 'non-disclosure of imperfection', with normative data of *M* = 39.45, *SD* = 10.85 and *M* = 23.64, *SD* = 7.62 respectively. Participants scored higher compared to the standardised sample on subscale 'non-display of imperfection', with normed values of *M* = 42.52, *SD* = 10.66.

Table 8. *PSPS descriptive statistics, N = 202.*

PSPS Subscale	Mean Total	Mean Total SD	Mean Item	Mean Item SD
Perfectionistic self-promotion	37.09	12.14	3.75	1.63
Non-display of imperfection	45.21	11.94	4.57	1.64
Non-disclosure of imperfection	21.01	7.80	3.03	1.52
Total Score	103.32	29.16	3.87	1.71

2.3.3 Data Preparation.

All measures were scored in accordance with the author's instructions. Likert data was included within parametric analysis to represent interval data, as is widely accepted in the field (Walker & Maddan, 2008). Normal distribution of data was checked through visual inspection of histograms, and by calculating the Z-score for skewness and kurtosis statistics for each variable. Z-scores exceeding +/-2.58 were considered non-normal, following guidance from Field (2009). The assumption of normally distributed data was violated for several of the variables, therefore data was bootstrapped during all parametric analysis to correct for this, again following advice from Field (2009).

Small sections of data were missing at random for nine participants, representing a minor overall proportion of the data set. Three of these participants had failed to complete ranking scores for whom they perceived to influence their ideas of how a clinical psychologist should be, by omitting only one of the four ranks. It was therefore possible to complete the missing data with the outstanding value. All data was included within analysis, as such a small proportion of each participants' entire data set was missing. During analysis, data cases were excluded pairwise through SPSS to account for remaining missing data, therefore reducing total *N* for some analyses.

2.3.4 Research Question 1.

Lower scores (higher ranks) indicated that the professional figure held greater influence on trainees' perceptions of the normative and appropriate attitudes and

behaviours of clinical psychologists. Table 9 shows that trainees reported clinical supervisors had the greatest influence on them (summed scores = 417), followed by other qualified psychologists (498), doctoral faculty (515) and cohort peers (600).

A related samples Friedman's two way analysis of variance non-parametric test was run to determine whether there was a significant difference between participants' rank of influence for different professional figures. Analysis concluded that there was a significant difference between the ranks for different professional figures, X^2 (3) = 49.93, $p < .001$. Pairwise Dunn-Bonferroni post hoc tests showed that there were significant differences between ranked scores for clinical supervisors and other qualified psychologists ($p < .05$), doctoral faculty ($p < .05$) and cohort peers ($p < .001$). There were also significant differences between ranked scores for other qualified psychologists and cohort peers ($p < .05$) and between ranked scores for doctoral faculty and cohort peers ($p < .05$). There was no significant difference between ranked scores for doctoral faculty and other qualified clinical psychologists ($p > .05$).

Table 9. *Descriptive statistics of ranks of influence, N=203.*

Rank of influence	**Sum of Scores**	**Mean**	**SD**
Cohort peers	600	2.96	1.00
Doctoral faculty	515	2.54	1.11
Clinical supervisor	417	2.05	1.06
Other qualified psychologists	498	2.45	1.12

2.3.5 Research Question 2.

2.3.5.1 Correlation.

A bivariate correlation matrix (including point-biserial correlations) was run to explore relationships between variables. Parametric assumptions were checked prior to analysis. Bivariate scatter plots showed that the assumption of linearity of bivariate relationships was met. As the assumption of normal distribution was violated, bivariate distribution was also violated, therefore data was bootstrapped (1,000 samples, bias corrected and accelerated [BCa] confidence intervals at 95%).

Levene's test showed that the assumption of homogeneity of variance of the continuous variables within each category of the dichotomous variable was violated for several of the point-biserial correlations. As point-biserial correlations are robust to this

violation (McGrath & Meyer, 2006), parametric analysis proceeded. No *consistent* outliers were found suggestive of data originating from a different population.

Due to the size of the data set, Table 10 shows only relationships between variables that significantly correlated with TATSPS subscales, and non-disclosure of imperfection.[13] Due to the large number of simultaneous analyses, a more conservative Fischer's criterion of $p < 0.01$ was employed to limit misinterpretations from increased chance of family wise error. Given the large nature of the dataset, only correlations deemed potentially important in understanding help-seeking amongst participants are discussed.

2.3.5.1.1 Important for professional growth.

Table 10 shows there was a significant positive relationship between participants perceptions of personal psychotherapy being important for profession growth, and experience of seeking help (current or past), $r_{pb}(199) = .33$, $p < .01$. There was a significant negative correlation between this same TATSPS subscale and help-seeking being 'not applicable', $r_{pb}(199) = -.221$, $p < .01$.

2.3.5.1.2 Concern with professional credibility.

There were significant positive correlations between participants' perceived attitudes of all figures within their profession towards the acceptability of clinical psychologists having experience of mental health difficulties and seeking help for their difficulties, and TATSPS subscale 'concern with professional credibility'. The strongest of these was with the perceived attitudes of doctoral faculty towards the acceptability of clinical psychologists seeking help, $r(199) = .423$, $p < .01$.

There were significant negative relationships between this TATSPS subscale and 'non-disclosure of imperfection', $r(199) = -.504$, $p < .01$, no history of help-seeking, $r_{pb}(199) = - .188$, $p < .01$, and not currently experiencing a mental health difficulty, $r_{pb}(199) = -.199$, $p < .01$. There were significant positive correlations between concern with professional credibility and having no experience of mental health difficulties, $r_{pb}(199) = .208$, $p < .01$, and with help-seeking being non-applicable $r_{pb}(199) = .218$, $p < .01$.

2.3.5.1.3 Concerns about confidentiality.

There were significant positive correlations between participants' perceived attitudes of all figures within their profession towards the acceptability of clinical

[13] For the comprehensive output of bivariate correlations, please see Appendix F.

psychologists having experience of mental health difficulties and seeking help for their difficulties, and the TATSPS subscale 'concerns about confidentiality'. The strongest of these relationships was with perceived attitudes of doctoral faculty regarding the acceptability of clinical psychologists seeking help for their difficulties, $r(199) = .394$, $p < .01$. Negative relationships were found between 'concerns about confidentiality' and 'non-disclosure of imperfection', $r(199) = -.498$, $p < .01$.

2.3.5.1.4 Need for self-sufficiency.

There were significant positive correlations between TATSPS subscale 'need for self-sufficiency' and perceived attitudes of doctoral faculty, supervisors and other qualified psychologists towards the acceptability of lived experience of mental health difficulties amongst psychologists. This subscale also positively correlated with perceived attitudes of cohort and supervisors regarding the acceptability of clinical psychologists seeking help for their difficulties (see correlation matrix).

The strongest of these associations was with perceived attitudes of supervisors regarding the acceptability of mental health difficulties amongst psychologists, $r(199) = .224$, $p < .01$, and seeking help for mental health difficulties, $r(199) = .235$, $p < .01$.

There was also a negative correlation between need for self-sufficiency and non-disclosure of imperfection, $r(199) = -.461$, $p < .01$.

2.3.5.1.5 Total score.

TATSPS total score formed significant positive correlations with perceived attitudes of all figures within trainees' profession towards the acceptability of mental health experience and help seeking amongst clinical psychologists. The strongest of these associations was with perceived attitudes of doctoral faculty, $r(199) = .341$, $p < .01$, and clinical supervisors, $r(199) = .350$, $p < .01$ towards the acceptability of clinical psychologists seeking help for mental health difficulties.

A negative correlation was found between overall attitudes towards seeking psychotherapy and non-disclosure of imperfection, $r(199) = -.416$, $p < .01$.

Year of study and gender did not significantly correlate with trainees' attitudes towards seeking psychotherapy.

2.3.5.1.6 Non-disclosure of imperfection.

Non-disclosure of imperfection formed significant negative correlations with trainees' perceptions of all figures within the profession towards the acceptability of

having lived experience of mental health difficulties and of help-seeking. Higher scores on 'non-disclosure of imperfection' was positively associated with current or previous experience of help-seeking, $r_{pb}(199) = .228$, $p < .01$, and currently experiencing a mental health difficulty, $r_{pb}(199) = .346$, $p < .01$.

Table 10. *Significant bivariate correlations with TATSPS Subscales.*

	Cohort MH accept.	**Doctoral staff MH accept.**	**Supervisor MH accept.**	**Other CPs MH accept.**	**Cohort HS accept.**	**Doctoral staff HS accept.**	**Supervisor HS accept.**	**Other CPs HS accept.**	**PSPS Non disclos.**	**Has or is HS**	**No HS**	**HS NA**	**No MH exp.**	**Current MH.**
Important for Professional Growth	0.430	-0.026	0.044	-0.026	-0.055	0.042	0.052	-0.006	0.082	0.334**	-0.159*	-0.221**	-0.167	0.024
Concern with professional credibility	0.366**	0.350**	0.330**	0.334**	0.403**	0.423**	0.411**	0.367**	-0.504**	-0.049	-0.188**	0.218**	0.208**	-0.199**
Concerns about confidentiality	0.269**	0.306**	0.292**	0.322**	0.301**	0.394**	0.375**	0.341**	-0.498**	0.029	-0.216**	0.159	0.184**	-0.196**
Need for self-sufficiency	0.121	0.185**	0.224**	0.196**	0.193**	0.180	0.235**	0.158	-0.461**	0.026	-0.179	0.130	0.138	-0.111
TATSPS Total Score	0.191**	0.254**	0.288**	0.258**	0.257**	0.341**	0.350**	0.275**	-0.416**	0.168	-0.262**	0.049	0.084	-0.149
PSPS Non disclos.	-0.229**	-0.208**	-0.338**	-0.291**	-0.258**	-0.225**	-0.243**	-0.211**	1.000	0.228**	0.036	-0.278**	-0.237**	0.346**

***Significant at p<0.01. Due to the size of the matrix it was not possible to include Bootsrapped confidence intervals, however all upper and lower intervals were within acceptable ranges. See Appendix for comprehensive statistical output.*

Key for Table 10

Cohort MH accept. = Perception of cohorts' attitudes regarding the acceptability of clinical psychologists having experience of mental health difficulties.

Doctoral staff MH accept. = Perception of doctoral faculty's' attitudes regarding the acceptability of clinical psychologists having experience of mental health difficulties.

Supervisor MH accept. = Perception of supervisors' attitudes regarding the acceptability of clinical psychologists having experience of mental health difficulties.

Other CPs MH accept. = Perception of other qualified clinical psychologists' attitudes regarding the acceptability of CPs having experience of mental health difficulties.

Cohort HS accept. = Perception of cohorts' attitudes regarding the acceptability of clinical psychologists seeking help for their mental health difficulties

Doctoral staff HS accept. = Perception of doctoral faculty's attitudes regarding the acceptability of clinical psychologists seeking help for their mental health difficulties

Supervisor HS accept. = Perception of supervisors' attitudes regarding the acceptability of clinical psychologists seeking help for their mental health difficulties

Other CPs HS accept. = Perception of other qualified psychologists' attitudes regarding the acceptability of clinical psychologists seeking help for their mental health difficulties

PSPS Non disclos. = PSP non-disclosure of imperfection

Has or is HS = Has previously or is currently seeking help for mental health difficulties

No HS = Has not previously and is not currently seeking help for mental health difficulties

HS NA = Help seeking has/is not applicable

No NH exp. = No current or past lived experience of mental health difficulties

Current MH = Currently experiencing a significant mental health difficulty/difficulties

2.3.5.1 Regression.

Variables that significantly correlated with the TATSPS total score (perceived attitudes of others [cohort, doctoral staff, supervisor, other qualified psychologists] towards the acceptability of clinical psychologists having lived experience of mental health difficulties and seeking help for their difficulties, non-disclosure of imperfection, and no experience of seeking help), were included within a multiple linear regression model to explore the ability of the model to predict participants' overall attitudes towards seeking psychotherapy (TATSPS total score). Parametric assumptions were assessed. Data was again Bootstrapped (1,000 samples, bias corrected and accelerated [BCa] confidence intervals at 95%) to account for non-normal distribution. Durbin-Watson testing showed that the residuals were not related. The assumption of no multicollinearity was also met, with acceptable Tolerance and VIF levels. Analysis of plots of standardised residuals and standardised predicted values showed that the assumption of homoscedasticity was met.

Data was entered via a hierarchical blockwise method. 'Non-disclosure of imperfection' was entered in block 1 to understand the unique contribution of PSP in predicting change in TATSPS total score, and to explore the impact of the addition of subsequent variables to the model's predictive capacity. Perceived attitudes of others were entered in block 2, and no experience of seeking help in block 3.

The regression model was a significant fit to the data, $F(10, 191) = 8.00$, $p < .001$, and adjusted r^2 showed this explained 25.8% of variance in TATSPS total score. Table 11 shows that the only variables to significantly contribute to the model were 'non-disclosure of imperfection' ($p < .001$) and 'no experience of seeking help' ($p = .001$). Unstandardised beta coefficients demonstrate that for every unit increase in variable 'non-disclosure of imperfection' (signifying an increase in perfectionism), a -.47 unit decrease in TATSPS total score is predicted (signifying less positive attitudes towards seeking psychotherapy), and for every unit increase in variable 'no experience of seeking help', a -5.55 unit decrease in TATSPS total score is predicted with all other variables held constant. Comparison of the magnitude of standardised coefficients shows that 'non-disclosure of imperfection' (-.32) is more important in predicting TATSPS total score than 'no experience of seeking help' (-.21). Bootstrap analysis supported conclusions of the general co-efficient analysis.

