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***Practising psychotherapy as a clinical
psychologist: What facilitates capable practice?***

Aisling McMahon

A project submitted in partial fulfilment of the requirements for the
degree of
Doctor in Psychotherapy by Professional Studies

Middlesex University
Metanoia Institute

2012

Acknowledgements

I am very grateful to have had many contributors and supporters from within the Irish psychology community during my final project research, particularly Dr. Katie Baird and Niamh O’Byrne in PSI; Dr. Michael Drumm and all the HPSI Managers; and those involved in the yet-to-form PSI supervision policy group: Dr. Niamh Coleman, Colm Regan, Teresa O’Mahony, Dr. Mary Creaner and Sarah Callanan.

My warm thanks to Dr. David Hevey for his expertise in all things statistical, to Dr. Rebecca Quin for her generous and affirming engagement with my IPA work, and to Darina Errity for her willing and able research assistance.

My grateful thanks to my academic advisors: Dr. Bobby Moore, for his guidance and affirmation of my plans and choices, and Professor Maja O’Brien, for her astute, detailed and invaluable guidance during the writing up of my research. I also want to thank Mandy Kersey for her unfailingly warm and expert support and Dr. Stephen Goss for his generous feedback on my survey design.

With many thanks to Dr. Rosemary Rizq, my Academic Consultant, for her calm, warm and enlightening expertise in IPA research – I very much enjoyed our consultations and always wanted more.

For their willing support of my research, my thanks to Professor Alan Carr and Dr. John O’Connor, my Learning Signatories, and also to Teresa O’Mahony, my “critical friend”, whom I’ve always admired for her wealth of experience and political nous.

My most grateful appreciation to all the psychologists who took part in my research, particularly those who generously shared their experience in the qualitative interviews.

And my heartfelt thanks to my very special family, Mark, Cian, Daragh, Killian, Rianna and Ben, who reminded me to have fun in the middle of the work.

Preface

This doctoral project is presented in two volumes. **Volume 1** is a RAL 5 project which was submitted in November 2010 and was awarded 180 credits on the D. Psych. (Prof.) programme in January 2011 by the Metanoia Institute and Middlesex University. Following this is **Volume 2**, which is the final project work. As the RAL 5 was awarded 180 credits, it is a small final project. To aid the reader's navigation, the volume number is in brackets beside the page numbers in Volume 1, just page numbers being noted for the more lengthy Volume 2.

The work in both volumes is focused on clinical psychologists and their psychotherapy practice. The work outlined in Volume 1 formed the basis for the development of the final project work in Volume 2. Particularly relevant parts of Volume 1 are the personal introduction, on p.1-4, which gives an initial flavour of my interest and personal views in this area of research, and also the final sections, p.14-18, which summarise the Volume 1 work and its linkage with the Volume 2 final project work.

Volume 1: RAL 5 project

Table of contents Volume 1, RAL 5	page
1. Personal introduction	1
2. Overview of RAL5 application for 180 credits	4
3. Description of doctoral-level work to date:	5
3.1 Articles published on therapeutic practice	5
3.2 Therapeutic practice workshops for psychologists	6
3.3 Phenomenological research with psychologists on their therapeutic practice	8
3.4. PSI Clinical Division AGM presentation on practising psychotherapy	9
3.5 Workshop at the 2010 PSI Annual Conference on therapeutic practice	11
3.6 Therapeutic practice seminars for trainee clinical psychologists	11
4. Development of capabilities and doctoral level competencies demonstrated	12
5. Looking back: review of professional contribution	14
6. Looking forward: linkage to proposed final doctoral product	15
7. Summary of application for 180 RAL 5 credits and concluding reflections	17
References	19
 <u>Appendices Volume 1, RAL 5 (located after both Volumes 1 and 2):</u>	
Appendix 1.1: Front pages of articles published in Irish professional journals on psychotherapeutic practice issues and examples of past written work	A1-i
Appendix 1.2: Therapeutic practice training workshops for psychologists and some past training work	A1-viii
Appendix 1.3: Phenomenological research with psychologists on their therapeutic practice	A1-xvii
Appendix 1.4: PSI Clinical Division AGM presentation and example of past committee work	A1-xx
Appendix 1.5: PSI Annual Conference workshop	A1- xxv
Appendix 1.6: Therapeutic Practice Seminars for Clinical Psychologists in Training and example of past teaching work with trainees	A1-xxix

1. Personal introduction

I recently had a meeting about my doctoral research plans with a long-established clinical psychologist who has many years of therapeutic experience as well as of teaching and supervising both psychologists and psychotherapists. We met over a light lunch in a warm hotel lounge on one of those “soft days” in Ireland at the turn of autumn into winter. After discussing my research plans in the area of clinical psychologists practising psychotherapy, we started to share some aspects of our professional journeys. This man (I’ll call him Paul), like me, originally trained as a clinical psychologist, and afterwards trained as a psychotherapist. He challenged me to consider where my identity lay – did I see myself as a clinical psychologist or as a psychotherapist? Surprised at being asked to choose, I said “I am both!” Our dialogue continued roughly as follows:

Aisling: Both identities are important to me, I’m a clinical psychologist and a psychotherapist. Do you not feel you are both too?

Paul: I am, but my identity is as a clinical psychologist – that identity encompasses more than my therapeutic work – it includes my assessment, formulation, research and consultancy skills, my training as a scientist-practitioner....

Aisling: Ah...interesting, because I don’t see my clinical psychology identity as superseding my identity as a psychotherapist. I have always seen my therapeutic work as primary and everything else pivoting around that – any assessment, consultancy, teaching or research work I see as leading towards or from the therapeutic work – otherwise it doesn’t seem meaningful to me. I know not all clinical psychologists would see it that way but therapeutic work is a large part of most psychologists’ workloads.

Paul: That’s true. But clinical psychologists offer much more than therapeutic skills. We offer strong formulation and assessment skills and understanding of developmental and psychiatric issues - such knowledge contains the therapeutic work. I would like to see a system where psychotherapists are supervised by psychologists and accountable to them – psychotherapy is naturally a sub-discipline of psychology.

Aisling: Oh, I have a strong reaction to that! Sure you could say the same about psychology being a sub-discipline of psychiatry and we’ve fought hard for our autonomy there.

Paul: Well, yes but psychological knowledge actually precedes psychiatry, coming from philosophical roots. And psychological knowledge about human nature provides the natural grounding for psychotherapy.

Aisling: *But there are so many experienced and highly knowledgeable psychotherapists – they’re a strong profession in their own right. I agree we have a valuable breadth of knowledge and experience but we also have so much to learn from how psychotherapists train and practice. We tend to treat our therapeutic practice as just another set of skills, not fully recognising the need for personal development, for process supervision, for strong theoretical understanding of the process of psychotherapy – and these things are well recognised and developed amongst psychotherapists. After my own clinical training, I struggled with the personal impact of therapeutic work, finding that it wasn’t just a skill-base that I could pull out on demand. It felt like a lone journey as I did my own personal therapy, tried unsuccessfully to find adequate supervision for my work, and read when I could manage the time. It was a full 10 years after my psychology training that I did psychotherapy training and only then did things fall into place for me - I felt more resourced in my work and better able to access what I needed to support myself, including exceptional psychotherapists as supervisors....It was a journey I had to figure out on my own, though.*

Paul (leaning forward in his chair): *But I had to figure out what I needed too – nobody mapped out the journey for me either!*

Aisling (surprised at Paul’s sudden energy on this): *You feel the same as I do then! We both remember the challenge of figuring out what we needed to feel capable in our therapeutic work. It shouldn’t have had to be that way and yet it still is. Clinical psychologists need more training and support for their practice as therapists – that should be standard, not have to be re-discovered by each psychologist as they risk becoming depleted over time...*

We talked a little more and I left our meeting feeling generally stimulated by the dialogue, but also perturbed by the political overtones. Is the old power struggle between psychiatry and clinical psychology being reconfigured between clinical psychology and psychotherapy – as the past oppressed, are we now claiming the role of the oppressors? And if so, where does my research work fit in, with me potentially opening up to question the capabilities of clinical psychologists in their practice as therapists at a time when some psychologists are claiming higher ground over psychotherapists?

I wanted to share this dialogue as an initial introduction to the story of my research work and to give a snapshot of my experience and views as a practising clinical psychologist and psychotherapist. In my first decade of professional experience, in the 1990’s, I established my identity as a clinical psychologist. I developed a

specialism in forensic psychology, spending most of my time working therapeutically with men who were imprisoned for sex offences. I valued the fact that my work mainly involved therapeutic practice, but I did not feel well enough resourced and supported in my work. I engaged in my own personal therapy and at times used that as a container for the emotional impact of my work as I did not have access to regular supervision. Also, my therapeutic training, as part of my clinical training, was in cognitive-behavioural therapy (CBT) and this model did not offer me a meaningful framework for my work with men who had deep developmental traumas and who had also created serious trauma in others.

As I moved into the new millenium, I embarked on further training in order to both replenish and develop my resources. I trained as a humanistic and integrative psychotherapist, the training having a strong psychodynamic element which offered me a deeper understanding of the developmental and relational issues in my therapeutic work. I enjoyed settling into my new identity as a psychotherapist, developed regular supervisory support for myself and also resigned from my clinical psychology job and moved into private practice. This was largely a personal decision as I wanted more time at home with my children in their early years. Towards the end of this decade, from 2008 onwards, I was feeling more established as a psychotherapist and had more creative energy available to me as my children were moving out into the world more. I started to consider then how I too could stretch out beyond my private practice rooms and engage more widely again in my professional work.

While I was enjoying my work as a psychotherapist, my clinical psychology roots were also important to me and I was interested in finding a voice and a place that would honour and express both aspects of my professional identity. I started to write articles in professional journals on therapeutic practice issues and then took up an opportunity to work with psychologists in clinical training - this started me on the road of re-engaging with the needs of clinical psychologists practising psychotherapy. The research and development journey outlined in the following pages continues from this reconnection with my clinical psychology peers around their therapeutic practice. It is also proving to be a valuable journey for me as I enter a new decade, one where I am moving into a new integration of my clinical

psychology and psychotherapy identities and exploring what I can offer to the clinical psychology profession from this place of integration.

2. Overview of RAL 5 application for 180 credits

I am applying for 180 RAL 5 credits as I believe my work to date has the necessary depth and quality. In particular, I believe my work shows a strong thematic progression through its various products and increasing range of influence. This work has provided essential groundwork for my planned final doctoral project and has also located me in a position of credibility and influence within the Irish clinical psychology profession.

My work for this doctoral programme focuses on the experiences and needs of clinical psychologists practising psychotherapy. While the work and products I am highlighting in this RAL 5 application have all been accomplished within the last two years, many aspects of my past work experience have been leading up to my capability for this work. There are earlier work strands which I will refer to at times to offer more understanding of the depth and range of experience that supports this more recent specialist work.

The figure below gives a graphic overview of the work I am including in this RAL 5 claim.

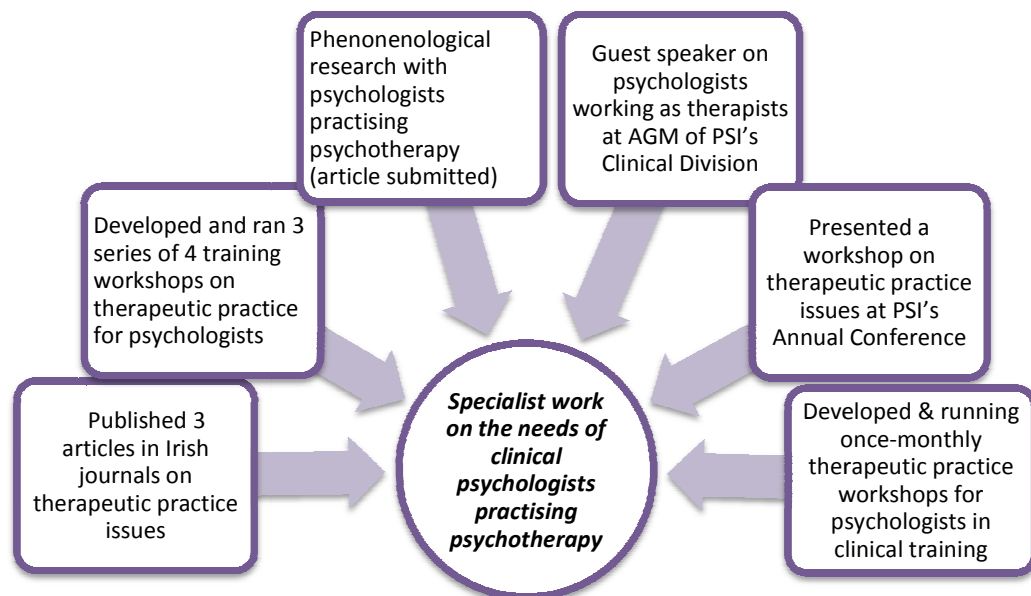


Figure 1: A graphic depiction of doctoral-level work done to date in the area of clinical psychologists practising psychotherapy

3. Description of doctoral-level work to date

3.1 Articles published on therapeutic practice:

My first published article was in 1997, where I described the therapeutic work of psychologists in prisons (McMahon, 1997). However, the first article I wrote with the aim of sharing knowledge on therapeutic theory and practice was published quite recently (McMahon, 2009a) in the Irish Psychologist (IP), the monthly professional journal for Irish psychologists. In order to also reach out to my psychotherapy peers, I wrote a different version of that article for an Irish psychotherapy journal, Eisteach (with permission from the IP editors; McMahon, 2009b). Both articles were written on working with resistance, offering a theoretical overview of four therapeutic schools on this issue, as well as illustrating theory and practice with anonymous, disguised client material. I submitted these articles to professional journals rather than peer-reviewed academic journals, my intention being to share knowledge and experience with Irish clinicians, these journals being widely read by practitioners. The Irish Psychologist article attracted a good response from a number of clinical psychologists, and was the beginning of my re-engagement with my Irish clinical psychology peers.