Table 11. *Multiple regression analysis to predict TATSPS Total Score, N = 202.*

Variable	Unstandardised Beta	SE	95% CI Lower	95% CI Upper	Standardised Beta
Constant	76.959	6.478	64.181	89.736	-
Non disclose. imperfection	-0.465	0.096	-0.655	-0.275	-0.323**
Cohort MH accept.	0.585	0.958	-1.304	2.474	0.061
Doctoral staff MH accept.	0.190	0.861	-1.508	1.887	0.024
Supervisor MH accept.	0.452	0.915	-1.352	2.257	0.052
Other CPs MH accept.	0.130	1.011	-1.864	2.124	0.014
Cohort HS accept.	-0.617	1.110	-2.807	1.574	-0.057
Doctoral staff HS accept.	1.272	1.034	-0.767	3.311	0.136
Supervisor HS accept.	1.396	1.128	-0.829	3.620	0.143
Other CPs HS accept.	-0.369	1.149	-2.636	1.898	-0.036
No experience HS	-5.553	1.714	-8.935	-2.172	-0.208**

Significant at p<0.001. Abbreviations: SE = Standard Error.

2.3.6 Hypothesis 1.

2.3.6.1 Mediation.

Multiple mediation analysis was conducted using PROCESS (Hayes, 2018), to explore whether the relationship between non-disclosure of imperfection and TATSPS total score was mediated by perceived attitudes of others (cohort peers, doctoral faculty, clinical supervisor and other qualified psychologists) regarding the acceptability of clinical psychologists seeking professional psychological help for mental health difficulties. Only perceived attitudes of others towards the acceptability of *help-seeking* were included in this stage of analysis, as these were most theoretically relevant to the TATSPS total score outcome variable.

Figure 2 shows that perceived attitudes of doctoral faculty and clinical supervisors (towards the acceptability of clinical psychologists seeking help for mental health

difficulties) mediated the relationship between PSP non-disclosure of imperfection and TATSPS total score, with indirect effect of perfectionism on help-seeking attitudes *b*= -0.10, bootstrapped *SE* = 0.05, BCa 95% CI [-0.21, -0.03].

Within this mediation pathway, increase in PSP non-disclosure of imperfection results in reduction in participants perceived attitudes towards the acceptability of help-seeking, in turn resulting in a reduction in TATSPS total score.

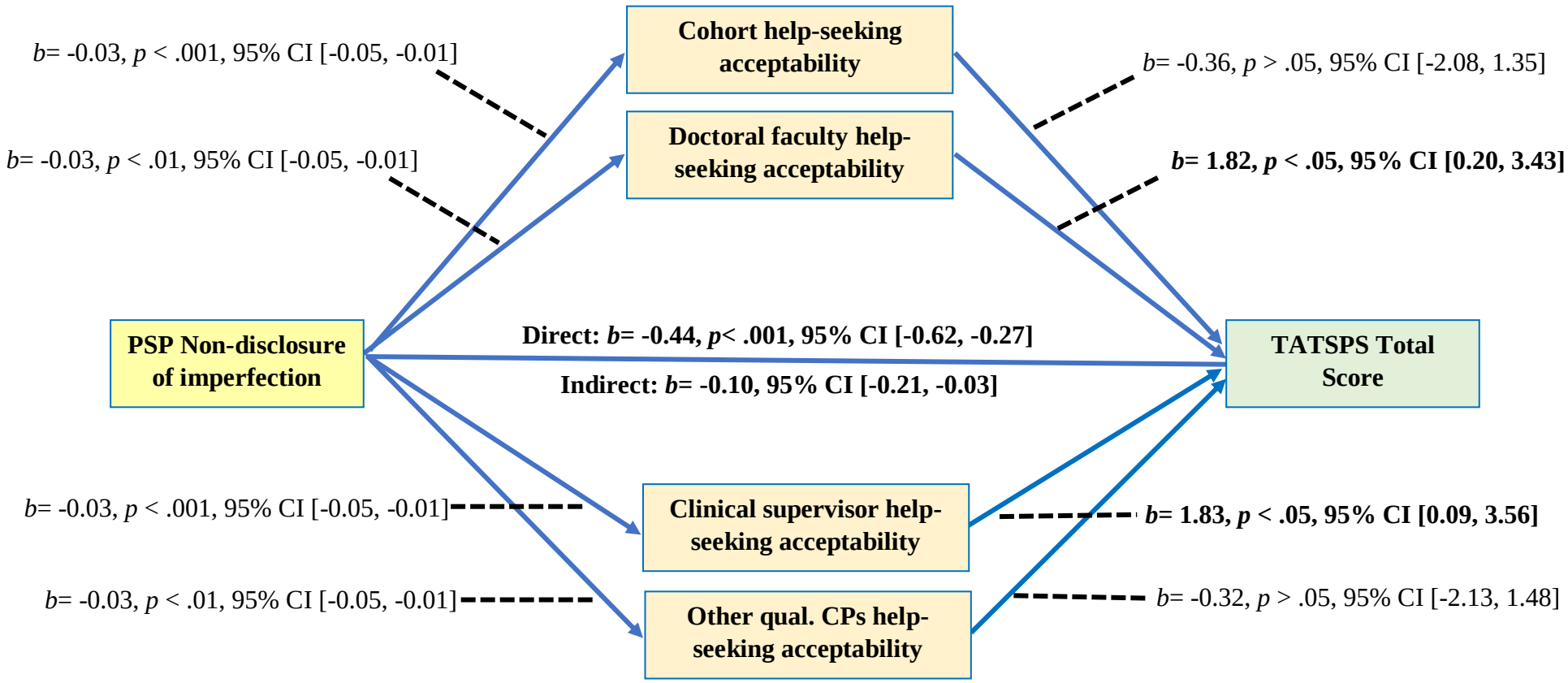


Figure 2. *Attitudes of others regarding the acceptability of clinical psychologists seeking help for their mental health difficulties mediating the relationship between non-disclosure of imperfection and TATSPS total score.*

2.4 Discussion

The study aimed to improve our knowledge of factors that influence trainees' attitudes towards seeking psychotherapy by developing a more nuanced understanding of the influence of key figures within trainees' professional group, and exploring the role of interpersonal perfectionism.

2.4.1 Descriptive analysis.

The results showed that the majority, 61.8%, of UK trainee clinical psychologists surveyed had lived experience of mental health difficulties. This is slightly lower than the finding of 67% in the same population in a recent study by Grice et al. (2018) and higher than Cushway's (1992) finding of 59%. This includes 10.3% of the total sample who described themselves as currently experiencing a significant mental health difficulty. Almost a third of trainees reported that there had been a time during their clinical training in which they were in need of professional psychological support for their mental health but did not seek it. This figure is lower than that reported by Bearse et al. (2013), which showed 59% of qualified psychologists had needed help but failed to source it.

These findings reinforce the need for trainee clinical psychologists to be actively engaging in self-care strategies (including accessing psychotherapy when needed), and highlight the importance of further research to understand the factors that influence trainees' attitudes towards seeking help.

Despite the now sizeable body of literature evidencing the ethical importance and benefits of self-care, a survey of 500 APA graduate students found more than 80% reported that their programme did not provide written resources on self-care, and approximately 60% felt that their training institute didn't promote self-care within its culture (Munsey, 2006b). Later research suggests that training cultures may be, in part, changing. A review of UK BPS accredited training programme handbooks and material by Vally (2018), found that the majority of programmes (93.5%) provided detailed information regarding self-care for trainees. In spite of this, results of the current study suggest there is clearly much left to do to encourage help-seeking amongst this population.

Results suggested that, in general, trainees perceived key figures in their profession to view lived experience of mental health difficulties and help-seeking amongst clinical psychologists to be very acceptable. It is concerning however that trainees' perceived their doctoral faculties to have the poorest attitudes of all the figures within the study towards the acceptability of lived experience of mental health difficulties. Furthermore, almost a

quarter of trainees rated their faculty's attitudes towards the acceptability of mental health experience as 'neutral' or poorer.

Results from the TATSPS suggested that trainees were most concerned with feeling that they should be able to solve their problems on their own. This links in with work by Deutsch (1985), in which therapists felt pressure to work through difficulties alone. Trainees in the current study had less positive attitudes towards seeking psychotherapy than the measure's standardisation sample in Farber's (2000) study. As attitudes towards help-seeking have been shown to predict help-seeking behaviour, it is perhaps unsurprising that almost 30% of trainees had needed help during training but failed to seek it.

When compared to the standardisation sample of psychology students (Hewitt et al., 2003), trainees from the current study showed lower scores on two measures of PSP. Conversely, trainees' desire to conceal behavioural imperfection exceeded that of a clinical sample of 1,045 psychiatric patients studied in the standardisation of the measure. As increased PSP is associated with psychopathology (Hewitt & Flett, 1991), this finding is concerning.

2.4.2 Research Question 1.

R1 asked which members of their professional group identity trainee clinical psychologists look to *most* to influence their understanding of the expected qualities and behaviours of a clinical psychologist. Results showed that trainees were most influenced by their clinical supervisors on placement. This is unsurprising, given that trainees have most opportunities to observe their supervisors in professional practice.

This finding is important in helping us to understand how to target efforts to change attitudes and cultures within the profession to counter the culture of silence and shame around experience of mental health difficulties (Pope & Tabachnick, 1994). Trainees may have ranked their cohort as least important as they are at a similar developmental level and may therefore feel less able to learn from them.

2.4.3 Research Question 2.

R2 asked what the ability of a regression model would be (consisting of previously researched and novel variables) to predict trainees' attitudes towards seeking psychotherapy, and how much relative variance in attitudes towards seeking psychotherapy could be explained by each variable.

2.4.3.1 Correlation analysis.

Exploratory correlations showed that increased belief in the importance of psychotherapy for professional growth was related to increased experience of seeking help; presumably because these individuals had experienced such benefits. These results relate to numerous studies that have detailed the self-reported professional benefits from engaging in psychotherapy, and increased belief in personal therapy efficacy (Orlinsky et al., 2011).

Perceiving cohort, faculty, supervisors and other qualified psychologists to view mental health experience and help-seeking amongst psychologists as more acceptable was associated with trainees' having fewer concerns about their professional credibility as a result of accessing psychotherapy, fewer concerns with confidentiality of help-seeking, and to having an overall more positive attitude towards seeking psychotherapy. This suggests that trainees' help-seeking attitudes *are* influenced by the attitudes of key figures within their profession.

From a SIT perspective, participants who perceive others within their group identity to view experience of mental health difficulties and of accessing therapy as more acceptable may feel these qualities and behaviours are more likely to represent normative behaviours and attitudes of the group. Trainees may therefore feel more positive towards accessing personal therapy, due to holding fewer concerns that this might violate group expectations. Those who perceive others in their group to view mental health experience and help-seeking and as less acceptable (and representing qualities and behaviours belonging to an 'out-group') may conversely have more negative attitudes towards seeking therapy for fear that accessing psychotherapy will reduce their normative fit within the group (Sindic & Condor, 2014).

The strongest correlations with TATSPS subscales 'concerns with professional credibility' and 'concerns about confidentiality' were trainees' perceptions of faculty and supervisors' attitudes towards the acceptability of psychologists seeking help. Strong association between these domains may relate to faculty and supervisors' roles in assessing trainees during their clinical training.

Dearing et al. (2005) had previously demonstrated training faculties' attitudes towards students being in psychotherapy influenced psychology students' attitudes towards seeking help. The authors go on to presume that the attitudes of mentors and supervisors would have similar influence on students' help-seeking attitudes. The current study goes some way to support this, but deconstructs this further to suggest that trainees' help-seeking attitudes are most influenced by perceived attitudes towards the acceptability of

mental health experience and help-seeking of individuals directly involved in their assessment during training.

Trainees with no previous experience of mental health difficulties had fewer concerns with how help-seeking may influence their professional credibility or with confidentiality of help-seeking. We can speculate that it may be harder for these individuals to appreciate or anticipate the stigma and shame reported by many of their peers in previous research (Wilson et al., 2015).

Results also showed that increased interpersonal perfectionism was associated with having greater concerns with how help-seeking would impact professional credibility, more concerns with help-seeking being kept confidential, feeling a greater need to solve problems independently, and with overall less adaptive attitudes towards seeking psychotherapy. Increased interpersonal perfectionism was also related to perceiving others within the professional group to view experience of mental health difficulties and help-seeking as less acceptable.

The influence of interpersonal perfectionism on trainees' attitudes towards seeking psychotherapy and their perceived attitudes of others can be understood by looking to the wider literature. People high in PSP are proposed to be pre-occupied with others' expectations of them and hyper-sensitive to their own flaws (Hewitt et al., 2003). The 'non-disclosure of imperfection' subscale of the PSPS has been shown to strongly correlate with the 'socially prescribed perfectionism' subscale of the Multidimensional Perfectionism Scale (MPS) (Hewitt et al. 2003). Hewitt et al. (2003) therefore propose that reluctance to disclose flaws may stem from perceiving others to expect perfection and to be critical of imperfection. Trainees higher in PSP are therefore more likely to anticipate negative appraisal from others for perceived imperfection, potentially explaining why these individuals perceive attitudes of others towards the acceptability of help seeking and mental health experience to be more critical.

Anticipation of negative judgement is likely to feel threatening to these individuals (Hewitt et al., 2003); potentially leading to them to conceal their 'imperfection' and result in poorer attitudes towards seeking psychotherapy.

Higher levels of interpersonal perfectionism was also associated with having experience of mental health difficulties and help-seeking. This supports previous research that shows different constructs of trait perfectionism relates to experience of psychopathology (Hewitt & Flett, 1991).

Interestingly, trainees' year of study and gender did not significantly relate to trainees' attitudes towards seeking psychotherapy as demonstrated in earlier research (Dearing et al., 2005). Variances in these findings may relate to underlying population differences.

2.4.3.2 Regression analysis.

The results from the study answered R2, and demonstrated that the regression model explained more than a quarter of variance in trainees' overall attitudes towards seeking psychotherapy. Results also showed that trainees' concern with concealing verbal disclosure of imperfection, and having no previous history of help-seeking significantly contributed to the regression model to uniquely explain variance in trainees' attitudes towards seeking psychotherapy.

Perceived attitudes of others did not significantly contribute to this model. This suggests that, when considered in the context of PSP and history of help seeking, perceived attitudes of others do not significantly predict change in trainees' help-seeking attitudes. This highlights the relative importance of PSP in predicting trainees' attitudes towards seeking psychotherapy, which has not been previously demonstrated in this population.

2.4.4 Hypothesis 1.

Hypothesis 1 predicted that the relationship between trainees' desire to avoid verbal disclosure of imperfection and overall attitudes towards seeking psychotherapy would be mediated by trainees' perceived attitudes of others in their profession towards the acceptability of clinical psychologists accessing professional psychological help for their difficulties.

As mediation analysis implies underlying causality (Loeys, Talloen, Goubert, Moerkerke, & Vansteelandt , 2016), analysis showed that trainees' interpersonal perfectionism influenced their attitudes towards seeking psychotherapy both directly and indirectly, with the direct pathway producing greater variance in trainees' attitudes towards seeking psychotherapy than the indirect pathway. In the indirect pathway, increased levels of interpersonal perfectionism influenced trainees' perception of the views of others within their professional group such that they perceive help-seeking to be viewed as less acceptable by faculty and supervisors. This, in turn, negatively influenced trainees' own attitudes towards seeking psychotherapy. Results therefore support the experimental hypothesis.

Interestingly, only perceived attitudes of faculty and supervisors significantly mediated the relationship between PSP and attitudes towards seeking psychotherapy. Once again, it is likely that this relates to faculty and supervisors being directly involved in trainee assessment.

2.4.5 Implications for training institutes.

This research highlights the importance of perceived faculty attitudes towards the acceptability of help-seeking and lived experience of mental health difficulties in influencing trainees' attitudes towards seeking psychotherapy. Although trainees' generally perceived these attitudes to be positive, a not insignificant minority of participants believed that help-seeking and experience of mental health difficulties are not viewed as acceptable by members of their faculty.

From a SIT perspective, training institutes are urged to follow recommendations by Barnett et al. (2007), who argued for self-care and transparency of difficulties to become part of the professional identify of psychology. This is particularly important given the formative nature of clinical training, socialising trainees to their professional identity. By working to include experience of mental health and help-seeking as norms of the professional group identity, trainees would not feel they are violating perceived group expectations should they make the ethical, responsible decision to seek help for their difficulties. If training cultures can change their culture so that having experience of mental health difficulties and seeking help is no longer perceived to signify having a flaw or imperfection, then these behaviours and qualities may be less threatening to individuals high in levels of trait perfectionism.

Given the importance of perfectionism in influencing help-seeking both directly and indirectly, training institutes should also consider psychoeducation and possible interventions to address associated problematic cognitions and behaviours. More information on the impact of perfectionim on trainees' experience of training is arguably required first.

2.4.6 Implications for the wider profession.

This research demonstrates the power of clinical supervisors to influence trainees' attitudes towards the acceptability of seeking help and more generally about behavioural norms within the profession. Supervisors therefore have a responsibility to promote adaptive attitudes towards seeking professional help for difficulties when needed. The wider profession, having a distinct group identity, also needs to similarly work towards cultural change to address the silence and stigma around mental health difficulties.

Some have argued that clinical psychologists bear a professional responsibility to promote de-stigmatisation; starting within our own profession. Barnett et al. (2007) called for qualified psychologists to develop work environments encouraging help-seeking and transparency of personal distress, to act as role models to trainees and colleagues from neighbouring professions.

2.4.7 Implications for trainees.

The findings of this study highlight the potential negative impact of trainees' interpersonal perfectionism on their help-seeking attitudes and behaviours. In addition to training institutes and the wider clinical psychology profession making adaptations to promote and de-stigmatise experience of mental health difficulties, trainees too are urged to act. As developing reflexive practitioners, trainees are encouraged to develop a skill that is key in their therapeutic practice (Sutton, 2016); self-awareness.

Trainees need to maintain an awareness of their mental health difficulties and seek profesional support where necessary, in accordance with self-care guidelines. In light of these findings, trainees are also encouraged to develop an awareness of their perfectionistic tendencies (where relevant), and how this may impact their attitudes towards seeking professional support. Increasing awareness may enable trainees' to make more mindful decisions regarding seeking professional help. Trainees are therefore encouraged to engage in the appropriate activities evidenced to promote this vital, active process.

2.4.8 Implications for future research.

The current research aimed to develop our understanding of factors influencing trainee clinical psychologists' atttiudes' towards seeking professional help. Yet this is likely to be influenced by a complex interplay of factors. More research is therefore needed to deepen our appreciation of variables involved in influencing help-seeking attitudes. Interventions can then be developed to facilitate help-seeking amongst this population to ensure the emotional wellbeing of practitioners and their clients.

There is a scarcity of research to date exploring perfectionism amongst trainee psychologists. Of the limted studies to date (including the current research) perfectionism has been shown to negatively influence disclosure (Grice et al., 2018) and help-seeking within this population. Further exploration of how PSP influences trainees' experience of clinical training (for instance the supervisory relationship, acacdemic demands and even in clinical practice) would be illuminating. Grice et al (2018) also urged the profession to increase awareness of perfectionism, and called for more research to understand it's impact.

2.4.9 Strengths and limitations.

Although the study focussed on the influence of a subset of variables on trainees' attitudes towards seeking psychotherapy, there are likely to have been a number of confounding variables that could not be controlled for within the scope of the project, including cost of accessing therapy, accessibility, and time restrictions. Results therefore need to be considered within the context of the wider literature on this subject.

Furthermore, participants who scored higher on facets of PSP may have been more inclined to conceal flaws from others, and therefore may have failed to disclose experience of mental health difficulties or even accurately report on their own perfectionistic traits. This has the potential therefore to bias the data. The research was also vulnerable to difficulties faced by all survey based research, including social desirability bias, response bias and difficulty clarifying meaning within questionnaires (Moy & Murphy, 2016).

It would have been interesting to explore the relaitonship between clinical orientation and help-seeking attitudes, and the possibility of particular schools of therapy having different approaches to help-seeking and self-care. This was however outside of the scope of the current research, and is an area for future investigation.

The study was vulnerable to response bias, as individuals with strong views on the research topic or with personal relevant experience were potentially more inclined to participate; thus impairing generalisability. Participants were mostly female, although this may reflect the female dominance within the profession (Farndon, 2016). The majority of participants were in their second year of study, and reported to be of eclectic/integrative orientation, which may again limit the generalisability of the findings. This was countered however by the large sample size and participation of students from a large proportion of UK BPS approved training institutes.

Based on the a priori calculation, the study was adequately powered to run the chosen analysis. Due to the large number of variables investigated and multiple testing, the data was vulnerable to increased likelihood of Type 1 errors, which was countered through use of a conservative Fisher's critereon.

2.5 Conclusion

To the authors' knowledge, this is the first study to explore the role of interpersonal perfectionism and perceived attitudes of key figures within trainees' professional identity towards acceptability of mental health and help-seeking in influencing trainees' attitudes towards seeking psychotherapy.

Findings showed that increased interpersonal perfectionism was associated with increased concerns with the impact of seeking psychotherapy on their professional credibility, more concerns about confidentiality of help-seeking, a heightened belief in the need for self-sufficiency and overall less positive attitudes towards seeking psychotherapy. The relationship between trainees' interpersonal imperfection and their overall attitudes towards seeking psychotherapy was mediated by perceived attitudes of programme faculty and clinical supervisors towards the acceptability of help-seeking, with increased perfectionism related to help-seeking being perceived as less acceptable.

The work highlights the need for training institutes and the wider profession to develop the norms of their group identity to include help-seeking and transparency of mental health difficulties, and invites further research into how interpersonal perfectionism influences trainees' experience of clinical training. It also emphasises the need for trainees to maintain an awareness of their interpersonal perfectionism, to prevent this from interfering with their help-seeking attitudes and behaviours.

Appendix A Participant information sheet

Participant Information Sheet

A Study Exploring Factors Influencing Trainee Clinical Psychologists' Attitudes Toward Seeking Psychological Help

Researcher: Anna Weller

ERGO number: 31653

You are being invited to take part in a research study. Please read this information carefully before deciding to take part. If you are happy to participate you will be asked to indicate your consent to take part.

What is the research about?

Research suggests both Clinical Psychologists and Trainee Clinical Psychologists experience a variety mental health difficulties, and encounter a number of work related risk factors for their development. Although Clinical Psychologists' and Trainees have been shown to access personal therapy at a rate higher than in the general population, research suggests they are often reluctant to engage in personal therapy, and access inadequate psychological support for their difficulties.

This study aims to explore factors that may potentially influence UK Trainee Clinical Psychologists' attitudes towards seeking psychological help. Understanding this may be instrumental in developing future interventions to support help-seeking in this population.

This research is being conducted in part fulfilment of the researcher's Doctorate in Clinical Psychology at the University of Southampton. The project is supervised by Clinical Psychologists Dr Nick Maguire and Dr Angharad Rudkin, and has been approved by the Southampton University School of Psychology ethics committee.

Why have I been asked to participate?

You have been asked to participate because you are a Trainee Clinical Psychologist currently enrolled in a British Psychological Society (BPS) approved UK training course.

What will happen to me if I take part?

If you choose to take part, you will firstly be asked to give your informed consent via an online consent form. You will then be asked to complete an online questionnaire which will take approximately 30-45 minutes to complete.

Are there any benefits in my taking part?

For taking part, you will be eligible to be entered into a prize draw to win a £100 Amazon voucher. Furthermore, findings from the study will extend our knowledge about the factors that may influence trainee clinical psychologists' attitudes towards seeking psychological help for mental health difficulties. This may in turn lead to strategies that assist trainees' to seek appropriate support for their difficulties; benefiting trainees' psychological wellbeing and their clinical practice.

Are there any risks involved?

The questionnaire will ask some sensitive questions about your experience of mental health difficulties (which you will be given the option to choose not to answer) and also about some of your personal traits. An example of such questions is "If you have had experience of mental health difficulties, are you currently seeking or have you ever accessed professional psychological support for this"? A further example question is "how much do you agree with this statement - If a person asks for help, it is a sign of weakness".

Although it is unlikely that you will experience any psychological discomfort as a result of completing the questionnaire, you will be informed of support that you can access should you feel any distress following participation.

Will my participation be confidential?

Only the primary researcher (Anna Weller) and the supervisors will have access to the data you provide. Your participation will be entirely anonymous (unless you wish to be entered into the prize draw) as the questionnaire will not gather any personal identifiable information about you or your University linking you to you data. If you would like to be entered into the prize draw for a chance to win a £100 Amazon voucher, you will be asked to provide your email address. However any data you provide will be anonymised in any subsequent report of the results.

All data will be handled, stored and destroyed in adherence to the Caldicott Principles and Data Protection Act 1998.

What should I do if I want to take part?

If you wish to take part in this study, then please read the statement below asking about consent. Once you have given your consent to take part, you will be asked to proceed to the study questionnaire by pressing the arrow at the bottom of the page.

What happens if I change my mind?

You can choose to discontinue completion of the study questionnaire at any point. Due to the anonymous nature of the data collection however, once you have submitted your answers to the questionnaire online we will be unable to withdraw your data from the study.

What will happen to the results of the research?

The results of the research will be written up into a research project and submitted for publication. Due to the anonymous nature of participation, we will be unable to send participants a copy of the final paper. Anonymised data gathered will not be made available for any future research projects, and will be stored for 10 years, as per University of Southampton policy. Any publications and anonymised data relating to this research will be made available through the institutional repository.

Where can I get more information?

Should you have any queries about the study or your participation, then please email the lead researcher, Anna Weller, at aw1g15@soton.ac.uk.

What happens if something goes wrong?

Should you have any concerns or wish to make a complaint about this study, then please contact Isla Morris, Research Integrity and Governance Manager for Southampton University Research Governance Office on 02380 595058 or on rgoinfo@soton.ac.uk.

Thank you!

Thank you for taking the time to read this information sheet and for considering taking part in the research.

Appendix B Email to training institutes

Dear Program Directors,

We are carrying out a research study at the University of Southampton exploring factors that influence UK trainee clinical psychologists' attitudes towards seeking psychological help.

Research demonstrates that both qualified and trainee clinical psychologists seek inadequate support for their mental health difficulties, which may adversely impact both their psychological wellbeing and clinical practice. Results from this research may be important in helping us to develop strategies to assist trainees to access adequate professional support for their difficulties to protect both their wellbeing and professional practice.

We are hoping to recruit in excess of 200 participants, therefore I would be extremely grateful if you would be willing to circulate the email below to all current trainee cohorts enrolled in your program? The email contains some information about the research, and a link taking trainees to an online questionnaire should they wish to participate.

The research is supervised by Clinical Psychologists Dr Nick Maguire and Dr Angharad Rudkin, and has been approved by the Southampton University School of Psychology ethics committee.

Any help you could offer would be greatly appreciated.

If you have any questions about the research, or feel someone else may be better placed to help me with this request, then please do not hesitate to contact me.

Kind Regards,

Anna Weller
3rd Year Trainee Clinical Psychologist
University of Southampton

Appendix C Email to potential participants

Dear Trainees,

I am writing to invite you to take part in a research study exploring factors that influence UK Trainee Clinical Psychologists' attitudes towards seeking psychological help.