I wrote another article, which was published in early 2010, on working with countertransference, describing work with a client who gave permission for our therapeutic journey to be published anonymously (McMahon, 2010). I published this article in an Irish psychotherapy journal, Inside Out, as it was a clinical article and more relevant for this journal. I have, however, shared this article with psychology peers and supervisees as an illustration of the value of working with countertransference (see Appendix 1 for the initial pages of the 3 articles).

I have also submitted an article on my research with psychologists earlier this year (see 3.3 below). Writing is a skill that I have made use of at various points in my career to raise awareness and inform policy and practice. For instance, in the Irish Prison Service I wrote psychology policy documents on key issues, such as drug rehabilitation in the prisons and post-incident care services for prison officers, which helped inform service development in these areas (see Appendix 1 regarding one of these documents). To give an early example of the value of my written

work, presenting audit-informed reports to the Medical Director of my first clinical post in the early 1990's created the impetus for changes in the use of the psychology service (most notably, time spent doing psychological assessments reduced, allowing more time to provide the therapeutic services that were commonly recommended following assessment). Following this, I was invited by the Director of Psychology to present my audit system to all the clinical psychologists from the associated child, adult and intellectual disability services (see a letter about this work at the end of Appendix 1).

3.2 Therapeutic practice workshops for psychologists:

Coming forward in time again to my more recent specialist work on psychologists' therapeutic practice, a key piece of work has been my development and running of a set of therapeutic training workshops for psychologists throughout 2010. There were four workshops in each set, run at one-monthly intervals. The workshops could be attended individually or as a set, my concern being to enhance accessibility for psychologists.

The workshops offered a balance of theoretical input, client discussion time and experiential skills-based work in some central aspects of psychodynamic theory and therapeutic practice. Some selected materials regarding these workshops are included in Appendix 2. At this point, I have run 12 of these workshops (three sets of four). Those attending have been predominantly clinical psychologists, but have also included a small number of counselling psychologists and one health psychologist – to date 43 psychologists from various services around Ireland have attended these workshops.

Participants completed an anonymous pre-workshop questionnaire (see Appendix 2) and from this I gathered some useful information about the psychologists. There was a spread of experience amongst the participants – one-third were practising less than 5 years, one-third were practising between 6-10 years, and the final third were practising 11 years or more. When I originally planned the workshops, I anticipated that it would be recently qualified psychologists who would attend in order to develop their skills and knowledge. It was an unexpected finding that

many experienced psychologists also attended, showing their ongoing need for input, reflection and development of their therapeutic practice.

All the participants were practising psychotherapy as part of their work, two-thirds spending the majority of their time (60-100%) doing so. Over one-third of the participants had also completed formal psychotherapy training since their psychological training. Interestingly, given that personal therapy is not mandatory for clinical psychologists in training, nearly all of the participants had engaged in their own personal therapy.

There has been a strongly positive response to these workshops and, as I have a list of psychologists keen to book in for any further workshops, I plan to continue to develop training events for psychologists practising psychotherapy. I have already set up a monthly psychodynamic process supervision group for psychologists in response to requests from workshop participants for ongoing support for their therapeutic work. I also have been getting requests from those who have attended the workshops for individual process supervision as well as for individual therapy work. I am happily either setting up such arrangements or referring on to colleagues. This is very satisfying to me as I feel that I am, in a small but significant way, supporting a ground-level development amongst Irish clinical psychologists to seek out more supports for their therapeutic work. As an example of this, one very senior clinical psychologist confided that attending my workshops had encouraged her to start her own personal therapy, having always been, to use her own words, “sceptical and somewhat afraid of therapy over the years”.

To ground this recent training work in my past experience, I would like to briefly mention some other therapeutic training work I have done over the years. In the 1990's I did counselling skills training with hospice volunteer counsellors (examples of participant feedback sheets are included in Appendix 2). Over 10 years working in the Irish Prison Service, I trained and supervised probation and welfare, prison officer and psychology staff who were running group programmes for prisoners. I also developed training manuals for prison officers' group work with prisoners in collaboration with an external consultant – details of this work was included in my RAL 4 claim.

3.3 Phenomenological research with psychologists on their therapeutic practice:

All the psychologists in my therapeutic practice workshops between February and June 2010 completed reflexive journals at the beginning and end of each training day. Participants were free to keep their journals private or to have them included anonymously as part of my research (see consent form in Appendix 3) – out of 28 participants, 25 chose to leave their journals with me. To ensure consent was fully informed, before submitting this study for publication I sent each of the psychologists a copy of the research analysis to offer them the choice at that point to withdraw consent for their reflections to be included. None of the psychologists chose to withdraw their material and I received many comments back saying how they found the analysis validating and normalising of their own experience.

I used two levels of qualitative analysis with the data. I first used Jonathan Smith’s interpretative phenomenological analysis (IPA, Smith et al, 2009) with a smaller group of 7 journals completed by clinical psychologists who attended the full set of four workshops. I then carried out a descriptive thematic analysis with the remaining 18 journals to look for further evidence of the themes identified through the IPA analysis. I identified ten themes in the psychologists’ reflections on their therapeutic work, subsuming these under two super-ordinate themes, as seen in Table 1 below:

<i>1. Impact on the self:</i>	<i>No. of 7 IPA journals:</i>	<i>No. of all 25 journals:</i>
Interpersonal challenge: <i>“challenging to the core”</i>	7	25
Impact on energy: <i>“can pull me down and drain me”</i>	7	23
Emotional impact: <i>“makes me feel vulnerable”</i>	7	22
Self-doubt: <i>“feeling like a fraud”</i>	7	15
Stress of service demands: <i>“struggling to keep up”</i>	5	9
 <i>2. Professional needs:</i>		
Therapeutic knowledge and skills: <i>“invigorated by learning”</i>	7	25
Personal awareness: <i>“a personal journey of discovery”</i>	7	19
Reflective space: <i>“space to pull back from the doings”</i>	7	19
Validation: <i>“to feel that I’m doing an OK job”</i>	7	16
Self-care: <i>“you really need to take care of yourself”</i>	7	12

Table 1: Table of super-ordinate themes and subthemes, showing the prevalence of each theme within the set of 7 journals subjected to IPA and within the full set of 25 journals.

An independent researcher closely reviewed my analyses and strongly endorsed my work, expressing confidence that the identified themes and my analytic account were credible and justified. My past research experience had been quantitative so I found engaging with this phenomenological research to be an immensely rich and valuable way of illuminating experience. Figure 2 below illustrates the connections I noted in these psychologists' reflections between the challenges experienced and their moderation through the meeting of associated needs (for e.g., energy levels were boosted by developing knowledge and skills as well as by self-care activities). I have submitted an article on this research to the peer-reviewed journal *Clinical Psychology and Psychotherapy* (see Appendix 3).

The knowledge gained from this exploratory research has provided a strong foundation for me to further develop my research work in this area. In my continuing work, I aim to do more to raise awareness and inform policy and practice regarding what is needed to develop and support clinical psychologists' capability for therapeutic work.

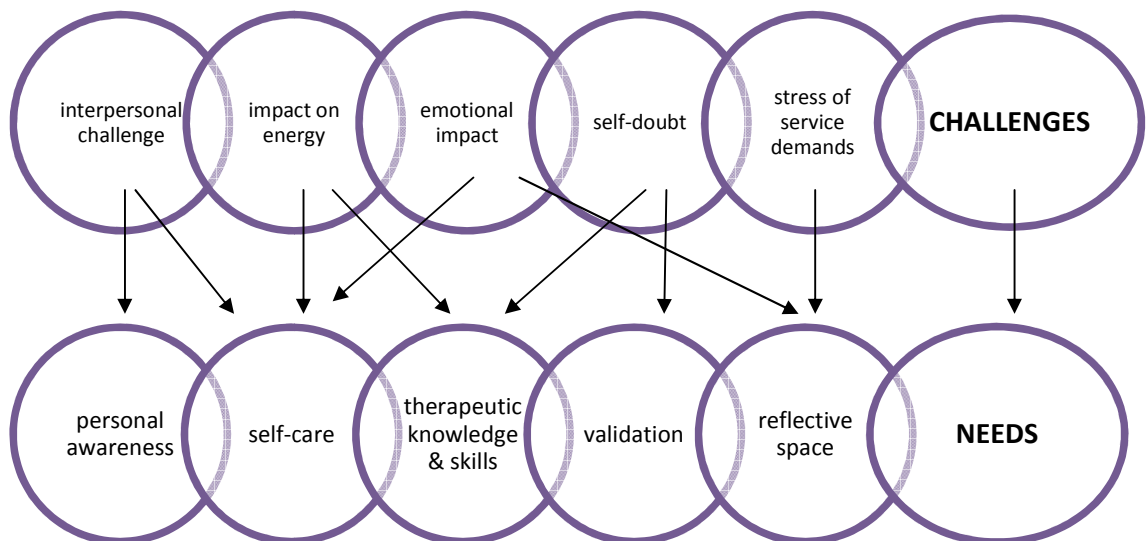


Figure 2: Connections between challenges and needs for psychologists practising psychotherapy

3.4 PSI Clinical Division AGM presentation on practising psychotherapy:

The success of my therapeutic training workshops for practitioners led to an invitation to be a guest speaker at the 2010 AGM of the Clinical Division of PSI. I

presented the results of my phenomenological research with psychologists on their therapeutic practice (see Appendix 4 for introductory slides). My presentation has been uploaded on the Clinical Division page of the PSI website (www.psihq.ie). I also facilitated an experiential reflection and discussion of the AGM participants' own therapeutic work, focusing on personal challenges and support strategies. The presentation was well-received, a number of psychologists expressing their appreciation of the experiential aspect.

I asked the AGM participants to complete a brief survey at the end of my presentation, to get a relatively simple snapshot of self-care, development and support practices for their therapeutic work (see Appendix 4). I have not formally written up this small piece of opportunistic research as my main reason for doing it was to get some current information to aid in planning my next stage of research. A brief overview of the findings is as follows:

- Nearly three-quarters had attended personal therapy.
- Just over one-third had current individual process supervision and over one-third had current peer group supervision.
- All engaged in reading and attending workshops to update and refresh their therapeutic knowledge and skills, although some noted these activities weren't regular enough – one-half said that they read once-monthly or less.
- Out of 13 activities named as ways of looking after their needs as psychologists practising psychotherapy, the top 4 activities, each listed by over one-half of the psychologists were: time with family or friends, supervision, reading, and sport or exercise.

Interestingly, personal therapy was only noted by just over 10% as a way of looking after their needs as therapists, and attending workshops or further training by just over 20%.

The findings of this survey offered some foundation to my concern that clinical psychologists do not have consistent formal support for their therapeutic practice – for instance, a significant proportion (22%) of these psychologists had never attended individual process supervision, currently or in the past.

The opportunity to present at this AGM was very welcome as it had been some years since I had been involved with the Clinical Division. I had previously served on the Clinical Division committee, as both secretary (1996-8) and chairperson (1998-2000). An example of some survey work I did with the Clinical Division membership is included at the end of Appendix 4. This timing of re-engaging with some key people in the professional body has been particularly valuable while planning further research work with clinical psychologists.

3.5 Workshop at the 2010 Annual PSI Conference on therapeutic practice:

I decided to present a workshop at the 2010 Annual PSI Conference to offer a further opportunity for psychologists to engage in theory and practice issues in relation to their therapeutic work and to continue to develop my professional presence in this area. This workshop offered practising psychologists some introductory theoretical input on working psychodynamically with adults, an opportunity for confidential discussion of practice, as well as an experiential exercise to allow personal engagement with the material (see Appendix 5 for the conference programme and a sample of feedback sheets).

This was only my second time presenting at a national psychology conference – my first conference presentation was in 1988 when I presented my BA psychology degree research findings on core self-schemas. Compared to that early experience, when it felt both exciting and terrifying to be taking a position of authority in front of my professional peers, this year’s experience felt more satisfying – the anticipatory adrenaline rush that tends to come with any public performance felt more comfortably contained and grounded in my lived experience rather than just relying on the “book learning” of my earlier years.