Participation would involve completing one online questionnaire asking about your attitudes towards seeking psychological help for mental health difficulties and some factors that may influence this. This will take approximately 30-45 minutes to complete.

As a thank you, participants will have the option to be entered into a prize draw to win a £100 Amazon voucher!

As a trainee myself I appreciate how busy you must be! However your participation will help to develop our understanding in this area which could ultimately lead to developments that help trainees to access the support that they need.

Should you wish to participate, please click on the link below which will take you to the online study information, consent form and the questionnaire:

[LINK TO ISURVEY]

The research has been approved by the Southampton University School of Psychology ethics committee.

Your participation in this study would be greatly appreciated. If you have any questions about the study or your participation, then please do not hesitate to contact myself as the lead researcher, Anna Weller, at aw1g15@soton.ac.uk.

Kind Regards,

Anna Weller
3rd Year Trainee Clinical Psychologist
School of Psychology, University of Southampton

Appendix D Debriefing statement

Debriefing Statement

A Study Exploring Factors Influencing Trainee Clinical Psychologists' Attitudes Toward Seeking Psychological Help

Thank you for taking part in this study!

The aim of this research was to explore the potential relationships between UK Trainee Clinical Psychologists' dysfunctional attitudes and perfectionism traits, and attitudes towards seeking psychological help, and their perception of the attitudes towards mental health and help-seeking held by key figures within their profession.

Research indicates that there are a range of factors that influence help-seeking attitudes amongst Trainee Clinical Psychologists and, in turn, their help-seeking behaviour. Your data will expand our understanding in this area, which may help us to develop interventions to assist Trainee Clinical Psychologists to access adequate professional support for their difficulties. This is important to protect the psychological wellbeing of the practitioners, and to ensure the quality of their professional practice.

If you have any further questions about the study or your participation, then please contact the lead researcher, Anna Weller, at aw1g15@soton.ac.uk.

If you feel distressed by any of the questions or issues raised by your participation in this study, then please contact your local GP, The Samaritans on 116 123 or pastoral support provided by your University who will be able to direct you to further support if appropriate.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk.

Appendix E Idiosyncratic questionnaire

SECTION 1

a. Age: _____

b. Gender (please select appropriate option):

- ☐ Male
- ☐ Female

c. Year of DClinPsych study (please select appropriate option):

- ☐ 1
- ☐ 2
- ☐ 3

d. Which of the following best describes your clinical orientation? Please select the appropriate option:

- ☐ Cognitive-behavioural
- ☐ Systemic
- ☐ Psychodynamic/psychoanalytic
- ☐ Eclectic
- ☐ Other (please specify):_____

e. Which of the following statements best describes you? Please select appropriate option:

- ☐ I am currently experiencing a significant mental health difficulty or difficulties*
- ☐ I am not currently experiencing a significant mental health difficulty, but I have previously experienced a significant mental health difficulty
- ☐ I am not currently experiencing a significant mental health difficulty, and I have never experienced a significant mental health difficulty
- ☐ I would prefer not to disclose

* For the purpose of this research, a significant mental health difficulty is defined as psychological and behavioural difficulties that cause significant distress and/or impairment in one or more important areas of functioning. This includes mental health difficulties detailed by DSM and ICD, however a formal diagnosis is not necessary (adapted from definitions suggested by Grice 2016, and Stein et al. 2010).

f. If you have had experience of mental health difficulties, are you currently accessing or have you ever accessed professional psychological support* for this? Please select the appropriate option:

- ☐ Yes
- ☐ No
- ~~☐ I would prefer not to disclose~~
- ☐ Not applicable

*This includes accessing psychological therapy/guidance via a number of routes (including 1:1 talking therapy of any therapeutic modality, group therapy or

psychological skills groups, online therapy and professionally guided self-help courses).

g. Has there ever been a time **during your clinical training** in which you felt that you were in need of professional psychological support for your mental health difficulties but did **not** seek it?

   ☐ Yes

   ☐ No

   ☐ I would prefer not to disclose

SECTION 2

a. What is your overall perception of the following individuals' attitudes towards the **acceptability** of **clinical psychologists** having current or past **mental health difficulties**? I.e. Do you think these individuals view clinical psychologists having current or past experience of mental health difficulties to be acceptable? Please select the appropriate options:

	Extremely unacceptable	Very unacceptable	Somewhat unacceptable	Neutral	Somewhat acceptable	Very Acceptable	Extremely acceptable
Members of your doctoral cohort							
Doctoral programme staff							
Your current placement supervisor							
Other qualified clinical psychologists (e.g. your mentor)							

b. What is your overall perception of the following individuals' attitudes towards the **acceptability** of **clinical psychologists** accessing **professional psychological help** for their mental health difficulties? I.e. Do you think these individuals view clinical psychologists accessing professional psychological help to be acceptable? Please select the appropriate options:

	Extremely unacceptable	Very unacceptable	Somewhat unacceptable	Neutral	Somewhat acceptable	Very acceptable	Extremely acceptable
Members of your doctoral cohort							
Doctoral programme staff							
Your current placement supervisor							
Other qualified clinical psychologists (e.g. your mentor)							

SECTION 3

a. Please rank in terms of importance who influences your ideas about what a clinical psychologist should be like (in terms of qualities, attitudes and behaviours). Please number each box from 1 to 4, with 1 representing the most important in influencing you, and 4 the least important in influencing you:

☐	Members of your doctoral cohort
☐	Doctoral programme staff
☐	Your current placement supervisor
☐	Other qualified psychologists (e.g. your mentor)

SECTION 4 – TATSPS*

*The TATSPS has not been included due to concerns over copyright breach.

SECTION 5 - PSPS

Listed below are a group of statements. Please rate your agreement with each of the statements using the following scale. If you strongly agree, select 7; if you disagree, select 1; if you feel somewhere in between, select any one of the numbers between 1 and 7. If you feel neutral or undecided the midpoint is 4.

	Disagree Strongly 1	2	3	Neutral 4	5	6	Agree Strongly 7
1. It is okay to show others that I am not perfect							
2. I judge myself based on the mistakes I make in front of other people							

(3) I will do almost anything to cover up a mistake							
(4) Errors are much worse if they are made in public rather than in private							
(5) I try always to present a picture of perfection							
(6) It would be awful if I made a fool of myself in front of others							
7. If I seem perfect, others will see me more positively							
8. I brood over mistakes that I have made in front of others							

9. I never let others know how hard I work on things							
10. I would like to appear more competent than I really am							
11. It doesn't matter if there is a flaw in my looks							
12. I do not want people to see me do something unless I am very good at it							
13. I should always keep my problems to myself							
I should solve my own problems rather than admit them to others							

I must appear to be in control of my actions at all times							
It is okay to admit mistakes to others							
It is important to act perfectly in social situations							
I don't really care about being perfectly groomed							
Admitting failure to others is the worst possible thing							
I hate to make errors in public							
I try to keep my faults to myself							
I do not care about making mistakes in public							

I need to be seen as perfectly capable in everything I do							
Failing at something is awful if other people know about it							
It is very important that I always appear to be “on top of things”							
I must always appear to be perfect							
I strive to look perfect to others							

Appendix F SPSS outputs

Descriptive Statistics

	N	Minimum	Maximum	Sum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties	204	1	7	1153	5.65	1.132	-1.359	.170	2.167	.339
Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties	204	1	7	1046	5.13	1.355	-.810	.170	.306	.339
Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties	204	1	7	1101	5.40	1.245	-.898	.170	.875	.339
Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties	204	1	7	1072	5.25	1.163	-.700	.170	.539	.339
Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties	204	1	7	1237	6.06	1.003	-1.579	.170	4.206	.339

Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties	204	1	7	1197	5.87	1.156	-1.573	.170	3.357	.339
Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties	204	1	7	1186	5.81	1.107	-1.164	.170	1.623	.339
Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties	204	2	7	1163	5.70	1.062	-.725	.170	.256	.339
Important for professional growth/effectiveness	204	14	40	6245	30.61	5.386	-.331	.170	-.334	.339
Concern with professional credibility	204	16	30	5327	26.11	3.372	-1.023	.170	.639	.339
Concerns about confidentiality	204	4	20	2700	13.24	3.883	-.440	.170	-.541	.339
Need for self-sufficiency	204	6	20	2668	13.08	2.836	.068	.170	-.176	.339
Total Score	204	55	104	16940	83.04	10.817	-.523	.170	-.273	.339
PSPS - Perfectionistic Self-Promotion	202	10	67	7567	37.46	11.623	-.060	.171	-.336	.341
PSPS - Nondisplay of Imperfection	202	12	68	9223	45.66	11.109	-.342	.171	-.094	.341
PSPS - Nondisclosure of Imperfection	202	7	47	4287	21.22	7.552	.487	.171	.305	.341
PSPS - Total Score	202	30	180	21077	104.34	27.410	-.037	.171	-.053	.341

Bivariate Correlations

		Perception of cohorts' attitudes reacceptability of CPs having experience of MH difficulties	Perception of doctoral programme staffs' attitudes reacceptability of CPs having experience of MH difficulties	Perception of supervisors' attitudes reacceptability of CPs having experience of MH difficulties	Perception of other qualified CPs' attitudes reacceptability of CPs having experience of MH difficulties	Perception of cohorts' attitudes reacceptability of CPs seeking help for their MH difficulties	Perception of doctoral programme staffs' attitudes reacceptability of CPs seeking help for their MH difficulties	Perception of supervisors' attitudes reacceptability of CPs seeking help for their MH difficulties	Perception of other qualified psychologists' attitudes reacceptability of CPs seeking help for their MH difficulties	Important for professional growth/effectiveness	Concern with professional credibility	Concerns about confidentiality	Need for self-sufficiency	Total Score	PSPS - Non disclosure of Imperfection	Has or is seeking help	Not seeking help	Not Applicable	No current MH, never had MH exp	No current MH, have prev MH exp	Currently experiencing MH prob	Prefer not to disclose	Gender	Year 1 DClinPsych	Year 3 DClinPsych	Year 2 DClinPsych
Perception of cohort	Pearson Correlation	1	.591**	.401**	.463**	.585**	.327**	.191**	.204**	-0.103	.366**	.269**	0.121	.191**	-.229**	-.212**	0.093	.148*	0.116	0.005	-0.110	-.176*	.149*	-0.031	-0.104	0.123

s' attitudes re acceptability of CPs having experience of MH difficulties	Sig. (2-tailed)			0.000	0.000	0.000	0.000	0.000	0.007	0.004	0.145	0.000	0.000	0.086	0.007	0.001	0.002	0.190	0.036	0.101	0.949	0.120	0.013	0.035	0.666	0.140	0.081
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0	-0.001	0.002	-0.001	-0.005	-0.009	-0.005	-0.005	0.001	-0.007	-0.004	0.002	-0.003	0.000	-0.001	0.001	0.000	0.000	-0.002	0.003	.006[e]	-0.002	-0.001	0.001	0.000
		Std. Error	0	0.056	0.080	0.074	0.070	0.087	0.078	0.077	0.076	0.079	0.070	0.074	0.076	0.076	0.073	0.070	0.069	0.069	0.072	0.079	.095[e]	0.043	0.071	0.074	0.067
		BCa 95% Confidence Interval Lower		0.478	0.235	0.317	0.426	0.162	0.043	0.068	-0.255	0.213	0.133	-0.038	0.049	-0.356	-0.343	-0.059	-0.001	-0.019	-0.143	-0.277	-.358[e]	0.067	-0.169	-0.255	-0.017
		BCa 95% Confidence Interval Upper		0.692	0.565	0.597	0.706	0.475	0.329	0.338	0.051	0.494	0.391	0.278	0.325	-0.084	-0.071	0.232	0.283	0.246	0.139	0.049	.026[e]	0.222	0.104	0.043	0.254
Perception of doctoral programme staffs' attitudes re acceptability of CPs having experi	Pearson Correlation		.591**	1	.497**	.597**	.376**	.603**	.308**	.370**	-0.026	.350**	.306**	.185**	.254**	-.208**	-0.107	-0.009	0.124	0.130	-0.009	-0.102	-.196**	0.070	0.123	-.177*	0.050
	Sig. (2-tailed)		0.000		0.000	0.000	0.000	0.000	0.000	0.000	0.710	0.000	0.000	0.009	0.000	0.003	0.131	0.898	0.080	0.065	0.903	0.150	0.005	0.321	0.081	0.012	0.483
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap	Bias	-0.001	0	0.001	-0.002	-0.009	-0.006	-0.005	-0.006	0.001	-0.005	-0.006	-0.001	-0.000	0.000	0.001	0.003	-0.004	-0.000	0.000	0.003	.008[e]	-0.000	0.000	0.002	-0.002

ence of MH difficulties	trap[d]														04					05	02			003			
		Std. Error	0.056	0	0.070	0.055	0.076	0.059	0.074	0.068	0.074	0.070	0.063	0.077	0.071	0.078	0.070	0.071	0.071	0.066	0.068	0.083	.131[e]	0.061	0.069	0.073	0.069
		BCa 95% Confidence Interval Lower	0.478		0.349	0.483	0.224	0.481	0.159	0.249	-0.186	0.211	0.189	0.036	0.125	-0.351	-0.246	-0.150	-0.018	0.005	-0.161	-0.268	-.409[e]	-0.057	-0.020	-0.319	-0.091
		Upper	0.692		0.631	0.698	0.502	0.699	0.438	0.482	0.118	0.469	0.412	0.327	0.375	-0.055	0.039	0.133	0.251	0.241	0.126	0.066	.100[e]	0.184	0.255	-0.027	0.175
Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties	Pearson Correlation		.401**	.497**	1	.599**	.173*	.192**	.508**	.284**	0.044	.330**	.292**	.224**	.288**	-.338**	-0.128	-0.015	.152*	.148*	-0.041	-0.120	-0.102	0.080	-0.004	0.002	0.002
	Sig. (2-tailed)		0.000	0.000		0.000	0.014	0.006	0.000	0.000	0.533	0.000	0.000	0.001	0.000	0.000	0.069	0.835	0.031	0.036	0.568	0.089	0.150	0.256	0.960	0.980	0.982
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0.002	0.001	0	0.001	0.004	0.002	-0.005	-0.002	0.001	-0.004	-0.004	-0.002	-0.003	0.001	0.002	0.001	-0.004	-0.004	0.000	0.005	.005[e]	-0.001	-0.001	-0.001	0.001
		Std. Error	0.080	0.070	0	0.064	0.076	0.077	0.080	0.074	0.072	0.071	0.069	0.067	0.066	0.084	0.072	0.072	0.069	0.067	0.071	0.087	.087[e]	0.055	0.071	0.072	0.073
		BCa 95% Lower	0.235	0.349		0.460	0.022	0.036	0.347	0.139	-0.085	0.189	0.155	0.095	0.153	-0.483	-0.282	-0.158	0.014	0.012	-0.101	-0.313	-.266[e]	-0.040	-0.148	-0.140	-0.145

		Confidence Interval																				88						
			Upper	0.565	0.631		0.720	0.335	0.350	0.648	0.417	0.194	0.457	0.415	0.349	0.409	-0.170	0.021	0.125	0.275	0.266	0.093	0.070	.064[e]	0.189	0.136	0.138	0.150
Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties	Pearson Correlation			.463**	.597**	.599**	1	.231**	.334**	.331**	.575**	-0.026	.334**	.322**	.196**	.258**	-.291**	-0.057	-0.043	0.099	0.058	-0.034	0.007	-0.094	0.095	0.095	-0.126	0.029
	Sig. (2-tailed)			0.000	0.000	0.000		0.001	0.000	0.000	0.000	0.716	0.000	0.000	0.005	0.000	0.000	0.425	0.544	0.161	0.415	0.637	0.927	0.184	0.182	0.179	0.074	0.684
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		-0.001	-0.002	0.001	0	-0.002	-0.003	-0.002	-0.002	-0.001	-0.003	-0.005	-0.004	-0.004	0.001	-0.001	0.003	-0.002	-0.002	-0.002	0.003	.006[e]	-0.001	0.001	-0.001	0.001
		Std. Error		0.074	0.055	0.064	0	0.068	0.071	0.072	0.065	0.079	0.071	0.067	0.076	0.072	0.081	0.072	0.079	0.069	0.068	0.070	0.064	.093[e]	0.055	0.068	0.070	0.073
		BCa 95% Confidence Interval	Lower	0.317	0.483	0.460		0.100	0.190	0.180	0.433	-0.178	0.189	0.193	0.045	0.125	-0.443	-0.193	-0.208	-0.042	-0.081	-0.176	-0.142	-.264[e]	-0.017	-0.038	-0.267	-0.112
			Upper	0.597	0.698	0.720		0.359	0.463	0.470	0.690	0.126	0.466	0.436	0.343	0.387	-0.137	0.079	0.123	0.224	0.190	0.098	0.133	.084[e]	0.197	0.234	0.012	0.173
Perception of cohort	Pearson Correlation			.585**	.376**	.173*	.231**	1	.578**	.512**	.461**	-0.055	.403**	.301**	.193**	.257**	-.258**	-0.129	-0.116	.241**	.169*	-0.0	-0.094	-.192**	0.128	-0.051	0.004	0.042

s' attitudes re acceptability of CPs seeking help for their MH difficulties																					52					
	Sig. (2-tailed)		0.000	0.000	0.014	0.001		0.000	0.000	0.000	0.441	0.000	0.000	0.006	0.000	0.000	0.069	0.101	0.001	0.017	0.466	0.186	0.006	0.070	0.473	0.952	0.550
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	-0.005	-0.009	0.004	-0.002	0	-0.011	-0.001	0.000	0.002	0.002	0.000	0.004	0.003	-0.007	-0.001	-0.002	0.003	0.002	-0.001	-0.001	.003[e]	-0.004	-0.003	0.006	-0.003
		Std. Error	0.070	0.076	0.076	0.068	0	0.077	0.058	0.062	0.072	0.063	0.056	0.082	0.076	0.073	0.070	0.069	0.067	0.068	0.074	0.064	.091[e]	0.051	0.069	0.079	0.069
		BCa 95% Confidence Interval Lower	0.426	0.224	0.022	0.100		0.421	0.395	0.334	-0.198	0.284	0.197	0.026	0.119	-0.386	-0.256	-0.256	0.093	0.009	-0.179	-0.219	-.354[e]	0.022	-0.198	-0.150	-0.093
		BCa 95% Confidence Interval Upper	0.706	0.502	0.335	0.359		0.698	0.622	0.576	0.095	0.532	0.410	0.369	0.409	-0.139	0.008	0.018	0.369	0.300	0.089	0.027	-.012[e]	0.217	0.069	0.173	0.164
Perception of doctoral programme staffs' attitudes re acceptability	Pearson Correlation		.327**	.603**	.192**	.334**	.578**	1	.569**	.599**	0.042	.423**	.394**	.180*	.341**	-.225**	0.052	-.241**	.156*	0.109	-0.037	-0.005	-.232**	0.130	0.116	-.150*	0.032
	Sig. (2-tailed)		0.000	0.000	0.006	0.000	0.000		0.000	0.000	0.555	0.000	0.000	0.010	0.000	0.001	0.461	0.001	0.027	0.123	0.600	0.939	0.001	0.065	0.102	0.033	0.650
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201

of CPs seeking help for their MH difficulties	Bootstrap[d]	Bias	-0.009	-0.006	0.002	-0.003	-0.011	0	0.001	0.000	0.000	0.000	-0.001	0.004	0.001	-0.007	0.000	-0.002	0.001	0.000	0.000	-0.003	.009[e]	-0.004	0.002	0.003	-0.004
		Std. Error	0.087	0.059	0.077	0.071	0.077	0	0.056	0.055	0.076	0.063	0.054	0.087	0.070	0.077	0.072	0.077	0.066	0.068	0.071	0.055	.139[e]	0.067	0.063	0.074	0.066
		BCa 95% Confidence Interval Lower	0.162	0.481	0.036	0.190	0.421		0.445	0.481	-0.099	0.303	0.283	-0.004	0.203	-0.365	-0.084	-0.402	0.014	-0.038	-0.189	-0.122	-.488[e]	-0.018	-0.023	-0.293	-0.105
		BCa 95% Confidence Interval Upper	0.475	0.699	0.350	0.463	0.698		0.684	0.704	0.194	0.552	0.496	0.369	0.486	-0.101	0.191	-0.082	0.293	0.236	0.099	0.092	.018[e]	0.250	0.244	0.008	0.151
Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties	Pearson Correlation		.191**	.308**	.508**	.331**	.512**	.569**	1	.658**	0.052	.411**	.375**	.235**	.350**	-.243**	-0.056	-.209**	.244**	.187**	-0.129	-0.050	-0.075	.143*	0.029	0.001	-0.028
	Sig. (2-tailed)		0.007	0.000	0.000	0.000	0.000	0.000		0.000	0.468	0.000	0.000	0.001	0.000	0.001	0.433	0.003	0.000	0.008	0.067	0.484	0.290	0.043	0.678	0.989	0.695
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	-0.005	-0.005	-0.005	-0.002	-0.001	0.001	0	0.002	-0.001	0.001	0.000	0.002	0.001	-0.004	0.001	0.000	-0.002	-0.001	-0.001	0.002	.002[e]	-0.006	0.001	0.001	-0.002
		Std. Error	0.078	0.074	0.080	0.072	0.058	0.056	0	0.071	0.072	0.053	0.062	0.065	0.071	0.072	0.080	0.055	0.062	0.073	0.083	.056[e]	0.058	0.072	0.065	0.068	

		BCa 95% Confidence Interval	Lower	0.043	0.159	0.347	0.180	0.395	0.445		0.505	-0.089	0.298	0.243	0.092	0.211	-0.358	-0.195	-0.374	0.133	0.055	-0.261	-0.233	-.192[e]	0.015	-0.117	-0.130	-0.155
			Upper	0.329	0.438	0.648	0.470	0.622	0.684		0.799	0.185	0.515	0.500	0.368	0.480	-0.120	0.095	-0.042	0.344	0.306	0.003	0.100	.023[e]	0.241	0.174	0.131	0.109
Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties	Pearson Correlation			.204**	.370**	.284**	.575**	.461**	.599**	.658**	1	-0.006	.367**	.341**	.158*	.275**	-.211**	-0.057	-.185**	.225**	0.131	-0.100	-0.015	-0.063	0.056	0.068	-0.055	-0.011
	Sig. (2-tailed)			0.004	0.000	0.000	0.000	0.000	0.000	0.000		0.933	0.000	0.000	0.025	0.000	0.003	0.421	0.008	0.001	0.063	0.157	0.837	0.377	0.431	0.339	0.437	0.873
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		-0.005	-0.006	-0.002	-0.002	0.000	0.000	0.002	0	-0.001	0.002	-0.001	0.001	0.000	-0.004	-0.001	0.002	-0.002	0.000	-0.001	0.001	.002[e]	-0.004	0.000	0.001	-0.001
		Std. Error		0.077	0.068	0.074	0.065	0.062	0.055	0.071	0	0.077	0.059	0.063	0.074	0.071	0.076	0.071	0.076	0.058	0.066	0.070	0.069	.056[e]	0.064	0.065	0.068	0.070
		BCa 95% Confidence Interval	Lower	0.068	0.249	0.139	0.433	0.334	0.481	0.505		-0.153	0.242	0.214	0.011	0.133	-0.356	-0.194	-0.341	0.104	-0.013	-0.230	-0.165	-.181[e]	-0.081	-0.072	-0.194	-0.144
			Upper	0.338	0.482	0.417	0.690	0.576	0.704	0.799		0.150	0.487	0.459	0.305	0.420	-0.069	0.081	-0.035	0.337	0.257	0.035	0.122	.038[e]	0.169	0.192	0.081	0.122

Important for professional growth/effectiveness	Pearson Correlation		-0.103	-0.026	0.044	-0.026	-0.055	0.042	0.052	-0.006	1	0.114	.267**	0.051	.641**	0.082	.334**	-.159*	-.221**	-.167*	.145*	0.024	0.005	0.059	-0.020	0.034	-0.013
	Sig. (2-tailed)		0.145	0.710	0.533	0.716	0.441	0.555	0.468	0.933		0.106	0.000	0.473	0.000	0.248	0.000	0.024	0.002	0.018	0.039	0.734	0.947	0.408	0.781	0.629	0.850
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0.001	0.001	0.001	-0.001	0.002	0.000	-0.001	-0.001	0	-0.001	-0.002	-0.001	-0.002	0.002	0.001	0.001	-0.002	-0.001	0.002	0.000	-.001[e]	0.000	0.000	-0.002	0.001
		Std. Error	0.076	0.074	0.072	0.079	0.072	0.076	0.072	0.077	0	0.066	0.064	0.076	0.042	0.075	0.062	0.065	0.068	0.068	0.071	0.068	.059[e]	0.063	0.069	0.074	0.073
		BCa 95% Confidence Interval Lower	-0.255	-0.186	-0.085	-0.178	-0.198	-0.099	-0.089	-0.153		-0.016	0.139	-0.104	0.554	-0.065	0.191	-0.284	-0.346	-0.288	0.010	-0.112	-.092[e]	-0.072	-0.154	-0.104	-0.162
		Upper	0.051	0.118	0.194	0.126	0.095	0.194	0.185	0.150		0.241	0.383	0.190	0.717	0.231	0.462	-0.027	-0.095	-0.041	0.294	0.158	.119[e]	0.181	0.118	0.169	0.129
Concern with professional credibility	Pearson Correlation		.366**	.350**	.330**	.334**	.403**	.423**	.411**	.367**	0.114	1	.759**	.413**	.749**	-.504**	-0.049	-.188**	.218**	.208**	-0.051	-.199**	-0.100	0.041	-0.117	0.000	0.106
	Sig. (2-tailed)		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.106		0.000	0.000	0.000	0.000	0.492	0.008	0.002	0.003	0.476	0.005	0.159	0.563	0.099	0.997	0.134

	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		-0.007	-0.005	-0.004	-0.003	0.002	0.000	0.001	0.002	-0.001	0	-0.001	0.001	-0.001	-0.001	-0.003	0.003	0.000	0.002	-0.001	-0.001	.003[e]	-0.005	0.001	0.002	-0.002
		Std. Error		0.079	0.070	0.071	0.071	0.063	0.063	0.053	0.059	0.066	0	0.031	0.057	0.032	0.057	0.072	0.078	0.062	0.067	0.073	0.067	.073[e]	0.068	0.067	0.070	0.067
		BCa 95% Confidence Interval	Lower	0.213	0.211	0.189	0.189	0.284	0.303	0.298	0.242	-0.016		0.697	0.290	0.676	-0.602	-0.184	-0.340	0.089	0.061	-0.202	-0.333	-.248[e]	-0.115	-0.251	-0.136	-0.020
			Upper	0.494	0.469	0.457	0.466	0.532	0.552	0.515	0.487	0.241		0.814	0.534	0.805	-0.389	0.083	-0.028	0.342	0.342	0.096	-0.077	.041[e]	0.156	0.020	0.139	0.234
Concerns about confidentiality	Pearson Correlation			.269**	.306**	.292**	.322**	.301**	.394**	.375**	.341**	.267**	.759**	1	.415**	.837**	-.498**	0.029	-.216**	.159*	.184**	-0.028	-.196**	-0.109	0.123	-0.052	-0.080	0.121
	Sig. (2-tailed)			0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000		0.000	0.000	0.000	0.684	0.002	0.024	0.009	0.697	0.005	0.124	0.081	0.465	0.257	0.087
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		-0.004	-0.006	-0.004	-0.005	0.000	-0.001	0.000	-0.001	-0.002	-0.001	0	0.001	-0.001	0.001	-0.003	0.004	0.000	0.002	-0.003	0.001	.004[e]	-0.003	-0.001	0.003	-0.002