3.6 Therapeutic practice seminars for trainee clinical psychologists:

A further outcome of good reports regarding my therapeutic training workshops was being invited from autumn 2010 to do once-monthly teaching work on therapeutic practice with final year psychologists in clinical training in Trinity College Dublin (TCD).

I have developed therapeutic practice seminars within a psychodynamic framework. Through this work, I am aiming to encourage and support the development of the trainees' understanding of the interpersonal challenges of therapeutic work as well the development of their own personal presence and attention to self care in the work (see Appendix 6 for an overview of the format of my seminars as well as a sample of feedback sheets).

This therapeutic teaching work with trainees is a new development but I have a long history of teaching work with two of the Irish clinical training programmes, TCD and UCD (University College Dublin). Through the 1990's, I gave teaching inputs on a few areas of expertise such as assessment work, forensic psychology and sleep disorders (a one-page overview of a past teaching input is included at the end of Appendix 6). I stopped doing this work during the 2000's when I moved into private practice. I became re-involved with trainee clinical psychologists when I took on work as a sessional staff member for the UCD programme in 2009-10, with the role of reviewing trainees' professional development on clinical placements. This latter work also involved being a member of the Course Advisory Committee. It was this work with the trainees and the training programme that re-sparked my interest in the needs of clinical psychologists practising psychotherapy. `

4. Development of capabilities and doctoral level competencies demonstrated

There has been significant growth in my knowledge and capabilities through engaging in the work I have outlined above. I would like to highlight a few key areas of growth which offer a useful grounding for my continuing doctoral work:

- The response to my therapeutic workshops has been strong, showing a real need amongst clinical psychologists for training inputs and professional support for their therapeutic practice. A surprise for me has been the number of long-established senior clinicians attending and benefitting from my workshops, this raising my awareness that there is an ongoing, career-long, need for validation, reflective space and theoretical and skills development.

- My phenomenological research with my workshop participants has highlighted a variety of challenges and needs for psychologists in their therapeutic practice, many of these needs not being reliably met (e.g., the lack of regular supervision). With this knowledge, I feel I have a stronger mandate to research these needs further and to give them a voice.
- Having had no prior experience, I have developed my knowledge and competency in qualitative analysis, specifically in thematic analysis and interpretative phenomenological analysis, which will be of great benefit in my next-stage research.
- I have moved from a place of relative professional anonymity into quite a well-known and influential position amongst my clinical psychology peers and within my professional association. This is already proving to be a valuable position to be in (for instance, leading to the invitation to present my phenomenological research at the AGM of my professional Division) and I intend to continue to develop this professional network. I trust that this will greatly enhance the likelihood of the findings of my continuing research being both heard and usefully applied.

I believe that the following doctoral level competencies are evidenced in the work I have outlined in this RAL 5 application:

- Ability to be innovative in designing and running training opportunities for my professional peers, from those at the early training stage to experienced practitioners.
- Ability to be self-directed and work autonomously, with a sense of leadership and responsibility towards the needs of my profession.
- Ability to research, formulate, critically evaluate and synthesise specialist knowledge in my field of psychotherapy, with a view to the applied use of this knowledge, seeking ongoing opportunities to share this with my professional peers.
- Sensitivity to, and responsibility at all times for, ethical issues when engaging in research with those I am teaching or training, and when presenting or publishing my work which reflects on my experience with clients or workshop participants.

- Willingness to develop and stretch my professional capabilities by entering the public domain, through publishing articles and doing national level presentations, along with openness to engaging with a critical community of peers to develop shared understandings and goals for my profession.

5. Looking back: review of professional contribution

I believe that there is a strong thematic progression in my work to date – I have been moving from written engagement through to training work, into applied research and active dissemination of my research findings as well as engagement with my professional body – and then moving back to training with those on the verge of entering the profession. This has been an important cycle of developmental work, one which is still ongoing.

I am generally happy with the quality of the work I have done in this area and I trust that I have offered some valuable contributions to my professional peers. The feedback I have received has been good to date and the success of each venture has led into opportunities for further work with my profession. For instance, I initially planned to do one set of therapeutic training workshops but have now done 3 runs, having still been unable to accommodate all who wanted to book in to attend. The invitations to present at the Clinical Division AGM and to run training workshops with clinical trainees have come from the positive feedback from my training workshops with practitioners. I understand this positive response in two ways – firstly, I believe that my work is timely and has tapped into a real and current need amongst psychologists in relation to their therapeutic practice; secondly, I realise that I have some grounded experience and knowledge in this area of therapeutic practice that has value and credibility amongst my professional peers. I have nearly 20 years experience behind me and I have done significant work, both personally and professionally, to develop my capability for therapeutic work. I also believe that my early years of clinical practice have allowed me to hold an appreciation of what it is like to practice therapy as a clinical psychologist without adequate supports, and this continues to guide me in my writing, presenting and development of training work for trainees and practitioners.

In terms of critiquing my work to date and my readiness for continuing work in this area, the issue I am particularly aware of is the challenge it can be for me to take a more public role. I have taken on leadership roles in the past and been trusted in them but I am a quiet leader - I prefer intimate connections and small groups rather than working with larger systems. And yet I feel that there is an influential role that professionals of my quieter character can take through creating ripples of interest in change and development from the ground-level up, in contrast to just working at policy or professional body level, where “imposed” changes can be met with resistance. Having said that, there is a need for both and I can already see how PSI’s recent CPD policy (PSI, 2008) has encouraged many psychologists to engage in professional development work that they may not otherwise have done.

I feel that I have done well so far to both create and meet opportunities to take a more public role even though I sometimes feel like retreating back into the comfortable obscurity of my private rooms! For instance, when I received the invitation to speak at the Clinical Division AGM I felt an immediate dart of fear and stress through my body – and yet I was excited too. I am glad that I decided to follow the excitement and promise of that opportunity. I am hoping to continue to stretch myself, while supporting myself in doing so, so that I can further develop my awareness-raising work on behalf of my professional peers.

6. Looking forward: linkage to proposed final doctoral product

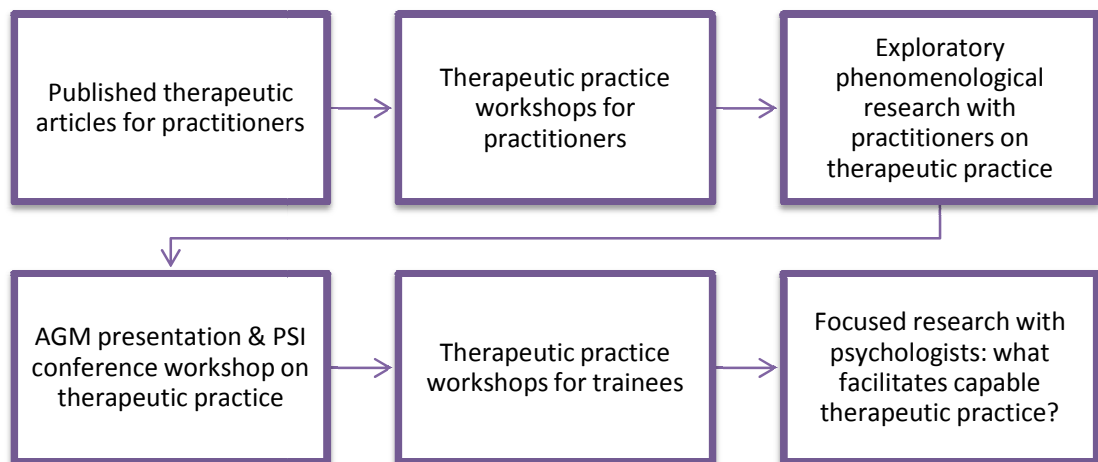


Figure 3: Progression of work towards final product work

Having engaged in therapeutic training work with both practitioners and trainees, carried out some initial exploratory research in this area, and both published and presented at national level in this field, I believe that I am now well placed and trusted by my professional peer group to engage in further research work in the area of clinical psychologists practising psychotherapy. In my final product work, I plan to explore what practising clinical psychologists believe facilitates, and limits, capability in their therapeutic practice in order to inform practitioners, trainers, managers and policy makers of potential initial training and continuing professional development needs (see Figure 3 above).

I will be using a mixed-methods research design, with both quantitative and qualitative elements. I plan to use a survey questionnaire to gather some quantitative and qualitative information from a large sample of Irish clinical psychologists on their therapeutic practice. This is a pragmatic, political decision as the tallying of experience and need across a larger, representative group has immediate credibility for influencing policy makers and managers. However, since starting on this professional doctorate, I have discovered the inherent richness and intuitive validity of more qualitative in-depth phenomenological research. So, in order to give more body to the necessarily limited and more descriptive survey information, I also plan to carry out a small number of qualitative interviews with clinical psychologists to explore capability in their therapeutic practice, analysing these with interpretative phenomenological analysis.

I am aware that my research is timely as there are wider movements occurring to develop professional supports for clinical psychologists practising psychotherapy. For instance, the Director of Professional Development in PSI is establishing a working group in the New Year to develop a supervision policy for psychologists and I have been invited to join this group. I am really pleased at the timing of this opportunity and I anticipate that my research will usefully inform this new policy.

This next stage of research, even in the planning stages, has involved more consultation and collaboration with other clinical psychologists and members of the professional body than my past work has done. Through this consultative work, I am keen to foster professional support for my continuing research work in order to

enhance the likelihood of arising recommendations being accepted by managers, trainers and policy makers, as well as by practitioners on the ground.

7. Summary of application for 180 RAL 5 credits and concluding reflections

I have engaged in a range of significant work in relation to the therapeutic practice of clinical psychologists. This work has covered writing, presenting, teaching, training and researching. Most of the work that I am including in this RAL 5 claim for 180 credits has been carried out within the last 2 years, and within that time I have found that my specialist interest in clinical psychologists' therapeutic practice has been gaining increasing momentum and range, with new opportunities continuing to evolve from earlier work. However, as I hope I have demonstrated in this application, my recent work has developed from a foundation of past work and competencies, and I feel I have moved into a more mature, integrated and focused application of my capabilities.

I started this document with a dialogue I had with a senior colleague about professional identity and I notice the theme of identity running through this review of my work. The theme is present at a number of levels. It relates to the growing integration of my identities as a clinical psychologist and as a psychotherapist, the re-engagement with my identity as a practitioner-researcher, the re-initiation and broadening of my identity as a teacher of psychologists in clinical training to include that of a trainer of qualified practitioners, and the inhabiting of a more mature identity as an experienced, reflective practitioner. However, probably the most interesting and challenging development for me currently is my movement into taking a more public, political identity in relation to my profession. In this, there is a real, and hopefully valuable, stretch for me personally and professionally.

I am also aware of entering into sensitive political territory, as I think again of my colleague's claim for psychologists to be the expert managers of psychotherapy. While I was surprised to hear this from him, claiming a leadership role in psychotherapy is not uncommon amongst psychologists (for example, consider the dominance of IAPT [Improving Access to Psychological Therapies] programmes throughout the British NHS). Such claims at the expense of other professions do

not sit well with me. However, I hold a particular concern due to my belief that clinical psychologists often have significant gaps in their therapeutic training and a lack of consistent supports for their therapeutic practice, unless they take their own initiative, as many do, to develop their capabilities and supports after their clinical training. I anticipate some resistance to my research as it may open up some gaps and needs to public view in a way that could be seen to undermine clinical psychologists' therapeutic competence. However, my fundamental hope and aim in doing this research is not to undermine clinical psychologists, but rather to enhance psychologists' therapeutic capability through developing awareness, policy and practice regarding the need for consistent access to stronger therapeutic training and ongoing professional supports.

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Volume 2: Final project

List of key terms and abbreviations used:

I defined **psychotherapy** (used interchangeably with therapy) in this study as follows:

A broad definition of psychotherapy is understood here - including engaging in counselling, psychological therapy or psychological treatment work with individuals, couples, families or groups with emotional, behavioural or adjustment problems.

I defined **clinical supervision** in this study as follows:

Clinical supervision is understood to be where the supervisee has a confidential and reflective space to explore and/or receive guidance on any aspects of their work and their own professional development, with the aim of supporting and enhancing clinical practice. In clinical supervision, there may or may not be a reporting relationship from supervisee to supervisor.

I defined **capability** as:

having confidence to do complex work as well as having unfolding potential, continuing to learn and develop over time through personal and professional avenues.

CPD: Continuing professional development, which has been defined as:

“any process or activity that provides added value to the capability of the professional through the increase in knowledge, skills and personal qualities necessary for the appropriate execution of professional and technical duties, often termed competence” (Professional Association Research Network, (www.parn.org.uk), quoted in Golding & Gray, 2006, p.2)

PSI: Psychological Society of Ireland

BPS: British Psychological Society

HPSI: Heads of Psychology Services of Ireland

HSE: Health Service Executive

CBT: Cognitive behavioural therapy

IPA: Interpretative Phenomenological Analysis

List of figures and tables:

Figure:	page:
Figure 3.1 Overview of final project timescale	32
Figure 4.1 Sequential mixed methods research design: exploratory and transformative	33
Figure 5.1 All survey participants in the Supervision and Psychotherapy studies	44
Figure 6.1 Therapeutic models trained in and identified with	57
Figure 6.2 Confidence in psychotherapy knowledge and skills	58
Figure 6.3 Additional formal training in psychotherapy	59
Figure 6.4 Satisfaction with supervisory support	60
Figure 6.5 Satisfaction with psychotherapy knowledge and skills gained during psychology training	61
Figure 8.1 Areas in need of development for clinical psychologists practising psychotherapy	107
Table:	page:
Table 5.1 Demographic statistics for the survey's clinical psychologists	45
Table 5.2 Interview participants	47
Table 6.1: CPD activities rated as necessary or valuable for developing qualified psychologists' psychotherapy knowledge and skills	57
Table 6.2 Significant predictors of confidence in psychotherapy knowledge and skills in the logistic regression model	63
Table 6.3 Reasons given for confidence in psychotherapy knowledge and skills	66
Table 6.4 Factors listed by the clinical psychologists that do, or would facilitate confidence and capability in psychotherapy practice	68
Table 6.5 Interview master themes and subthemes	69

Abstract:

This is a practitioner-based project, deriving from clinical experience and aiming to positively contribute to awareness and practice within the clinical psychology profession. Clinical psychologists' experience of practising psychotherapy is explored and factors associated with confidence and capability in this area of work are identified.

Past research has shown that therapist confidence contributes to successful client outcome. However, it has also been found that professional self-doubt and feelings of inadequacy persist throughout psychologists' careers, indicating an ongoing need for professional support to maintain confidence. Psychotherapy practitioners have reported many professional benefits from attending supervision, attending their own personal therapy and engaging in continuing professional development. This project explores whether these factors are relevant to clinical psychologists' confidence in their psychotherapy practice.

This was a sequential mixed methods study. A nationwide survey in Ireland (46% full population response rate) was followed by four in-depth interviews, which were analysed using Interpretative Phenomenological Analysis (IPA).

The results from both the quantitative and qualitative stages of this study provide a consistent picture. They indicate the importance of having satisfying and cohesive training in psychotherapy knowledge and skills, the need to have satisfying supervisory support, and the value of longer experience of personal therapy. All these factors were found to significantly contribute to confidence in psychotherapy practice and were of greater significance than experience. Based on these research findings, I am making three key recommendations to clinical psychology trainers and managers: development of more cohesive, structured training in psychotherapy; introduction of mandated personal therapy during training; and attendance at clinical supervision to be established as standard, career-long practice.

Table of contents Volume 2, Final Project **page**

List of key terms and abbreviations used	i
List of figures and tables	ii
Abstract	iii
1. Introduction	1
2. Literature review	11
3. Research rationale, objectives, hypotheses and timescale	30
4. Research design and methodology	33
5. Research methods and ethical considerations	41
6. Results	56
7. Discussion	85
8. Implications, recommendations and future directions	101
9. Reflective review	114
References	125

Appendices Volume 2, Final Project:

Appendix 2.1: Survey material	A2-i
Appendix 2.2: Interview material	A2-iv
Appendix 2.3: Conference presentations, 2011: Psychotherapy study and Supervision study	A2-xii
Appendix 2.4: Research reports: Psychotherapy study and Supervision study	A2-xiii

Accompanying CD:

Survey material: pilot survey questionnaires and SPSS data files; SPSS data and statistical analysis files for the clinical psychology group and for the full Psychotherapy study.

Interview material: all full transcripts with analytic notes; analytic summaries for participants; thematic development material and quotes; independent audit material.

1. Introduction

1.1 Opening comments

All the project work outlined in both Volumes 1 and 2 is concerned with clinical psychologists and their psychotherapy practice. The final project work, largely carried out during 2011, drew from and built on the research and development work completed during 2009 and 2010, as described in Volume 1. While I have already given a flavour of the reasons for my own personal engagement in this area of practice (see p.1-3, Vol.1), in introducing my final project work I will describe the personal context to my work more fully and also give close consideration to the professional and political context to this work, this being a significant dimension of this project.

As a brief orientation to the following pages, a few points about the training and practice of clinical psychologists are worth highlighting here. Clinical psychologists have a broad, wide training that equips them to work in many clinical settings and with varying populations. While they normally have many roles in their workplaces, including assessment, teaching, systemic and consultancy work, the majority of clinical psychologists engage in some form of psychotherapy as a significant part of their workload. This research aimed to explore this practice, with the specific aim of identifying what facilitates capability for clinical psychologists in their psychotherapeutic work. The impetus behind this research was my experience and belief that some development is needed in the initial training and ongoing support structures for clinical psychologists in order to facilitate capable psychotherapeutic practice.

1.2 Personal context

I trained as a clinical psychologist in Ireland in the early 1990's, qualifying in my mid-twenties. While my clinical training covered various areas of interesting work, I was particularly drawn to working psychotherapeutically with adults – engaging with people's internal worlds fascinated me and it felt like valuable and meaningful work to be a companion and guide in someone's journey through personal distress or unease. In my workplaces, I have been able to follow my interests and the

majority of my workload over the years has been engaging in psychotherapeutic work with adults, individually and in groups. I initially worked in a community-based adult psychiatric service and then worked for ten years in the Irish prison service, working therapeutically with men who had committed sex offences for most of these years. I have now been in private practice for the last seven years, offering individual psychotherapy for adults, psychotherapy supervision and training for psychologists, and also doing some university and hospital-based work.

Personal therapy work was not required when I did my clinical training (and is still a moot issue for clinical psychologists) but during my training I found myself strongly impacted by working therapeutically with others while not having done such work myself. I felt I couldn't be an authentic part of my clients' journeys without making a commitment to engage in a similar journey myself. I started my own personal therapy, both in groups and individually, and have moved in and out of personal work at various stages over the last 20 years. It has been a significant part of my own development as a person and as a psychotherapist, and I have valued it as a personal support during times of change or loss. I have also used personal therapy as a form of clinical supervision at times, and it has helped me both to process the emotional impact of working at the painful edges of life with my clients as well as to work through the personal echoes reverberating in me from my clients' stories. This was particularly true for me through the 1990's as I did not have adequate supervision for my therapeutic work, and even less so once I achieved senior status. This has not been an uncommon experience for clinical psychologists in Ireland and in the UK, supervision meetings often focusing on caseload/service management, not including dedicated time for process supervision of therapeutic work. Progress is slowly being made on this issue in clinical psychology and clinical supervision arrangements are now being made in many services, although still often only at the initiative and felt need of individual psychologists rather than it being standard practice as it is for counselling psychologists and psychotherapists.

As another source of support for my work, and as is common practice for clinical psychologists who have such a broad-based training, I continued to develop my knowledge and skills in my area of specialism. I read books on therapeutic practice and went on occasional therapeutic training days, but over time I felt increasingly

worn down by the demands of my work. As well as the lack of process supervision, the predominantly cognitive-behavioural approach of clinical psychology didn't go deep enough for me and I found that some fundamental substrate was missing for me in understanding my clients' journeys, both in their early development and in their work with me. This led me to the decision to embark on further training as a psychotherapist in the early 2000's, about ten years after my initial clinical training. While I was completing that training, I resigned from the prison service and set up a private practice, which allowed me more time with my young and growing family.

During this more independent but also somewhat cocooned period, I moved away from my clinical psychology roots and I identified more strongly with the private practice world of my psychotherapy colleagues. I accessed regular process supervision from experienced psychotherapists and continued the more directed in-depth reading on therapeutic process that I started during my psychotherapy training. While the richness of this narrower, more intimate focus in my private work as a psychotherapist was valuable to me (and remains so), as my children grew more independent I became more available to stretch beyond my private practice rooms again. I felt a particular interest in connecting back to the clinical psychology world from the more resourced place I had developed for myself through my psychotherapy training. I started to develop projects on psychotherapy practice for clinical psychologists, this work gaining increasing momentum once I started on the Metanoia doctoral programme and more consciously inhabited this area as a specialist interest. The project work I have outlined in Volume I describes the work I have done with my psychology colleagues over the last few years - writing articles on psychotherapeutic theory and practice in Irish professional journals; joining the staff on the Doctorate in Clinical Psychology in University College Dublin (UCD) on a sessional basis; doing teaching on psychotherapy practice with clinical psychology trainees on the Trinity College (TCD) doctoral programme; as well as doing training, research and supervision work with practising clinical psychologists on their psychotherapy work.

I was motivated initially in this work by my own experience of having limited guidance and support for my therapeutic practice and my wish to contribute to my profession so that more therapeutic guidance and support would be accessible to

clinical psychology trainees and practitioners. I have been spurred on to continue this work as there has been strong response from both new and seasoned practitioners, as well as clinical trainees, showing their ongoing needs for development and support of their psychotherapy work. Through my final project research, my intention was to further explore these needs and do what I could to advocate on their behalf. In this, I also hoped to support recent tentative but salutary developments in clinical training programmes and the professional bodies to develop stronger supports for clinical psychologists practising psychotherapy. Such developments include the planning of a PSI policy on supervision for psychologists; the inclusion of a more central personal and professional development (PPD) module during clinical psychology training doctorates in Ireland and the UK (see Sheikh et al, 2007), with a short period of personal therapy now being mandated in two of the Irish doctorates; and the increased recognition of CPD throughout clinical psychologists' careers, both supervision and personal therapy being given a strong weighting by PSI as a CPD activity (PSI, 2008a).

At times this research and development work has been challenging of my resources and capacities and I have particularly felt the personal stretch of moving into a more public, political role within the Irish clinical psychology profession (as I described in Volume 1, see p.15). However, I have also felt a great sense of satisfaction and personal fit in moving into a place of integration of the two aspects of my professional identity - as a clinical psychologist and as a psychotherapist – and in working towards making what I hope will be a meaningful contribution to the clinical psychology community.

1.3 Professional and political context

There is a particular professional and political context to my research and development work, which in part motivated this work but also may affect its potential to inform and influence policy and practice. Clinical psychologists have quite a strong position regarding psychotherapeutic practice, not just in Ireland and the UK but around the world. In fact, in some European countries, only psychologists or medical doctors are licensed to practice psychotherapy (e.g., Germany and Italy). In the public health and voluntary services in Ireland, clinical

psychologists are the dominant profession in terms of providing psychotherapeutic services, and occupy the vast majority of permanent posts, relative to the allied professions of counselling psychology and psychotherapy. However, trained counselling psychologists and psychotherapists are increasing in numbers and are starting to access more paid posts in Ireland, having traditionally being more commonly in private practice. This is posing a threat to the dominance of clinical psychology. In Britain, psychotherapists are more established professionally and are more commonly employed in the public health services, but here also there has been a dominant position taken by clinical psychology, particularly with the recent and widespread introduction of IAPT (Improving Access to Psychological Therapies) throughout the NHS. Such developments have caused significant tensions between clinical psychologists and psychotherapists.

With such a political context, I anticipated that there would be some resistance amongst clinical psychologists to research exploring their capability for therapeutic practice, which may be seen as undermining and challenging of the status quo. I believed that clinical psychologists' therapeutic training and practice needed development in significant ways but my strong intention was to identify and support what is needed to build capability, not to undermine or attack. I found support for this position from Leadbeater's (2008) writings, where he argues that sustainable change more reliably occurs by working with the status quo and offering motivation to change and develop from within. As I developed my work, I found that many practitioners within the profession held this motivation and need for change. For instance, clinical psychologists on my psychotherapy training workshops questioned me at times on my research, asking when the reports would be available so they could use them to lobby management for resources for supervision and CPD. While this offered a welcome ground-level support for my research work, I still anticipated a challenge ahead at management level to facilitate change. In my final project research, my position was one of hoping to explore psychologists' experience, to find out what may be needed to develop and support capability in psychotherapy practice, and to offer a considered and interactive dialogue with the status quo. To facilitate this I worked to engage

involvement and support from within a few key stakeholder groups in the Irish clinical psychology community:

1. Ireland's professional psychology organisation, PSI. During the planning stage of my final project work, I was invited by the PSI Director of Professional Development, Dr. Katie Baird, to join a working group which was being established to develop a PSI supervision policy for applied psychologists. Seeing this as a valuable opportunity to use my research to inform this policy and give practising psychologists a chance to voice their needs, I sought and received approval from PSI Council to collaborate with Katie in my research. As a consequence, my survey research had a second purpose beyond my exploration of clinical psychologists' capability in psychotherapy practice. I expanded the supervision section of my survey and distributed it to all applied psychologists (including counselling, educational, organisational, health, neuropsychological and forensic psychologists, as well as clinical). This created a significant increase in the research work, both increasing the length of my survey and increasing the number of returned questionnaires by 75%. There was also a significant hitch in that Katie resigned from her PSI post just after the survey was distributed and there was a year's gap before a new Director was in place. I applied for, and received, funding from PSI Council for a small amount of research assistance from a postgraduate researcher, Darina Errity, in lieu of Katie's planned collaboration with me.