		Std. Error		0.070	0.063	0.069	0.067	0.056	0.054	0.062	0.063	0.064	0.031	0	0.061	0.019	0.058	0.070	0.068	0.065	0.065	0.070	0.072	.087[e]	0.073	0.066	0.073	0.070
		BCa 95% Confidence Interval	Lower	0.133	0.189	0.155	0.193	0.197	0.283	0.243	0.214	0.139	0.697		0.275	0.795	-0.603	-0.103	-0.352	0.039	0.048	-0.173	-0.332	-.272[e]	-0.015	-0.185	-0.213	-0.025
			Upper	0.391	0.412	0.415	0.436	0.410	0.496	0.500	0.459	0.383	0.814		0.535	0.871	-0.378	0.154	-0.068	0.289	0.324	0.098	-0.043	.070[e]	0.249	0.080	0.067	0.251
Need for self-sufficiency	Pearson Correlation			0.121	.185**	.224**	.196**	.193**	.180*	.235**	.158*	0.051	.413**	.415**	1	.565**	-.461**	0.026	-.179*	0.130	0.138	-0.053	-0.111	-0.043	-.167*	-0.079	-0.032	0.101
	Sig. (2-tailed)			0.086	0.009	0.001	0.005	0.006	0.010	0.001	0.025	0.473	0.000	0.000		0.000	0.000	0.715	0.011	0.066	0.051	0.453	0.118	0.543	0.017	0.266	0.649	0.152
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		0.002	-0.001	-0.002	-0.004	0.004	0.004	0.002	0.001	-0.001	0.001	0.001	0	0.000	-0.001	-0.003	0.002	0.002	0.002	-0.001	-0.002	.002[e]	-0.001	-0.001	0.000	0.001
		Std. Error		0.074	0.077	0.067	0.076	0.082	0.087	0.065	0.074	0.076	0.057	0.061	0	0.048	0.056	0.068	0.069	0.074	0.071	0.071	0.069	.100[e]	0.064	0.071	0.073	0.068
		BCa 95% Co	Lower	-0.038	0.036	0.095	0.045	0.026	-0.004	0.092	0.011	-0.104	0.290	0.275		0.454	-0.560	-0.113	-0.300	-0.018	0.000	-0.183	-0.238	-.204[e]	-0.277	-0.219	-0.174	-0.030

		nfidence Interval	Upper	0.278	0.327	0.349	0.343	0.369	0.369	0.368	0.305	0.190	0.534	0.535		0.656	-0.349	0.144	-0.032	0.283	0.284	0.086	0.014	.160[e]	-0.041	0.053	0.118	0.237
Total Score	Pearson Correlation			.191**	.254**	.288**	.258**	.257**	.341**	.350**	.275**	.641**	.749**	.837**	.565**	1	-.416**	.168*	-.262**	0.049	0.084	0.033	-.149*	-0.079	0.042	-0.085	-0.020	0.096
	Sig. (2-tailed)			0.007	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000		0.000	0.017	0.000	0.486	0.236	0.647	0.034	0.264	0.550	0.228	0.775	0.174
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		-0.003	-0.004	-0.003	-0.004	0.003	0.001	0.001	0.000	-0.002	-0.001	-0.001	0.000	0	0.001	-0.003	0.000	0.000	0.001	-0.001	0.000	.003[e]	-0.003	0.000	0.001	-0.001
		Std. Error		0.076	0.071	0.066	0.072	0.076	0.070	0.065	0.071	0.042	0.032	0.019	0.048	0	0.066	0.067	0.068	0.068	0.068	0.071	0.074	.091[e]	0.067	0.069	0.074	0.070
		BCa 95% Confidence Interval	Lower	0.049	0.125	0.153	0.125	0.119	0.203	0.211	0.133	0.554	0.676	0.795	0.454		-0.529	0.041	-0.389	-0.070	-0.051	-0.108	-0.295	-.261[e]	-0.083	-0.219	-0.165	-0.052
			Upper	0.325	0.375	0.409	0.387	0.409	0.486	0.480	0.420	0.717	0.805	0.871	0.656		-0.278	0.288	-0.126	0.183	0.223	0.171	-0.008	.096[e]	0.158	0.047	0.130	0.232
PSPS - Nondisclosure of	Pearson Correlation			-.229**	-.208**	-.338**	-.291**	-.258**	-.225**	-.243**	-.211**	0.082	-.504**	-.498**	-.461**	-.416**	1	.228**	0.036	-.278**	-.237**	0.017	.346**	0.001	0.006	0.048	0.033	-0.075

Imperfection	Sig. (2-tailed)		0.001	0.003	0.000	0.000	0.000	0.001	0.001	0.003	0.248	0.000	0.000	0.000	0.000		0.001	0.612	0.000	0.001	0.814	0.000	0.991	0.933	0.495	0.639	0.293
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0.000	0.000	0.001	0.001	-0.007	-0.007	-0.004	-0.004	0.002	-0.001	0.001	-0.001	0.000	0	0.002	-0.001	-0.001	0.000	0.002	-0.004	.001[e]	0.003	-0.002	0.000	0.002
		Std. Error	0.076	0.078	0.084	0.081	0.073	0.077	0.071	0.076	0.075	0.057	0.058	0.056	0.066	0	0.065	0.065	0.059	0.064	0.073	0.078	.078[e]	0.067	0.064	0.068	0.070
		BCa 95% Confidence Interval Lower	-0.356	-0.351	-0.483	-0.443	-0.386	-0.365	-0.358	-0.356	-0.065	-0.602	-0.603	-0.560	-0.529		0.084	-0.086	-0.394	-0.354	-0.132	0.194	-.155[e]	-0.130	-0.074	-0.100	-0.205
		Upper	-0.084	-0.055	-0.170	-0.137	-0.139	-0.101	-0.120	-0.069	0.231	-0.389	-0.378	-0.349	-0.278		0.355	0.155	-0.162	-0.112	0.179	0.479	.148[e]	0.148	0.175	0.166	0.059
Has or is seeking help	Pearson Correlation		-.212**	-0.107	-0.128	-0.057	-0.129	0.052	-0.056	-0.057	.334**	-0.049	0.029	0.026	.168*	.228**	1	-.496**	-.645**	-.613**	.414**	.289**	0.005	-0.015	0.033	0.044	-0.070
	Sig. (2-tailed)		0.002	0.131	0.069	0.425	0.069	0.461	0.433	0.421	0.000	0.492	0.684	0.715	0.017	0.001		0.000	0.000	0.000	0.000	0.000	0.944	0.836	0.642	0.534	0.320
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	-0.001	0.001	0.002	-0.001	-0.001	0.000	0.001	-0.001	0.001	-0.003	-0.003	-0.003	-0.0	0.002	0	0.002	-0.001	0.000	0.000	-0.003	.000[e]	0.000	0.001	-0.001	-0.001

																03										
		Std. Error		0.073	0.070	0.072	0.072	0.070	0.072	0.072	0.071	0.062	0.072	0.070	0.068	0.067	0.065	0	0.041	0.042	0.052	0.064	0.052	.069[e]	0.069	0.074	0.071	0.069
		BCa 95% Confidence Interval	Lower	-0.343	-0.246	-0.282	-0.193	-0.256	-0.084	-0.195	-0.194	0.191	-0.184	-0.103	-0.113	0.041	0.084		-0.590	-0.721	-0.713	0.293	0.174	-.128[e]	-0.152	-0.111	-0.098	-0.208
			Upper	-0.071	0.039	0.021	0.079	0.008	0.191	0.095	0.081	0.462	0.083	0.154	0.144	0.288	0.355		-0.413	-0.564	-0.508	0.542	0.379	.133[e]	0.122	0.181	0.178	0.062
No seeking help	Pearson Correlation			0.093	-0.009	-0.015	-0.043	-0.116	-.241**	-.209**	-.185**	-.159*	-.188**	-.216**	-.179*	-.262**	0.036	-.496**	1	-.343**	-.189**	.213**	-0.096	0.102	0.076	0.030	-0.111	0.075
	Sig. (2-tailed)			0.190	0.898	0.835	0.544	0.101	0.001	0.003	0.008	0.024	0.008	0.002	0.011	0.000	0.612	0.000		0.000	0.007	0.002	0.177	0.150	0.284	0.677	0.116	0.290
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		0.001	0.003	0.001	0.003	-0.002	-0.002	0.000	0.002	0.001	0.003	0.004	0.002	0.003	-0.001	0.002	0	0.001	-0.002	0.001	0.002	-.003[e]	0.001	0.001	-0.001	0.000
		Std. Error		0.070	0.071	0.072	0.079	0.069	0.077	0.080	0.076	0.065	0.078	0.068	0.069	0.068	0.065	0.041	0	0.033	0.060	0.065	0.054	.089[e]	0.076	0.072	0.064	0.071
		BCa 95% Confidence Interval	Lower	-0.059	-0.150	-0.158	-0.208	-0.256	-0.402	-0.374	-0.341	-0.284	-0.340	-0.352	-0.300	-0.303	-0.086	-0.590		-0.416	-0.202	0.086	-0.176	-.063[e]	-0.073	-0.110	-0.231	-0.064

		Confidence Interval													89					94						
			Upper	0.232	0.133	0.125	0.123	0.018	-0.082	-0.042	-0.035	-0.027	-0.028	-0.068	-0.032	-0.126	0.155	-0.413		-0.275	-0.071	0.341	0.019	.266[e]	0.231	0.170	0.018	0.213
Not Applicable	Pearson Correlation			.148*	0.124	.152*	0.099	.241**	.156*	.244**	.225**	-.221**	.218**	.159*	0.130	0.049	-.278**	-.645**	-.343**	1	.830**	-.635**	-.228**	-0.095	-0.051	-0.062	0.050	0.010
	Sig. (2-tailed)			0.036	0.080	0.031	0.161	0.001	0.027	0.000	0.001	0.002	0.002	0.024	0.066	0.486	0.000	0.000	0.000		0.000	0.000	0.001	0.179	0.473	0.384	0.480	0.885
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		0.000	-0.004	-0.004	-0.002	0.003	0.001	-0.002	-0.002	-0.002	0.000	0.000	0.002	0.000	-0.001	-0.001	0.001	0	0.000	-0.001	0.002	.003[e]	-0.001	-0.003	0.002	0.001
		Std. Error		0.069	0.071	0.069	0.069	0.067	0.066	0.055	0.058	0.068	0.062	0.065	0.074	0.068	0.059	0.042	0.033	0	0.041	0.046	0.029	.024[e]	0.067	0.070	0.072	0.071
		BCa 95% Confidence Interval	Lower	-0.001	-0.018	0.014	-0.042	0.093	0.014	0.133	0.104	-0.346	0.089	0.039	-0.018	-0.070	-0.394	-0.721	-0.416		0.746	-0.725	-0.289	-.139[e]	-0.175	-0.183	-0.085	-0.127
			Upper	0.283	0.251	0.275	0.224	0.369	0.293	0.344	0.337	-0.095	0.342	0.289	0.283	0.183	-0.162	-0.564	-0.275		0.910	-0.547	-0.169	-.045[e]	0.083	0.068	0.187	0.148
No current MH,	Pearson Correlation			0.116	0.130	.148*	0.058	.169*	0.109	.187**	0.131	-.167*	.208**	.184**	0.138	0.0	-.237**	-.6	-.1	.830**	1	-.77	-.261**	-0.	-0.	-0.091	0.037	0.049

never had MH exp																84		13**	89**			5**		109	069			
	Sig. (2-tailed)		0.101	0.065	0.036	0.415	0.017	0.123	0.008	0.063	0.018	0.003	0.009	0.051	0.236	0.001	0.000	0.007	0.000		0.000	0.000	0.124	0.332	0.198	0.597	0.492
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0.000	-0.005	-0.004	-0.002	0.002	0.000	-0.001	0.000	-0.001	0.002	0.002	0.002	0.001	0.000	0.001	-0.002	0.000	0	-0.002	0.002	.004[e]	-0.002	-0.004	0.002	0.002
		Std. Error	0.069	0.066	0.067	0.068	0.068	0.068	0.062	0.066	0.068	0.067	0.065	0.071	0.068	0.064	0.052	0.060	0.041	0	0.038	0.032	.028[e]	0.067	0.068	0.072	0.071
		BCa 95% Confidence Interval Lower	-0.019	0.005	0.012	-0.081	0.009	-0.038	0.055	-0.013	-0.288	0.061	0.048	0.000	-0.051	-0.354	-0.713	-0.294	0.746		-0.847	-0.328	-.157[e]	-0.197	-0.222	-0.097	-0.093
		Upper	0.246	0.241	0.266	0.190	0.300	0.236	0.306	0.257	-0.041	0.342	0.324	0.284	0.223	-0.112	-0.508	-0.071	0.910		-0.703	-0.192	-.052[e]	0.062	0.033	0.181	0.193
No current MH, have prev MH exp	Pearson Correlation		0.005	-0.009	-0.041	-0.034	-0.052	-0.037	-0.129	-0.100	.145*	-0.051	-0.028	-0.053	0.033	0.017	.414**	.213**	-.635**	-.775**	1	-.347**	-.145*	-0.035	0.046	-0.053	0.007
	Sig. (2-tailed)		0.949	0.903	0.568	0.637	0.466	0.600	0.067	0.157	0.039	0.476	0.697	0.453	0.647	0.814	0.000	0.002	0.000	0.000		0.000	0.041	0.624	0.518	0.451	0.919
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201