2. Psychology managers within the public health and voluntary services – a key group here is HPSI, which represents the senior psychology managers nationally. This group is currently made up of 58 Principal and Director level psychologists. I have liaised closely with this group through two avenues – I liaised with the Chair of the group, Dr. Michael Drumm, in disseminating my survey through all the HPSI managers to their staff, and I am also on the planned PSI supervision policy group with two of the HPSI managers, Teresa O'Mahony and Dr. Niamh Coleman. Teresa O'Mahony, as my critical friend in this research process, is a key source of support and political guidance in the dissemination of my research reports to the psychology managers.

3. Directors of clinical training – there are only 4 clinical doctorates in the Republic of Ireland and I have good contacts with staff in each of these, with particularly close contacts in the two Dublin doctorates, having had significant teaching inputs in both of these. The two learning signatories for my research, Professor Alan Carr and Dr. John O'Connor, are key figures in the course staff of the two Dublin doctorates and these connections have been invaluable in reporting back the research findings to the training staff.

It also is worth noting that this research was carried out during a major recession, at a time when resources were stretched and the public sector was under close scrutiny in terms of offering value for money. Clinical psychologists had taken significant cuts in their salaries, as had all other public sector workers, but were still expensive commodities for their employers. Looking for activities such as supervision, CPD or personal therapy to be accepted as standard and regular practices for clinical psychologists, thus causing more expense in terms of either time or money, was bound to be unpopular with employers. However, I felt it was important not to be limited by political constraints while pursuing this final project research, but rather to openly explore clinical psychologists' needs, and then to consider how to engage with the political context to advocate for these needs. In this, I noted a statement the 2010-11 PSI president made in her inaugural presidential address to the society:

"My voice is only as strong as the policies that are there to support it." (Morrissey, 2010).

I see this statement as underlining the importance of bringing my research findings into the public arena so that policy development in PSI, employing organisations and training universities are appropriately informed by the needs of practising clinical psychologists.

1.4 Do clinical psychologists practice psychotherapy?

A core question underlying my project work is what is understood as "psychotherapy"? The Greek origin of the word means healing of the soul but, while some might engage in such transformative work, most would agree that the

term psychotherapy covers a wide range. The nature and depth of psychotherapy practice varies according to individual client needs and circumstances, service needs, and therapist capabilities, the latter being influenced by various factors, including training, personal resources and preferred therapeutic modalities. I defined psychotherapy broadly for my study (see p.i), this being consistent with the inclusive definitions offered by various organisations, such as the United Kingdom Council for Psychotherapy (UKCP, 2012), the British Association of Counselling and Psychotherapy (see www.bacp.co.uk) and the European Federation of Psychologists' Associations (EFPA; Lane & Althouse, 2011).

A related and more politically nuanced question is what kind of psychotherapy do clinical psychologists practice? During this research work, an occasional query I met was: "But do clinical psychologists practice *psychotherapy*?" The understanding for some was that clinical psychologists are trained to offer more limited skills-based or cognitive interventions, such as CBT, and do not engage in more substantial, relational or depth psychotherapy. Indeed, the term "psychological therapies" has recently been used to describe the evidence-based therapeutic practice of psychologists and to distinguish it from the practice of psychotherapists (BPS, 2010). CBT has been adopted as the baseline therapeutic modality of clinical psychologists, and this can involve more skills-based, cognitive work. However, CBT has developed to include a more relational focus, with a recent appreciation of the value of CBT therapists engaging in their own personal development work (Bennett-Levy et al, 2003; Laireiter & Willutzki, 2003).

My own experience is that clinical psychologists' therapeutic practice covers a broad range. Close to 100 clinical psychologists have attended my psychotherapy training workshops in the last few years (representing a significant proportion of the full population of just over 600 health service psychologists in Ireland: Breaden & Woods, 2010). These psychologists have consistently described engaging in complex and personally impactful therapeutic work, matching my own experience as a clinical psychologist. I believe that the interpersonal engagement of therapeutic work draws therapists of all orientations into complex territory, whether or not this is formally acknowledged. My view that this has not been appropriately acknowledged within the clinical psychology profession underpins my

final project work. Clinical psychology training traditionally focuses on developing skills and competencies rather than paying close attention to the personal development of trainees and the inherent vulnerability and uncertainty that accompanies therapeutic work (McMahon, 2012, see p.8, Vol.1). The development of a competent persona is strongly reinforced (O'Connor, 2001; Walsh & Cormack, 1994) and I believe this leaves a vulnerable interior hidden and unsupported, rather than a personally rooted sensitivity and humanity being appreciated as an essential resource for psychotherapy work. As the final part of my introduction to my work, I would like to share a poem I recently wrote, which expresses my experience of the polarisation of competence and vulnerability in clinical psychology and how opening up this vulnerability in relationship (for instance, through personal therapy or process supervision) develops a stronger therapeutic capability.

Inside Out (the emotional journey of a clinical psychologist)

*Smooth and clear,
So healthy, so able,
Ready for the world,
Hiding vulnerable guts,
Pulsing inside,
But safe.*

*A whisper "I'm not able",
Scared of the empty echo,
Frightened of the sharp retort,
Breathe in, breathe in,
Pulsing inside,
Stay safe.*

*A thrusting mind
Carves a channel,
Straight edges, clean lines,
Breathe out, breathe out,
Pulsing inside,
Still safe.*

*A louder whisper,
A flagging mind,
Torn edges, weaving lines,
Breathe in, breathe out,
Pulsing inside,
Too safe.*

*Reaching out, raw guts,
Scared of the empty echo,
Frightened of the sharp retort,
Meeting a warm heart,
Pulsing inside, pulsing outside
Not safe.*

*Not safe,
But vital, alive,
Pulsing inside,
Pulsing outside,
Vulnerable.
Able.*

1.5 Overview of the final project work

In introducing my final project work I have outlined my personal interests, views and involvement in the field of clinical psychologists practising psychotherapy as well as some aspects of the professional and political landscape of this area of practice. In Chapter 2, as part of my review of the literature, I look more closely at the clinical psychology profession, its involvement in psychotherapy practice, and the factors that may be associated with confidence and capability in this work. In Chapter 3, I outline the rationale, objectives, and hypotheses of my research, as well as the timescale of its implementation. I discuss and describe the research design and methodology of this final project research in Chapter 4, followed by a description of the methods and ethical considerations in Chapter 5. The most substantial chapter in this final project is Chapter 6, in which I give the results of the two stages of this mixed-methods study. I discuss these results in some detail in Chapter 7 and, in Chapter 8, I consider the implications of the findings, my initial work to disseminate the research findings and some future directions. I conclude in Chapter 9 with a reflective review of my research journey.

2. Literature review

2.1 Introduction

To ground and contextualise my research in the existing literature, I will review and discuss a number of key areas here. Firstly, I will look at clinical psychology as a profession, including its history and the political dimensions of its engagement in psychotherapy practice. Following this, I will review the concepts of confidence and capability and the research that has been done to date on their relationship to psychotherapy practice. Within this, three specific areas of research and literature are reviewed which I believed from clinical experience were likely to be connected to capability in psychotherapy practice – supervision, personal therapy, and quality of training in psychotherapy.

2.2 The clinical psychology profession

2.2.1 Clinical psychologists' breadth of application: Jack of all trades, Master of none?

Clinical psychology is the oldest and most established of the psychology professions, having a strong status in the healthcare systems of most developed countries (as confirmed by recent surveys of applied psychologists in Irish and English health services: Breaden & Woods, 2010; Lavender, 2005). Clinical psychologists could be described as the general practitioners of the psychology professions, having a broader training compared to the newer and more specialised psychology professions (e.g., counselling, educational, forensic, health, occupational), where the range of application is more focused.

PSI (2009) has defined clinical psychology as *"the application of psychological theories, models and research to a range of psychological, emotional, mental health and developmental problems. Clinical psychologists provide a variety of services including assessment, therapy, and consultancy services."* (p.3) O'Connor (2001) has highlighted the multiplicity of psychologists' roles, saying that: *"Psychologists may be teacher, administrator, researcher, therapist, mediator, entrepreneur, crisis counsellor and referral source all in the course of a day, sometimes changing roles*

by the hour” (p.346). Similarly, the BPS (2010) description of clinical psychology practice shows how wide the profession’s remit is:

“clinical psychologists work with individuals, couples, families, groups...and at the organisational and community level. They work in a variety of settings...and with all age groups...They work with people with mild, moderate and severe mental health problems, developmental and learning disabilities, physical and sensory disability, and brain injury; people who have substance misuse problems and people with a range of physical health problems.” (p.15)

Given this breadth of practice, the BPS (2010) appropriately emphasise that clinical psychology training offers a generic or foundation level training, further skills and knowledge in particular areas of practice needing to be acquired through post-qualification CPD. In the US, the breadth of a clinical psychologist’s training has undergone some debate, with questions being raised about whether more specialisation should occur during doctoral training (e.g., Drum & Blom, 2001; Roberts, 2006). Roediger (2003) evocatively described how most clinical training programmes *“try to steer between Scylla of narrow mentoring and Charybdis of a vacuous general program”* (p. 5). The clinical psychology training offers valuable experience across a broad range of client groups and presentations, each trainee in the Irish and UK training system chalking up 3,000 hours of supervised practice over three years. After completing their core training placements (in child, adult and intellectual disability services), psychologists in clinical training can request specialist placements in their area of interest (e.g., psychodynamic psychotherapy, play therapy, neuropsychology). However, accommodating such requests depends on the availability of specialist placements and supervisors. As such, the nature of more in-depth or specialist development of skills can be unpredictable and dependent on luck. It has been suggested that there should be greater acknowledgement and regulation of the opportunities available for depth of training, as there is for breadth of training (Bell, 2009). This is a view that I share and I believe this is an important issue into the future for the clinical psychology profession.

The clinical psychology training does produce flexible practitioners of high calibre. However, part of the impetus behind my final project work is my belief that the

wide breadth of clinical training can affect feelings of confidence and capability in particular areas of practice. I have experienced and observed how clinical psychologists can feel like “Jacks of all trades and master of none”, lacking enough in-depth training in any one area. In my opinion, this needs attention, either during clinical training or through adding post-training options for specialisation. The BPS stance is that clinical psychologists will continue to develop their specialist skills and knowledge through their ongoing CPD. This route will meet clinical psychologists’ needs in certain areas of practice. However, my experience and observations are that isolated reading and attendance at occasional CPD events are not substantial enough for developing a more solid grounding in psychotherapy knowledge and skills.

2.2.2 The changing focus of the profession: from psychometrics to psychotherapy

The primary area of practice for clinical psychologists has gone through some changes over its history, the profession’s flexibility and adaptability being one of the reasons for its substantial growth. Psychological assessment dominated the profession early in the twentieth century, psychologists operating largely as psychometric technicians for psychiatrists and only rarely practising psychotherapy. The aftermath of World War II brought a pivotal opportunity for the psychology profession, there not being enough psychiatrists to meet the US military’s need for mental health services. As a result, psychologists were given the professional freedom to practise psychotherapy and US clinical training doctorates offered training in the three main fields of diagnosis, therapy and research. By the end of the 1970’s, clinical psychologists had become the main providers of psychotherapy in the US (Benjamin, 2005).

In the UK at the time, there was less agreement about the appropriateness of psychologists being trained to practice psychotherapy. Eysenck (1949) was an influential and vocal critic of this development, stating that ‘*therapy is something essentially alien*’ and unscientific (p.173), clinical psychology requiring competence in diagnosis and research, not therapy. However, as behaviour therapy developed, this was embraced by UK psychologists (and Eysenck) as a more scientific,

empirically grounded therapeutic practice. The UK and Irish clinical training programmes adopted behavioural therapy, and later cognitive behavioural therapy (CBT) as their model of practice. This differed from the US training model (also adopted by other countries, e.g., New Zealand and South Africa) which historically tended to favour psychodynamic models during training (although training in CBT, as an evidence-based treatment, is now also common practice in the US). While CBT remains the mainstay in clinical psychology training in Ireland and the UK, psychodynamic psychotherapy is now becoming popular as a second model, particularly as the evidence-base for it grows (for e.g., I offer a year-long training input in psychodynamic psychotherapy in one Irish clinical doctorate).

2.2.3 Clinical psychologists' psychotherapy work: practice and politics

In the last few decades, surveys on both sides of the Atlantic have repeatedly found psychotherapy to be the primary activity of the clinical psychology profession, typically followed by engagement in assessment and diagnosis. A survey by Aherne and colleagues (2001) found that 88% of Irish clinical psychologists practiced psychotherapy. A more recent Irish survey found psychological treatment and psychotherapy to be clinical psychologists' primary professional activity, involving 28% of work time on average (O'Dowd, 2008). Similarly in the UK, psychological treatment was found to be engaged in by 94% of clinical psychologists and involving 36% of their work time (Norcross et al, 1992). In the US, Norcross et al (2002) found that 95% of psychologists were spending a high average of 58% of their time practising psychotherapy.

A substantial review of the British clinical psychology profession in the late 1980's led to a report which copperfastened the central role clinical psychologists had as expert providers of psychotherapy in the health services (Management Advisory Service: MAS, 1989). This report also influenced the development of clinical psychology in Ireland, the profession in the two countries being closely aligned. In the MAS report, a role for clinical psychologists in providing training and consultation to other professionals delivering psychotherapy was proposed and this consultative role was developed even further with the recent publication of what is commonly referred to as the Layard report (London School of Economics, 2006; see

also Layard et al, 2007). Layard asserted that everyone in Britain should have access to psychological therapy as a means of addressing the healthcare and employee absenteeism costs caused by mental health difficulties. This led to the rolling out of the IAPT programme (Improving Access to Psychological Therapies) in the UK, clinical psychologists being placed in a central position overseeing the delivery of largely short-term psychotherapy services. On a much smaller scale in Ireland, funding has been provided for the development of primary care teams, with a similar goal of improving access in the community to short-term psychotherapy services.

While psychotherapy practice remains a substantial part of clinical psychologists' work, there has been some recent debate about this in the UK and the US. Hassall and Clements (2011) recently argued that the profession has allowed a "*drift towards psychotherapy*" (p.7), with an increasingly narrow focus on individual pathology rather than addressing the social and environmental problems contributing to individual distress. As well as their concern for social issues, there is a self-preservation subtext here as clinical psychologists' primary role in providing psychotherapy is increasingly being fulfilled by growing numbers of psychotherapists, counsellors and counselling psychologists. In the US, Benjamin (2005) named the reality of this shift away from clinical psychologists being the central providers of psychotherapy:

"Psychotherapy, the brass ring for clinical psychologists, is not likely to disappear from their job description, but there seems little doubt that the position of pre-eminence in that arena is gone and will not return." (p.25)

Benjamin and many UK clinicians (e.g., Hall and Marzillier, 2009; Kinderman, 2011) remain confident that clinical psychologists have the skills and flexibility to adapt to these political changes. They suggest that clinical psychology will remain a key healthcare profession through continuing to broaden out from individual psychotherapy practice into more systemic social change and consultancy roles.

While I find this debate interesting and of value to ensure that the diversity and potential within the clinical psychology profession continues to thrive, it does raise the question of what prompts people to enter clinical psychology and what work

they find meaningful and rewarding. While there will always be varied preferences within such a broad profession, I know I am not alone in the value I attribute to practising psychotherapy. In O'Dowd's (2008) survey, engaging in psychological treatment and psychotherapy was the top factor endorsed by Irish clinical psychologists as contributing to job satisfaction (endorsed by 75% of respondents). Practising psychotherapy is a valued part of many clinical psychologists' practice and not a role that would be relinquished easily by the profession.

In line with this, other political developments have been occurring to more securely establish psychology's right and capacity to engage in psychotherapy into the future. The BPS developed a register of psychologists specialising in psychotherapy, to offer formal recognition for this area of practice from within the psychology profession (BPS, 2005). Similarly, a European-wide development has been in train since 1994 to develop EFPA training and accreditation standards for psychologists with specialist expertise in psychotherapy. It is of note that psychotherapy is the largest specialism within psychology in most of the 34 member countries of EFPA (Lane and Althouse, 2011). Both the BPS and EFPA groups emphasise that they do not intend to restrict the legitimate psychotherapy practice of those psychologists who do not sign up to the specialist registers, their goal being to offer professional recognition for those who go on to develop specialised expertise in this area.

In my own career, I have chosen to take the route of an additional full training as a psychotherapist and am accredited with a psychotherapy organisation as well as maintaining my registration as a clinical psychologist with PSI. Having experienced both clinical psychology and psychotherapy training, I can see the relative strengths of both for psychotherapy practice. The varied and extensive placement experience during my clinical training continues to be invaluable to my psychotherapy work. For instance, having worked with clients across the lifespan, with various levels of disturbance (such as those with active psychosis and those with dementia), and with individuals, groups, families, couples and teams gives a broad context and rich understanding of developmental and systemic issues in my work with clients. During my psychotherapy training, the intensive personal development work in individual and group therapy, the in-depth supervision of my psychotherapy work

with longer-term clients, and the focused reading in psychotherapy have been most valuable in enhancing my therapeutic presence, skills and understanding.

I understand that only a proportion of clinical psychologists will, or indeed should, follow the path that I have taken to do a second full professional training, or will work to meet the detailed criteria for the specialist registers in psychotherapy. However, while this may seem a somewhat treacherous stance for a clinical psychologist to take, I believe that there are valid reasons for clinical psychologists to be experiencing a threat to their dominant position as providers of psychotherapy in the health services. In my opinion, clinical psychologists in Ireland and the UK, with their current level of psychotherapy training, no longer deserve such a privileged, expert status (the situation is somewhat different in the US, where psychotherapy training has traditionally been a more extensive part of clinical psychology doctorates). There are fully qualified, accredited psychotherapists in increasing numbers who are, de facto, better equipped to practice psychotherapy, this being their specialist and dedicated area of work. I believe that the clinical psychology profession needs to make some changes if they want psychotherapy work to remain a significant part of their practice. There are healthy developments occurring in clinical psychology training and practice which will better support their ongoing capability for psychotherapy work (for e.g., the addition of a reflective component to the traditional scientist-practitioner model and the requirement for career-long supervision; see section 2.3.3 below) but more is needed, and my hope is that this final project research will help to illuminate the way forward in this area.

2.3 Capability and confidence in psychotherapy practice

This research explores clinical psychologists' sense of capability in their psychotherapy practice and the factors that may facilitate such felt capability. While I held the concept of capability quite centrally during this work, I also worked with the related concept of confidence ("*a certainty about handling something*", Stajkovic, 2006, p.1208) and other associated concepts such as competence and self-efficacy (see Stajkovic, 2006, for a discussion of the overlapping nature of some of these concepts).

2.3.1 Capability as unfolding potential

I would like to offer an overview of the concept of capability and its meaning for me in this project work. Compared with the more static notion of competence, which involves having the skills to perform effectively in the here-and-now, capability goes beyond this to include a forward-looking dimension. Capability has “*a dual connotation of the ability to do, coupled with an inference of being able to become (more) able*” (p.91-2, Doncaster & Lester, 2002). Stephenson (1992, 1998) describes the capable person as one who uses intuition, judgement and courage to apply skills adaptively in complex and changing circumstances, and who continues to learn over time. Lester (1999) further describes how capability is learned rather than taught, and includes experiential, emotional learning as well as reflective practice. Thus, capability in this study is a dynamic concept, defined as having confidence to do complex work as well as having unfolding potential, continuing to learn and develop over time through personal and professional avenues. I believe that this is a particularly valuable concept for my research, offering respect for the ongoing development of ability and knowledge in psychotherapy practice.

2.3.2 Felt capability, confidence and self-efficacy in psychotherapy practice

Psychotherapy outcome research consistently shows that the so-called “common factors” in psychotherapy contribute significantly to successful outcomes, more so than specific therapeutic approaches (e.g., Lambert & Barley, 2001; Wampold, 2001). Such common factors include creating the therapeutic alliance, instilling hope, offering a healing context and giving the client a meaningful explanation of his or her difficulties (Wampold, 2001). It is likely that a therapist’s confidence and sense of capability are relevant in creating these common conditions for therapeutic change. Indeed, in an early review of psychotherapy outcome research, Orlinsky and Howard (1986) found that client outcome was positively related to therapist self-confidence in two-thirds of the research results. There is limited recent research in this area, although one study found that the therapist’s confidence in the therapeutic process contributed to successful client outcome (as did the client’s confidence; Clemence et al, 2005). While establishing a link between therapist confidence or felt capability and positive outcome for clients is

clearly valuable, I believe exploring professionals' experiences in relation to such confident practice is worthwhile in its own right to guide us towards what is needed to optimise their professional development.

In reviewing the literature on confidence and capability in therapeutic practice, there was little research exploring these particular concepts, related terms often being used. One past study (Glidewell & Livert, 1992) did directly explore therapeutic confidence in a survey with 425 US clinical psychologists. These authors found (in order of importance) that those who felt clearer about when they were attaining their goals, had a stronger belief that clinical psychologists knew how to conduct therapy, spent more time practising psychotherapy, and had more experience, reported more clinical confidence. It is interesting that experience was the least important predictor of confidence in this study, it also being found that client load and theoretical orientation had no relationship to therapeutic confidence.

Another relevant survey study with a large group of 4,000 therapists (nearly two-thirds of whom were psychologists), found that self-reported "therapeutic mastery" increased with more experience but current "growth in therapeutic skill" remained high over therapists' careers (Orlinsky et al, 1999). This research offers a useful insight into the fact that professional development for psychotherapy practice is career-long.

The most research in this area has been done in relation to self-efficacy (one's perceived ability to effectively accomplish something: Bandura, 1997), self-efficacy beliefs having been argued to be "*the primary causal determinant of effective counselling action*" (Larson and Daniels, 1998, p. 180). Self-efficacy is believed to arise from four sources (in order of importance): enactive mastery experiences (success in tasks), vicarious experiences (e.g., learning from other models), verbal persuasion (e.g., feedback from others), and feedback from one's own physiological and affective states (e.g., ability to manage anxiety responses; Bandura, 1977). However, engaging in psychotherapeutic work is mostly a private enterprise between professional and client, meaning that opportunities for observing others and receiving feedback are rare. While mostly carried out with trainee counsellors,

various studies have shown that counselling self-efficacy beliefs change over time and are enhanced with exposure to training, supervision, opportunities to observe others, and clinical experience (see Lent et al, 2009).

A professional's sense of capability, confidence or self-efficacy is not a static attribute and the complexity of psychotherapy work has been found to offer career-long challenges to confidence. Both quantitative and qualitative studies have revealed that professional self-doubt (Cushway & Tyler, 1994; Mehta, 2006) and feelings of inadequacy are normal and continue throughout psychologists' careers (Thierault & Gazzola, 2005), highlighting the ongoing need for professional support and development. Following qualitative research which described Irish counsellors' fears and doubts regarding their abilities, O'Shea and O'Leary (2009) argued that the "successes" and "failures" of counselling practice are far less definable compared to other professions, while also being confused by diverse theories and goals in relation to personal development. Drawing from Bandura's model on self-efficacy, these authors recommended the use of role play, observation of others, supervision and personal therapy to normalise and allay ongoing doubts in this work.

In the following sections, I will review three key professional areas and their relationship to therapists' professional development and capability, these areas being central in my final project research. From my own clinical experience, I expected that these three factors might have a significant influence on clinical psychologists' felt capability in practising psychotherapy: ***access to clinical supervision, experience of personal therapy, and quality of training in psychotherapy.***

2.3.3 Supervision as a contributor to professional development and capability

In recent years, there has been a significant increase in attention to supervision as a central feature of post-qualification practice and development for psychologists. Psychologists have named supervision as one of their top three sources of positive professional development (along with personal therapy and experience with clients, Norcross, 2005). Bernard and Goodyear (2009) have also recently named

supervision as the “cornerstone of professional development” (p.218), arguing that supervision is psychology’s “signature pedagogy” (p. 273, Goodyear, 2007).

It is also relevant that the clinical psychology profession in Ireland and the UK have recently expanded their traditional scientist-practitioner model to adopt a reflective scientist-practitioner model (Lavender, 2003). The reflective component, drawn from Schon’s (1983) delineation of reflective practice, affords greater recognition of the value of self-awareness, experiential knowledge, clinical judgement and consultative practice (see Stedman et al, 2003). I believe that this adoption of a reflective component is a crucial one as it legitimises personal development and clinical supervision practices as central rather than peripheral elements of the profession’s work, as they traditionally have been (see Sheikh et al, 2007).

The purpose of supervision is normally seen as twofold – to promote and protect the welfare of the client and the development of the supervisee (Carroll, 1996). Watkins (2011) and Wheeler and Richards (2007) summarise the accumulated research to date, from both quantitative and qualitative studies, regarding the many benefits of supervision as reported by supervisees. These include enhancement of self-awareness, of treatment knowledge, of skill acquisition and utilisation, of self-efficacy and a strengthening of the supervisee-patient relationship. From these findings, it can be seen that supervision is a relevant factor in a practitioner’s felt capability and confidence for their psychotherapy practice. However, the quality of the supervision is significant, for instance Poulin & Walter (1993) finding that having clinical supervision was related to reduced levels of burnout in social workers, but only when they rated their supervision as supportive.

While post-qualification attendance at clinical supervision is an established practice for counselling psychologists and psychotherapists, the BPS has only recently developed a policy requiring career-long supervision for clinical psychologists in the UK (BPS, 2003, 2006). In Ireland, there is no PSI policy on supervision, although its development is in process. Partly as a result of this slow policy development, studies have found that not all clinical psychologists have had reliable access to supervision. Gabbay and his colleagues (1999) found that a sizeable 28% of clinical

psychologists in their English survey were not receiving supervision, despite the vast majority of them wanting access to the same. In addition, they found that a worrying 42% of those receiving supervision were dissatisfied with it for various reasons, including its lack of regularity. In the US, receiving clinical supervision or attending peer support groups have been rated as rarely used strategies for professional support by psychologists (Stevanovic and Rupert, 2004), the authors noting that this may reflect the lack of availability of these resources.