	Bootstrap[d]	Bias		-0.002	0.002	0.000	-0.002	-0.001	0.000	-0.001	-0.0001	0.002	-0.001	-0.003	-0.001	-0.0001	0.0002	0.0001	0.0001	-0.001	0	0.003	.005[e]	-0.001	0.003	0.000	-0.003
		Std. Error		0.072	0.068	0.071	0.070	0.074	0.071	0.073	0.0700	0.071	0.073	0.0700	0.071	0.0711	0.073	0.064	0.065	0.046	0.038	0	0.041	.037[e]	0.0711	0.070	0.071	0.071
		BCa 95% Confidence Interval	Lower	-0.143	-0.161	-0.188	-0.176	-0.179	-0.189	-0.261	-0.2300	0.010	-0.202	-0.173	-0.183	-0.1108	-0.132	0.293	0.086	-0.725	-0.8447		-0.428	-.214[e]	-0.165	-0.099	-0.188	-0.127
			Upper	0.139	0.126	0.093	0.098	0.089	0.099	0.003	0.035	0.294	0.096	0.098	0.086	0.1711	0.179	0.542	0.341	-0.547	-0.7003		-0.255	-.068[e]	0.104	0.207	0.080	0.139
Currently experiencing MH prob	Pearson Correlation			-0.110	-0.102	-0.120	0.007	-0.094	-0.005	-0.050	-0.015	0.024	-.199**	-.196**	-0.111	-.149*	.346**	.289**	-0.096	-.228**	-.261**	-.347**	1	-0.049	.144*	0.074	-0.002	-0.065
	Sig. (2-tailed)			0.120	0.150	0.089	0.927	0.186	0.939	0.484	0.837	0.734	0.005	0.005	0.118	0.034	0.000	0.000	0.177	0.001	0.0000	0.0000		0.493	0.041	0.298	0.976	0.357
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		0.003	0.003	0.005	0.003	-0.001	-0.003	0.002	0.001	0.000	-0.001	0.001	-0.002	0.0000	-0.004	-0.003	0.002	0.002	0.0002	0.0003	0	.002[e]	0.004	0.000	-0.002	0.002
		Std. Error		0.079	0.083	0.087	0.064	0.064	0.055	0.083	0.069	0.068	0.067	0.072	0.069	0.074	0.078	0.052	0.054	0.029	0.032	0.041	0	.013[e]	0.088	0.076	0.073	0.067

		BCa 95% Confidence Interval	Lower	-0.277	-0.268	-0.313	-0.142	-0.219	-0.122	-0.233	-0.165	-0.112	-0.333	-0.332	-0.238	-0.295	0.194	0.174	-0.176	-0.289	-0.328	-0.428		-.088[e]	-0.025	-0.077	-0.122	-0.184
			Upper	0.049	0.066	0.070	0.133	0.027	0.092	0.100	0.122	0.158	-0.077	-0.043	0.014	-0.008	0.479	0.379	0.019	-0.169	-0.192	-0.255		-.019[e]	0.338	0.222	0.130	0.071
Prefer not to disclose	Pearson Correlation			-.176*	-.196**	-0.102	-0.094	-.192**	-.232**	-0.075	-0.063	0.005	-0.100	-0.109	-0.043	-0.079	0.001	0.005	0.102	-0.095	-0.109	-.145*	-0.049	1	0.046	-0.011	0.066	-0.051
	Sig. (2-tailed)			0.013	0.005	0.150	0.184	0.006	0.001	0.290	0.377	0.947	0.159	0.124	0.543	0.264	0.991	0.944	0.150	0.179	0.124	0.041	0.493		0.521	0.881	0.348	0.470
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		.006[e]	.008[e]	.005[e]	.006[e]	.003[e]	.009[e]	.002[e]	.002[e]	-.001[e]	.003[e]	.004[e]	.002[e]	.003[e]	.001[e]	.000[e]	-.003[e]	.003[e]	.004[e]	.005[e]	.002[e]	0[e]	.000[e]	.001[e]	-.003[e]	.001[e]
		Std. Error		.095[e]	.131[e]	.087[e]	.093[e]	.091[e]	.139[e]	.056[e]	.056[e]	.059[e]	.073[e]	.087[e]	.100[e]	.091[e]	.078[e]	.069[e]	.089[e]	.024[e]	.028[e]	.037[e]	.013[e]	0[e]	.093[e]	.070[e]	.082[e]	.064[e]
		BCa 95% Confidence Interval	Lower	-.358[e]	-.409[e]	-.266[e]	-.264[e]	-.354[e]	-.488[e]	-.192[e]	-.181[e]	-.091[e]	-.248[e]	-.272[e]	-.204[e]	-.261[e]	-.151[e]	-.126[e]	-.063[e]	-.141[e]	-.161[e]	-.224[e]	-.080[e]	.[e]	-.068[e]	-.105[e]	-.079[e]	-.135[e]
			Upper	.026[e]	.100[e]	.064[e]	.084[e]	-.011[e]	.018[e]	.023[e]	.038[e]	.119[e]	.041[e]	.070[e]	.160[e]	.096[e]	.144[e]	.133[e]	.266[e]	-.044[e]	-.051[e]	-.068[e]	-.021[e]	.[e]	.236[e]	.126[e]	.214[e]	.073[e]

Gender	Pearson Correlation		.149*	0.070	0.080	0.095	0.128	0.130	.143*	0.056	0.059	0.041	0.123	-.167*	0.042	0.006	-0.015	0.076	-0.051	-0.069	-0.035	.144*	0.046	1	0.066	0.061	-0.116
	Sig. (2-tailed)		0.035	0.321	0.256	0.182	0.070	0.065	0.043	0.431	0.408	0.563	0.081	0.017	0.550	0.933	0.836	0.284	0.473	0.332	0.624	0.041	0.521		0.354	0.390	0.102
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	-0.002	-0.003	-0.001	-0.001	-0.004	-0.004	-0.006	-0.004	0.000	-0.005	-0.003	-0.001	-0.003	0.003	0.000	0.001	-0.001	-0.002	-0.001	0.004	.000[e]	0	0.002	-0.002	0.000
		Std. Error	0.043	0.061	0.055	0.055	0.051	0.067	0.058	0.064	0.063	0.068	0.073	0.064	0.067	0.067	0.069	0.076	0.067	0.067	0.071	0.088	.093[e]	0	0.077	0.075	0.064
		BCa 95% Confidence Interval Lower	0.067	-0.057	-0.040	-0.017	0.022	-0.018	0.015	-0.081	-0.072	-0.115	-0.015	-0.277	-0.083	0.130	-0.152	-0.073	-0.175	-0.197	-0.165	-0.025	-.068[e]		-0.092	-0.084	-0.232
		Upper	0.222	0.184	0.189	0.197	0.217	0.250	0.241	0.169	0.181	0.156	0.249	-0.041	0.158	0.148	0.122	0.231	0.083	0.062	0.104	0.338	.237[e]		0.228	0.203	0.014
Year 1 DClin Psych	Pearson Correlation		-0.031	0.123	-0.004	0.095	-0.051	0.116	0.029	0.068	-0.020	-0.117	-0.052	-0.079	-0.085	0.048	0.033	0.030	-0.062	-0.091	0.046	0.074	-0.011	0.066	1	-.401**	-.544**
	Sig. (2-tailed)		0.666	0.081	0.960	0.179	0.473	0.102	0.678	0.339	0.781	0.099	0.465	0.266	0.228	0.495	0.642	0.677	0.384	0.198	0.518	0.298	0.881	0.354		0.000	0.000

	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	-0.001	0.000	-0.001	0.001	-0.003	0.002	0.001	0.000	0.000	0.001	0.001	-0.001	-0.001	0.000	-0.002	0.001	0.001	-0.003	-0.004	0.003	0.000	.001[e]	0.002	0	0.000	0.002
		Std. Error	0.071	0.069	0.071	0.068	0.069	0.063	0.072	0.065	0.069	0.067	0.066	0.071	0.069	0.064	0.074	0.072	0.070	0.068	0.070	0.076	.070[e]	0.077	0	0.035	0.039
		BCa 95% Confidence Interval Lower	-0.169	-0.020	-0.148	-0.038	-0.198	-0.023	-0.117	-0.072	-0.154	-0.251	-0.185	-0.219	-0.219	-0.074	-0.111	-0.110	-0.183	-0.222	-0.099	-0.077	-.105[e]	-0.092		-0.481	-0.624
		Upper	0.104	0.255	0.136	0.234	0.069	0.244	0.174	0.192	0.118	0.020	0.080	0.053	0.047	0.175	0.181	0.170	0.068	0.033	0.207	0.222	.126[e]	0.228		-0.330	-0.465
Year 3 DClin Psych	Pearson Correlation		-0.104	-.177*	0.002	-0.126	0.004	-.150*	0.001	-0.055	0.034	0.000	-0.080	-0.032	-0.020	0.033	0.044	-0.111	0.050	0.037	-0.053	-0.002	0.066	0.061	-.401**	1	-.551**
	Sig. (2-tailed)		0.140	0.012	0.980	0.074	0.952	0.033	0.989	0.437	0.629	0.997	0.257	0.649	0.775	0.639	0.534	0.116	0.480	0.597	0.451	0.976	0.348	0.390	0.000		0.000
	N		201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias	0.001	0.002	-0.001	-0.001	0.006	0.003	0.001	0.001	-0.002	0.002	0.003	0.000	0.000	0.000	-0.001	-0.001	0.002	0.002	0.000	-0.002	-.003[e]	-0.002	0.000	0	0.000
		Std. Error	0.074	0.073	0.072	0.070	0.079	0.074	0.065	0.068	0.074	0.070	0.073	0.073	0.000	0.068	0.071	0.064	0.072	0.000	0.000	0.073	.082[e]	0.075	0.035	0	0.040

															74					72	71						
		BCa 95% Confidence Interval	Lower	-0.255	-0.319	-0.140	-0.267	-0.150	-0.293	-0.130	-0.194	-0.104	-0.136	-0.213	-0.174	-0.165	-0.100	-0.098	-0.231	-0.085	-0.097	-0.188	-0.122	-.080[e]	-0.084	-0.481		-0.630
			Upper	0.043	-0.027	0.138	0.012	0.173	0.008	0.131	0.081	0.169	0.139	0.067	0.118	0.130	0.166	0.178	0.018	0.187	0.181	0.080	0.130	.215[e]	0.203	-0.330		-0.472
Year 2 DClin Psych	Pearson Correlation			0.123	0.050	0.002	0.029	0.042	0.032	-0.028	-0.011	-0.013	0.106	0.121	0.101	0.096	-0.075	-0.070	0.075	0.010	0.049	0.007	-0.065	-0.051	-0.116	-.544[**]	-.551[**]	1
	Sig. (2-tailed)			0.081	0.483	0.982	0.684	0.550	0.650	0.695	0.873	0.850	0.134	0.087	0.152	0.174	0.293	0.320	0.290	0.885	0.492	0.919	0.357	0.470	0.102	0.000	0.000	
	N			201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201	201
	Bootstrap[d]	Bias		0.000	-0.002	0.001	0.001	-0.003	-0.004	-0.002	-0.001	0.001	-0.002	-0.002	0.001	-0.001	0.002	-0.001	0.000	0.001	0.002	-0.003	0.002	.001[e]	0.000	0.002	0.000	0
		Std. Error		0.067	0.069	0.073	0.073	0.069	0.066	0.068	0.070	0.073	0.067	0.070	0.068	0.070	0.070	0.069	0.071	0.071	0.071	0.071	0.067	.064[e]	0.064	0.039	0.040	0
		BCa 95% Confidence Interval	Lower	-0.017	-0.091	-0.145	-0.112	-0.093	-0.105	-0.155	-0.144	-0.162	-0.020	-0.025	-0.030	-0.052	-0.205	-0.208	-0.064	-0.127	-0.093	-0.127	-0.184	-.135[e]	-0.232	-0.624	-0.630	
			Upper	0.254	0.175	0.150	0.173	0.164	0.151	0.109	0.122	0.129	0.234	0.251	0.237	0.232	0.059	0.062	0.213	0.148	0.193	0.139	0.071	.073[e]	0.014	-0.465	-0.472	

Multiple Linear Regression

Model Summary[d]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.415[a]	.172	.168	9.909	.172	41.494	1	200	.000	
2	.506[b]	.256	.222	9.583	.085	2.730	8	192	.007	
3	.543[c]	.295	.258	9.355	.039	10.495	1	191	.001	1.772

a. Predictors: (Constant), PSPS - Nondisclosure of Imperfection

b. Predictors: (Constant), PSPS - Nondisclosure of Imperfection, Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties , Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties, Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties, Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties, Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties

c. Predictors: (Constant), PSPS - Nondisclosure of Imperfection, Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties , Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties, Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties, Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties, Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties, No seeking help

d. Dependent Variable: Total Score

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4074.654	1	4074.654	41.494	.000[b]
	Residual	19639.510	200	98.198		
	Total	23714.163	201			
2	Regression	6080.772	9	675.641	7.357	.000[c]
	Residual	17633.391	192	91.841		
	Total	23714.163	201			
3	Regression	6999.228	10	699.923	7.998	.000[d]
	Residual	16714.935	191	87.513		
	Total	23714.163	201			

a. Dependent Variable: Total Score

b. Predictors: (Constant), PSPS - Nondisclosure of Imperfection

c. Predictors: (Constant), PSPS - Nondisclosure of Imperfection, Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties , Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties, Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties, Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties, Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties

d. Predictors: (Constant), PSPS - Nondisclosure of Imperfection, Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties , Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties, Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties, Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties, Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties, Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties, No seeking help