A more recent English survey by Golding (2003) reported a much improved rate of 86% of clinical psychologists receiving regular supervision. In this study, supervision was the most frequently expressed CPD training need for the year ahead for the clinical psychologists, with the availability of good and regular supervision being noted as a key factor for attracting and keeping psychologists in their posts (as has been reported in other studies, e.g., Lavender & Thompson, 2000). Two recent Irish surveys also suggest relatively good access to supervision for clinical psychologists, despite the lack of a policy line from PSI on this. O'Dowd (2008) found that receiving supervision was reported as involving an overall average of 3% of Irish clinical psychologists' professional time, which is a healthy one hour a week. In this study, 90% of the participants said that supervision was essential in the ongoing development of clinical psychologists. In another Irish survey, Booth and her colleagues (2010) reported that two-thirds of their sample of Irish clinical psychologists were receiving clinical supervision for at least 2 hours a month.

These recent surveys in Ireland and Britain suggest that there is a welcome improvement in the availability of supervision for clinical psychologists. They also support Fleming and Steen's (2004) observation that post-qualification supervision has gained a higher profile in the clinical psychology profession. However, it remains the case that supervision is still not available as standard to all and most of these recent surveys did not access information about the type of supervision (e.g., distinguishing between line management and clinical supervision) or clinical psychologists' level of satisfaction with their supervision arrangements. As well as accessing limited information, the Irish surveys also had low response rates which affects their generalisability (O'Dowd, 2008, had a 30% response rate, with 73 participants; Booth et al, 2010, do not give a response rate, but their nationwide

invitation resulted in only 84 participants). It was planned that this final project research would offer a more comprehensive picture of Irish clinical psychologists' experiences and needs in relation to supervision for their psychotherapy practice. To achieve this, in my survey research I queried about various supervision arrangements (separating clinical supervision and line management supervision) as well as about satisfaction with supervisory support.

2.3.4 Experience of personal therapy as a contributor to capability

In most therapeutic traditions, trainees are normally required to experience personal therapy of a type that is consistent with the therapy they are intending to practice (e.g., UKCP). Sandell et al (2006) have observed that, without experience of personal therapy: *"It is difficult to see how therapists-to-be would otherwise learn how a person might feel being a patient, how experienced therapists 'do it' and how theoretical concepts manifest themselves"* (p.314).

However, in contrast to counselling psychology and psychotherapy training programmes, personal therapy work has not been a requirement on clinical psychology training programmes. CBT has been the predominant therapeutic training on clinical psychology doctorates and attending personal therapy is not normally required for CBT practitioners. There are some recent developments on this issue - two of the Irish clinical training programmes now mandate a small number of personal therapy sessions (16-20 sessions) and the professional bodies accrediting clinical training programmes in Ireland and Britain now require attention to personal and professional development work during training (PPD: BPS, 2010; PSI, 2009). Such PPD work is being advocated to foster personal awareness and resilience (Gilmer & Marckus, 2003) and is seen as an important criterion of competent, ethical practice (Hughes & Youngson, 2009). The PPD model leaves the choice of personal development work with the trainee, there being no requirement to attend personal therapy.

Attending personal therapy is the most common avenue for personal development amongst therapists, however, between 75%-87% of therapists having done so (Orlinsky, 2011; Orlinsky et al, 2005). In addition, the large majority of therapists have consistently claimed both personal and professional benefits from engaging in

personal therapy (92% reported positive effects in Bike et al, 2009; and 90% in Orlinsky et al, 2005). A range of quantitative and qualitative studies have described the professional benefits that practitioners have experienced. An early study found that having experienced more hours of personal therapy was significantly related to therapists' ability to display empathy and genuineness, as rated by independent observers (Peebles, 1980). A complementary finding was reported in a small qualitative study, Murphy's (2005) counselling psychologists describing development of their empathic ability through personal therapy. In an in-depth qualitative study, Rizq and Target's (2008a, 2008b) counselling psychology participants reported various benefits from engaging in personal therapy, including learning from their therapist as a professional role model, developing self-awareness, professional and emotional resilience, and a stronger sense of empathy and kinship with their clients. Grimmer and Tribe (2001) also found that their participants experienced their therapist as a potent role model for their own therapeutic practice. In a quantitative survey study, attending personal therapy (presently or in the past) was found to be protective against burnout for clinical and counselling psychologists (Linley & Joseph, 2007).

Thus, the evidence strongly suggests that personal therapy is a significant contributor to felt capability in psychotherapy practice. However, while a sizeable 75% of psychologists in the US have done their own personal work (Orlinsky et al, 2005), this is significantly less common amongst clinical psychologists in the UK, rates as low as 41% being reported (Darongkamas et al, 1994; Gabbay et al, 1999; a higher figure of 65% was reported in Orlinsky et al's 2011 study, but the sample size was small and included counselling psychologists). There is limited data in relation to Irish clinical psychologists, there being just one unpublished survey which indicated that a high rate of 78% of Irish clinical psychologists have engaged in their own personal therapy (Moore-Corry, 2008). However, there was a relatively low response rate to this survey (34%), there being value in investigating Irish clinical psychologists' rates of personal therapy attendance through this final project work, while also exploring the relevance of personal therapy to their confidence and capability in their psychotherapy practice.

2.3.5 *The relevance of the quality of training in psychotherapy to capability*

A third factor being explored in this study was how the degree and quality of initial and ongoing training in therapeutic knowledge and skills related to confidence and felt capability. There has been limited research exploring this issue but it has been found that more years in training contributed to higher counselling self-efficacy beliefs amongst counselling psychologists, it being of note that longer time in training contributed more to the variance in self-efficacy than subsequent clinical experience (Melchert et al., 1996). However, other studies have yielded mixed findings on the relationship between counsellor self-efficacy and levels of training (see Tang et al, 2004). In post-qualification practice, reading literature and participating in continuing professional development activities have been rated as moderately important professional supports by US psychologists (Stevanovic & Rupert, 2004). In my recent qualitative research with Irish clinical psychologists practising psychotherapy (McMahon, 2012; see Volume 1, p.8-9), the need to develop and affirm their therapeutic understanding and skills was a salient issue for all the psychologists, including those with many years' experience.

I believe that this is a significant issue for clinical psychologists as, due to the breadth of competencies being developed during clinical training, the depth of psychotherapeutic training is necessarily less than in psychotherapy or counselling psychology training courses. Significant training in psychotherapy practice does occur over the three years of doctoral training, both on clinical placements and in academic inputs, but tends to be more focused on application to different client presentations (e.g., anxiety, depression, eating disorders), offering less engagement with broader psychotherapy processes and theories compared to formal psychotherapy training programmes. The PSI (2009) accreditation criteria note that substantial teaching must be provided during clinical psychology training in *“psychological therapies which include a range of evidence based approaches”* (p.8). The equivalent BPS (2010) document offers a little more guidance, asserting that trainees must demonstrate the ability to: *“implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological therapy, of which one must be cognitive-behaviour therapy”* (p.19). The BPS also state that clinical training programmes: *“must provide a substantial*

coverage of psychological therapies...[including] the philosophical and theoretical bases of therapies, their practical application to various client groups, and their current empirical status” (p.25). It is good to see a direction to include the philosophical and theoretical bases of therapies and this may be the beginning of some needed expansion of this area during clinical training.

While there has been limited research on the relationship between the quality of psychotherapy training and confidence or capability, there has been some significant debate on the issue for clinical psychologists. A number of practitioners have expressed concerns about clinical psychology’s emphasis on evidence-based treatments without enough connection to a broader theoretical base. Rowan (2011) has argued that psychologists need to have a more reflective, critical stance in applying evidence based therapies, asserting that the evidence base doesn’t offer a fundamental understanding of what it means to live and suffer as human beings. Sharpless and Barber (2009) describe the difference between “*techne*” (craftsmanship, using instrumental reasoning) and “*phronesis*” (practical wisdom, connected to ideals, values and judgement), as originally described by Aristotle. These authors propose that we would engender more therapeutic competence if we provide our psychologist trainees with a wealth of source materials on therapy and encourage them to “*read widely and deeply*” (p.53) so that they can develop a more broad-based *phronesis* rather than just *techne*. In a similar vein, Zeldow (2009) has argued that clinical psychology would benefit from a more scholarly grounding in the humanities (literature, history and philosophy) to counterbalance their evidence-based practice and produce more “*sophisticated clinicians*” (p.9).

A related issue is the typical therapeutic orientation of clinical psychologists in Ireland and the UK. They most commonly label themselves as CBT therapists, as well as either eclectic or integrative therapists (e.g., Carr, 1995; O’Dowd, 2008). It is common practice for clinical psychologists to continue to add to their therapeutic repertoire with ongoing attendance at training workshops (for instance, training workshops in mindfulness-based CBT, attachment-based therapy and cognitive-analytic therapy are currently popular within clinical psychology in Ireland and the UK). Having an eclectic or integrative practice is appropriate as clinical psychologists mostly work in health service settings and have to be adaptive to

diverse client and system needs (as argued by Hall & Marzillier, 2009). However, there is a significant difference between eclecticism and integration, the former being a more pragmatic, atheoretical movement between therapeutic approaches and the latter involving a theoretical assimilation of approaches, with a core identification with one or two models (Lampropoulos, 2001). The BPS group on psychologists with specialist expertise in psychotherapy argue that psychological psychotherapy practice is 'generative' and not necessarily 'integrative', no single set of perspectives being seen as essential (BPS, 2005). They describe this generative approach as: *"generating relevant, useful and sometimes unexpected interventions...the approach is inherently pragmatic and innovative, being put together from the most effective combinations of theory, experience, knowledge and practical methods"*. (p.18). While the BPS offer an attractive "generative" label, I believe that they are essentially describing atheoretical eclectic practice. In my experience, such practice can leave clinical psychologists without a strong theoretical grounding, affecting confidence and capability in therapeutic practice. Developing a truly integrative practice with a stronger theoretical basis requires significant breadth and depth in theoretical, clinical and empirical research domains, this being an ongoing undertaking for therapists (Boswell et al, 2010).

As can be seen, the nature and quality of clinical psychologists' psychotherapy training and practice has provoked some interesting debate. I believe this is an important issue in the current economic climate, with increasing pressure being put on clinical psychologists to provide cost-effective short-term treatments which may not be grounded in a deeper understanding of personal growth and change. While clinical psychologists normally engage in ongoing CPD activities to develop their therapeutic knowledge and skills after training, one of the aims of my final project was to explore their experience and satisfaction in this area and its relevance to confidence and felt capability.

2.4 The complex relationship between therapist confidence and efficacy

This project focuses on psychologists' own judgements of their confidence and capability for psychotherapy practice, and does not explore how this relates to their objective capability and efficacy. As noted earlier, therapist confidence has been

found to be related to positive client outcome (Clemence et al, 2005; Orlinsky & Howard, 1986), but there is little evidence linking the three main professional areas I have reviewed to client outcome. For instance, while therapists have reported many professional benefits from attending clinical supervision, we still lack direct research demonstrating a positive link to client outcome (Watkins, 2011). Similarly, the research on the value of therapists' personal therapy has largely focused on therapist attributions and perceptions, with client outcome studies providing inconsistent evidence of benefits for clients (e.g., Clark, 1986; Macran et al, 1999; Sandell et al, 2006).

The extensive psychotherapy outcome research by Lambert, Bergin and their colleagues has concluded that extra-therapeutic factors (e.g., life events, social support) contribute most to client progress (accounting for 40% of outcome: Lambert & Barley, 2001; Lambert & Bergin, 1994). Given that so many factors contribute to client outcome, the most influential of these being external to the therapeutic endeavour, there are methodological difficulties in establishing the unique impact of therapists' engagement in professional activities (Ronnestad & Ladany, 2006). For instance, in relation to therapists' personal therapy, Orlinsky et al (2005) commented: *“Suppose, for the sake of argument, that 50% of the success of therapy is due to qualities and resources of the client, that 35% is due to the therapy relationship, and that 15% is due to the therapist's individual qualities and resources. In this context, how much influence on client outcome can be due to the therapist's personal therapy?”* (p.224-5).

Ultimately, therapists engage in activities such as continued training, supervision and personal therapy with at least some intention to improve their practice (personal development also often being part of the motivation). For those of us involved in training and supervising therapists, it behoves us to try and determine what contributes to greater therapist efficacy, even if therapists' professional development activities have a minor impact on client outcome. My research did not aim to add to the outcome literature but had the more modest goal of exploring what is related to psychologists' confidence and felt capability in their

therapeutic practice. Thus, this research was done with the understanding that such confidence is only a minor variable relating to client outcome.

Stepping back somewhat to take a broader view, I am also conscious that humility may be of more value than confidence, given the complexity of psychotherapy work (e.g., Skovholt & Ronnestad, 2003). Rather than greater confidence having a direct relationship to more effective practice, a psychologist who claims strong therapeutic confidence may actually be less attuned and responsive to the multi-layered intricacies and limitations of this work than a psychologist who feels moderate or variable confidence. In my own experience, it is often important for a therapist not to push change and “progress” for his or her clients and to be able to tolerate times of feeling uncertain about one’s capabilities to foster change. Indeed, therapeutic work often involves staying with the client’s and one’s own despair in the face of life’s vagaries, accepting and grieving together what cannot be changed.