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correla	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Pa
1	(Constant)	95.716	2.084		45.925	.000	91.607	99.826		
	PSPS - Nondisclosure of Imperfection	-.596	.093	-.415	-6.442	.000	-.779	-.414	-.415	
2	(Constant)	73.416	6.541		11.224	.000	60.514	86.317		
	PSPS - Nondisclosure of Imperfection	-.460	.099	-.320	-4.662	.000	-.655	-.265	-.415	
	Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties	.209	.974	.022	.215	.830	-1.712	2.130	.189	
	Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties	-.074	.878	-.009	-.084	.933	-1.805	1.658	.254	
	Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties	.524	.937	.060	.559	.577	-1.324	2.372	.287	
	Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties	.285	1.034	.031	.276	.783	-1.755	2.325	.251	

	Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties	-.500	1.137	-.046	-.439	.661	-2.742	1.743	.243
	Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties	1.902	1.040	.203	1.829	.069	-.149	3.953	.335
	Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties	1.498	1.155	.153	1.297	.196	-.780	3.776	.337
	Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties	-.447	1.177	-.044	-.380	.704	-2.769	1.874	.264
3	(Constant)	76.959	6.478		11.880	.000	64.181	89.736	
	PSPS - Nondisclosure of Imperfection	-.465	.096	-.323	-4.826	.000	-.655	-.275	-.415
	Perception of cohorts' attitudes re acceptability of CPs having experience of MH difficulties	.585	.958	.061	.611	.542	-1.304	2.474	.189
	Perception of doctoral programme staffs' attitudes re acceptability of CPs having experience of MH difficulties	.190	.861	.024	.220	.826	-1.508	1.887	.254

Perception of supervisors' attitudes re acceptability of CPs having experience of MH difficulties	.452	.915	.052	.495	.621	-1.352	2.257	.287
Perception of other qualified CPs' attitudes re acceptability of CPs having experience of MH difficulties	.130	1.011	.014	.129	.898	-1.864	2.124	.251
Perception of cohorts' attitudes re acceptability of CPs seeking help for their MH difficulties	-.617	1.110	-.057	-.555	.579	-2.807	1.574	.243
Perception of doctoral programme staffs' attitudes re acceptability of CPs seeking help for their MH difficulties	1.272	1.034	.136	1.231	.220	-.767	3.311	.335
Perception of supervisors' attitudes re acceptability of CPs seeking help for their MH difficulties	1.396	1.128	.143	1.237	.218	-.829	3.620	.337
Perception of other qualified psychologists' attitudes re acceptability of CPs seeking help for their MH difficulties	-.369	1.149	-.036	-.321	.749	-2.636	1.898	.264
No seeking help	-5.553	1.714	-.208	-3.240	.001	-8.935	-2.172	-.263

a. Dependent Variable: Total Score

```
Run MATRIX procedure:

*************** PROCESS Procedure for SPSS Version 3.00
*****************

          Written by Andrew F. Hayes, Ph.D.       www.afhayes.com
    Documentation available in Hayes (2018). www.guilford.com/p/hayes3

**************************************************************************
*
Model  : 4
    Y  : TATSPSTo
    X  : PSPSNond
   M1  : CohortMH
   M2  : Doctoral
   M3  : Supervis
   M4  : OtherCPs
   M5  : CohortIm
   M6  : Doctor_1
   M7  : Superv_1
   M8  : OtherC_1

Sample
Size:  204

**************************************************************************
*
OUTCOME VARIABLE:
 CohortMH

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .2297      .0528     1.2206    11.2519     1.0000   202.0000
.0009

Model
              coeff         se          t          p       LLCI
ULCI
constant     6.3525      .2227    28.5225      .0000     5.9134
6.7917
PSPSNond     -.0333      .0099    -3.3544      .0009     -.0529     -
.0137

**************************************************************************
*
OUTCOME VARIABLE:
 Doctoral

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .2173      .0472     1.7578    10.0137     1.0000   202.0000
.0018

Model
              coeff         se          t          p       LLCI
ULCI
```

```
constant     5.9206      .2673    22.1512      .0000     5.3936
6.4476
PSPSNond     -.0377      .0119    -3.1644      .0018     -.0613     -
.0142

**************************************************************************
*
OUTCOME VARIABLE:
 Supervis

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .3383      .1144     1.3803    26.0991     1.0000   202.0000
.0000

Model
             coeff         se          t          p       LLCI
ULCI
constant     6.5317      .2368    27.5782      .0000     6.0647
6.9987
PSPSNond     -.0540      .0106    -5.1087      .0000     -.0748     -
.0332

**************************************************************************
*
OUTCOME VARIABLE:
 OtherCPs

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .2864      .0820     1.2485    18.0538     1.0000   202.0000
.0000

Model
             coeff         se          t          p       LLCI
ULCI
constant     6.1524      .2253    27.3129      .0000     5.7083
6.5966
PSPSNond     -.0427      .0101    -4.2490      .0000     -.0625     -
.0229

**************************************************************************
*
OUTCOME VARIABLE:
 CohortIm

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .1339      .0179     1.1774     3.6898     1.0000   202.0000
.0562

Model
             coeff         se          t          p       LLCI
ULCI
constant     5.9577      .2187    27.2363      .0000     5.5264
6.3891
PSPSNond     -.0187      .0098    -1.9209      .0562     -.0380
.0005

**************************************************************************
*
```

```
OUTCOME VARIABLE:
 Doctor_1

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .0991      .0098     1.3838     2.0025     1.0000   202.0000
.1586

Model
             coeff         se          t          p       LLCI
ULCI
constant     5.6627      .2371    23.8791      .0000     5.1951
6.1303
PSPSNond     -.0150      .0106    -1.4151      .1586     -.0358
.0059

**************************************************************************
*
OUTCOME VARIABLE:
 Superv_1

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .1575      .0248     1.3600     5.1361     1.0000   202.0000
.0245

Model
             coeff         se          t          p       LLCI
ULCI
constant     5.7643      .2351    24.5189      .0000     5.3008
6.2279
PSPSNond     -.0238      .0105    -2.2663      .0245     -.0445     -
.0031

**************************************************************************
*
OUTCOME VARIABLE:
 OtherC_1

Model Summary
          R       R-sq        MSE          F        df1        df2
p
      .1626      .0264     1.2721     5.4851     1.0000   202.0000
.0202

Model
             coeff         se          t          p       LLCI
ULCI
constant     5.7101      .2274    25.1138      .0000     5.2618
6.1585
PSPSNond     -.0238      .0101    -2.3420      .0202     -.0438     -
.0038

**************************************************************************
*
OUTCOME VARIABLE:
 TATSPSTo

Model Summary
          R       R-sq        MSE          F        df1        df2
p
```

```
      .5407      .2923    86.6408     8.9044     9.0000   194.0000
.0000

Model
              coeff         se          t          p       LLCI
ULCI
constant    68.8329     5.7443    11.9829      .0000    57.5037
80.1621
PSPSNond     -.4316      .0905    -4.7683      .0000     -.6101     -
.2531
CohortMH     -.9119      .8313    -1.0969      .2740    -2.5514
.7277
Doctoral     -.0207      .7855     -.0263      .9790    -1.5699
1.5286
Supervis     1.2865      .8243     1.5607      .1202     -.3393
2.9122
OtherCPs      .7977      .9264      .8610      .3903    -1.0295
2.6248
CohortIm     2.5642      .9876     2.5965      .0101      .6165
4.5120
Doctor_1     2.3261     1.0791     2.1557      .0323      .1980
4.4543
Superv_1     -.0588     1.1076     -.0531      .9577    -2.2433
2.1256
OtherC_1    -1.7265     1.2058    -1.4319      .1538    -4.1047
.6516

****************** DIRECT AND INDIRECT EFFECTS OF X ON Y
*****************

Direct effect of X on Y
     Effect         se          t          p       LLCI       ULCI
     -.4316      .0905    -4.7683      .0000     -.6101     -.2531

Indirect effect(s) of X on Y:
            Effect     BootSE   BootLLCI   BootULCI
TOTAL       -.1128      .0556     -.2313     -.0104
CohortMH     .0304      .0306     -.0272      .0948
Doctoral     .0008      .0333     -.0711      .0669
Supervis    -.0695      .0481     -.1755      .0114
OtherCPs    -.0341      .0456     -.1324      .0497
CohortIm    -.0481      .0337     -.1294      .0006
Doctor_1    -.0348      .0335     -.1194      .0123
Superv_1     .0014      .0343     -.0677      .0765
OtherC_1     .0410      .0441     -.0260      .1446

********************** ANALYSIS NOTES AND ERRORS
************************

Level of confidence for all confidence intervals in output:
  95.0000

Number of bootstrap samples for percentile bootstrap confidence
intervals:
  5000

NOTE: Variables names longer than eight characters can produce incorrect
output.
      Shorter variable names are recommended.

------ END MATRIX ----
```

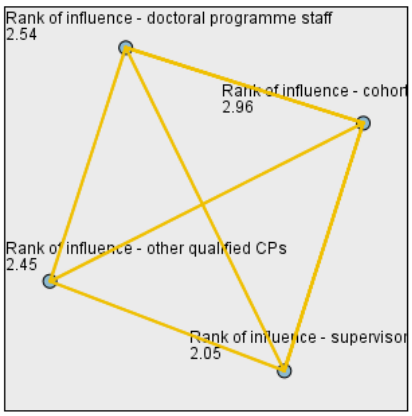
Friedman's Test

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distributions of Rank of influence - cohort, Rank of influence - doctoral programme staff, Rank of influence - supervisor and Rank of influence - other qualified CPs are the same.	Related-Samples Friedman's Two-Way Analysis of Variance by Ranks	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

Pairwise Comparisons



Each node shows the sample average rank.

Sample1-Sample2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj.Sig.
Rank of influence - supervisor-Rank of influence - other qualified CPs	-.399	.128	-3.114	.002	.011
Rank of influence - other qualified CPs-Rank of influence - doctoral programme staff	.084	.128	.654	.513	1.000
Rank of influence - doctoral programme staff-Rank of influence - cohort	.419	.128	3.268	.001	.007
Rank of influence - supervisor-Rank of influence - doctoral programme staff	.483	.128	3.767	.000	.001
Rank of influence - other qualified CPs-Rank of influence - cohort	.502	.128	3.921	.000	.001
Rank of influence - supervisor-Rank of influence - cohort	.901	.128	7.035	.000	.000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .05.
Significance values have been adjusted by the Bonferroni correction for multiple tests.

Repeated Measures ANOVA

Mauchly's Test of Sphericity[a]

Within Subjects Effect	Measure	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon[b] Greenhouse-Geisser	Epsilon[b] Huynh-Feldt	Epsilon[b] Lower-bound
profession	MH_difficulties	.920	16.775	5	.005	.946	.960	.333
	helpseeking	.940	12.457	5	.029	.962	.977	.333

Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix.

a. Design: Intercept

Within Subjects Design: profession

b. May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

Univariate Tests

Source	Measure		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
profession	MH_difficulties	Sphericity Assumed	30.951	3	10.317	14.360	.000	.066
		Greenhouse-Geisser	30.951	2.837	10.911	14.360	.000	.066
		Huynh-Feldt	30.951	2.881	10.743	14.360	.000	.066
		Lower-bound	30.951	1.000	30.951	14.360	.000	.066
	helpseeking	Sphericity Assumed	14.072	3	4.691	9.391	.000	.044
		Greenhouse-Geisser	14.072	2.886	4.876	9.391	.000	.044
		Huynh-Feldt	14.072	2.932	4.799	9.391	.000	.044
		Lower-bound	14.072	1.000	14.072	9.391	.002	.044
Error(profession)	MH_difficulties	Sphericity Assumed	437.549	609	.718			
		Greenhouse-Geisser	437.549	575.845	.760			
		Huynh-Feldt	437.549	584.855	.748			
		Lower-bound	437.549	203.000	2.155			
	helpseeking	Sphericity Assumed	304.178	609	.499			

	Greenhouse-Geisser	304.178	585.882	.519			
	Huynh-Feldt	304.178	595.231	.511			
	Lower-bound	304.178	203.000	1.498			

Tests of Within-Subjects Contrasts

Source	Measure	profession	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
profession	MH_difficulties	Level 1 vs. Level 2	56.123	1	56.123	43.012	.000	.175
		Level 2 vs. Level 3	14.828	1	14.828	8.696	.004	.041
		Level 3 vs. Level 4	4.123	1	4.123	3.503	.063	.017
	helpseeking	Level 1 vs. Level 2	7.843	1	7.843	7.955	.005	.038
		Level 2 vs. Level 3	.593	1	.593	.546	.461	.003
		Level 3 vs. Level 4	2.593	1	2.593	3.323	.070	.016
Error(profession)	MH_difficulties	Level 1 vs. Level 2	264.877	203	1.305			
		Level 2 vs. Level 3	346.172	203	1.705			
		Level 3 vs. Level 4	238.877	203	1.177			
	helpseeking	Level 1 vs. Level 2	200.157	203	.986			
		Level 2 vs. Level 3	220.407	203	1.086			
		Level 3 vs. Level 4	158.407	203	.780			

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