2.5 Review

This literature review has covered a number of areas of professional practice. To contextualise this final project work, I described the clinical psychology profession, its training, history, practice and political backdrop. While prompting some current debate about its prominence into the future, psychotherapy practice is still the predominant activity for clinical psychologists and is one that has been found to strongly contribute to professional satisfaction (O’Dowd, 2008).

As this final project focuses on clinical psychologists’ felt capability in their psychotherapy practice, I defined the key concept of capability and then gave an overview of research in the related areas of psychotherapeutic confidence, self-efficacy and self-doubt. Following this, I reviewed the literature in three areas I believed to be relevant to capability in psychotherapy practice: supervision, personal therapy and quality of training in psychotherapy. Having been informed by this literature review and how this linked with my own clinical experience, observations and professional interests, the next chapter includes a description of the rationale and objectives of my final project research work.

3. Research rationale, objectives, hypotheses and timescale

3.1 Research rationale

My clinical experience and review of the literature highlighted the value of researching three key areas in relation to clinical psychologists' psychotherapy practice: supervision, personal therapy and quality of training in psychotherapy. The literature to date endorsed the importance of at least two of these areas in supporting psychotherapy practice – supervision and personal therapy. However, there has been limited research in these areas specifically relating to clinical psychologists (most research having mixed professional groups), indicating the value of a more focused exploration of these factors with clinical psychology professionals. There has also been very little research on the relevance of quality of training in psychotherapy for any professional groups. However, as I have shown, there has been significant professional debate in the literature on this latter issue, particularly in relation to clinical psychologists, suggesting that this warranted investigation in this final project work also.

As well as there being limited research with clinical psychologists in these areas, I was also acutely aware that there are some key differences in these very areas for clinical psychologists compared to allied professions, such as counselling psychologists and psychotherapists. The most striking differences are that:

- attendance at clinical supervision is not currently required for ongoing accreditation for practising clinical psychologists;
- personal therapy is not normally mandated during training for clinical psychologists; and
- psychotherapy training is not as extensive during clinical psychology training as it is for the allied therapy professions.

It was my own personal and observational experience of these differences that underpinned my investment in, and initiation of, this research work.

3.2 Research objectives

Following on from the above, I had two main objectives in my final project research. My first objective was to explore clinical psychologists' experience of practising psychotherapy and identify what may be linked to confidence and felt capability in this work, paying particular attention to supervision, personal therapy and quality of training in psychotherapy. My second objective was to use the insights gained from my research to influence awareness, policy and practice regarding the initial training and ongoing needs of clinical psychologists for their psychotherapy practice. While there are some recent and welcome developments occurring for clinical psychologists in this area (e.g., professional policy development leading to an increase in access to clinical supervision), I aimed to explore and identify needs for further development in my research, bringing my findings into the public domain through conference presentations, research reports and journal articles.

To meet these objectives, I decided to carry out a mixed methods study, an Irish nationwide survey followed by a small number of in-depth interviews, my intention being to access both breadth and depth of information on clinical psychologists' therapy practice. Some of the factors influencing this choice of methodology are discussed in more detail in chapter four.

3.3 Research hypotheses

Based on my clinical experience and review of the literature, I had a number of a priori hypotheses in relation to the quantitative survey data. I predicted that those who reported more confidence in their psychotherapy knowledge and skills would:

H1: Have additional formal psychotherapy training;

H2: Report more frequent engagement in psychotherapy-related professional and personal development activities over the last year;

H3 & H4: Be more likely to attend clinical supervision and attend it more regularly;

H5: Report greater satisfaction with their current supervisory support;

H6: Be more likely to have attended personal psychotherapy;

H7: Spend more of their work time practising psychotherapy;

H8: Be longer qualified as a psychologist.

In the interview stage of the study, my aim was to engage in an open exploration of the interviewees' experience of practising psychotherapy as a clinical psychologist.

3.4 Project timescale

Although it was a small final project, this research study was a sizeable undertaking as it was a two-stage mixed methods study. In Figure 3.1 below, I offer a graphic overview of the timescale of the final project, from the Learning Agreement (LA) and RAL5 project submission to initial professional dissemination of the results and submission of the thesis. The quantitative survey development and data collection stage spanned a 4-month period from November 2010 to March, 2011, while the qualitative interview stage spanned a 3-month period from April to June 2011. The subsequent analytic and report development work with these two different sets of data overlapped and extended through the rest of 2011 and into 2012.

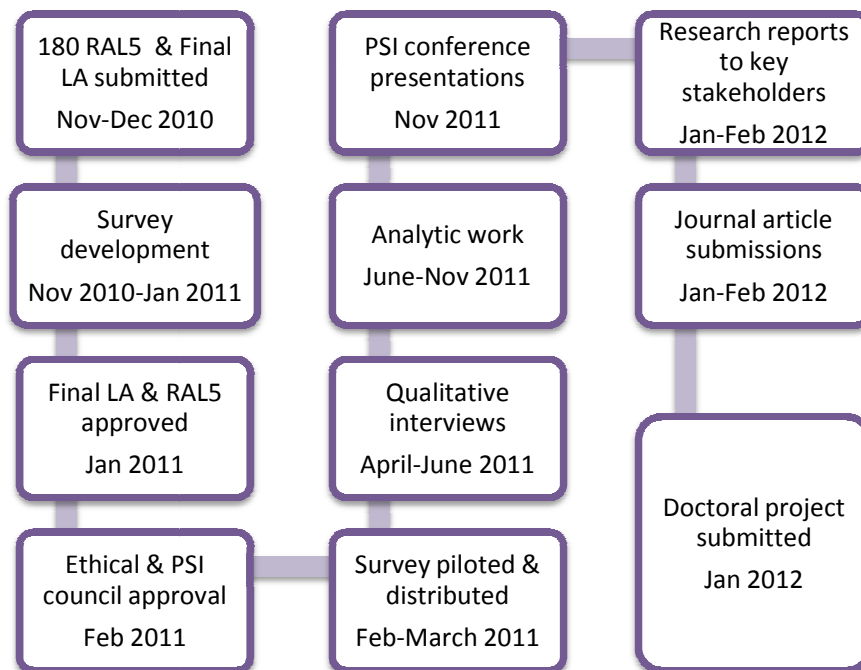


Figure 3.1: Overview of final project timescale

Before moving into the detail of how I carried out this research in chapter five, the next chapter outlines the methodological basis to my research design.

4. Research design and methodology

This chapter will address some relevant political, contextual and epistemological issues regarding the research design and methodology.

4.1 Choice of research design: political and contextual factors

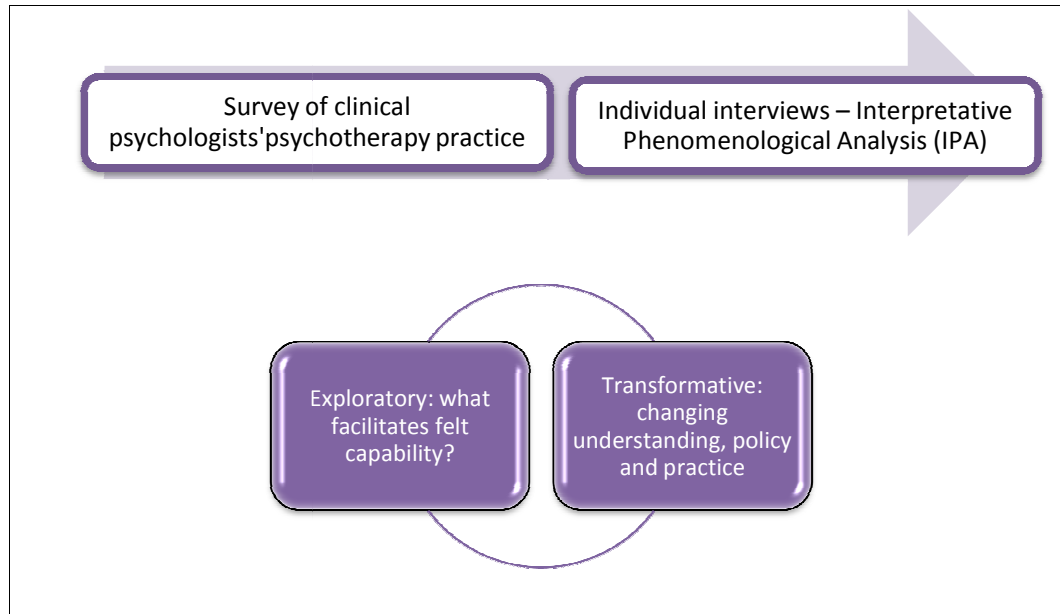


Figure 4.1: Sequential mixed methods research design: exploratory and transformative

I chose a mixed methods design for this research, involving a largely quantitative survey followed by in-depth qualitative interviews. The design followed a sequential exploratory/transformative model (cf. Creswell et al, 2003; see Figure 4.1 above), equal weight being given to the quantitative and qualitative stages of the research. The exploratory element of the research involved exploring what facilitates capable and confident psychotherapy practice. The transformative dimension involved an intention to transform understanding, policy and practice in how clinical psychologists are equipped for, and supported in, their psychotherapeutic work.

It is worth describing the decision-making and external influences that were involved in selecting a mixed methods design as my original intention was to do a fully qualitative study, incorporating a focus group and individual interviews. With

my clinical psychology background, designing a quantitative study would have been a familiar route for me but one that I had little motivation for, my beliefs about how useful and valid knowledge is gained having changed over time. My personal development work and psychotherapy training had moved me into a place of valuing experiential, embodied, storied knowing and this was further developed during my learning of qualitative research methods during the early stages of this doctorate. As described in my RAL5 (see p.8-9, Vol.1), my first foray into qualitative research was with psychologists in relation to their psychotherapy practice in 2010, and the richness of this endeavour reinforced my intention to continue on with a qualitative design for my next stage research.

However, as I fine-tuned my design and consulted with a range of clinical psychologists regarding the planning of my research, it became increasingly clear that quantitative survey research would be of stronger political value with regard my objective to influence policy and practice. This was particularly true for my main target audiences – clinical psychologists, health service managers and policy makers in PSI. For these groups, larger scale quantitative research had more familiarity, credibility and influence than smaller scale qualitative research. As part of my research planning, I consulted with the Director of Professional Development in PSI, Dr. Katie Baird, and then realised that there was a timely opportunity to have an immediate professional application for some of my research work if I included a quantitative survey. As I described in the introduction (p.6), PSI were planning to set up a working group to develop a supervision policy for all applied psychologists. As I was already planning to explore the area of clinical supervision in relation to psychotherapy practice, this was an ideal opportunity to expand the supervision part of my research and collaborate with PSI to inform this policy development. While I had some residual struggle about engaging in quantitative survey research, I could not miss this opportunity. I also felt energised by the value of enabling psychologists throughout Ireland to express their opinions and needs in relation to a supervision policy at this key time.

So, instead of facilitating and doing a qualitative analysis of a focus group discussion, I designed a dual-purpose survey questionnaire to gain predominantly

quantitative information about the supervision and psychotherapy practice of psychologists working in Ireland. I also included some key qualitative open response questions in the survey to afford participants the opportunity to express themselves more individually and personally in this stage of the research. In this, I hoped that it would moderate the potential for what feminist and critical researchers have called the disempowering and dehumanising nature of surveys (see Rubin and Rubin, 2005).

However, I remained keen to include a more significant qualitative dimension to this research, of equal importance to the quantitative dimension. I decided to engage in a small number of in-depth interviews in order to carry out a more open-ended qualitative exploration of the experiences of clinical psychologists practising psychotherapy. In this, I aimed to contextualise, humanise and deepen the scope of my research. Rubin & Rubin (2005) describe well the advantages of interview research in comparison to survey research:

“Rather than stripping away context, needlessly reducing people’s experience to numbers, responsive interviewing approaches a problem in its natural setting, explores related and contradictory themes and concepts, and points out the missing and the subtle, as well as the explicit and the obvious” (p.viii).

While qualitative research is less familiar for clinical psychology practitioners and service managers, I hoped that the combination of the two research methods would provide richer and more rounded information for practitioners, managers, clinical training directors and policy makers.

As can be seen from the decision-making process I engaged in during my research design, I believe it is crucial with applied research that an eye is always kept to pragmatic, contextual and political considerations, otherwise the findings won’t reach the intended audience with enough potency. Qualitative, in-depth research with a small number of participants is valuable, meaningful work to do and I feel a much stronger attraction to such research than to quantitative, broad-sweep nomothetic work. However, I believe different forms of research and communication are needed to access and facilitate different ways of knowing and understanding. My fellow clinical psychologists tend to rely significantly on

information from the intellect, from academic, acquired knowledge, and this form of knowing offers a strong resource. However, the size of the reliance on such intellectual knowing is overdeveloped within the profession and I believe it needs counterbalancing with a growth of intuitive, emotional, experiential, interactive knowledge – and a greater valuing of such knowledge. The slow growth of qualitative research within clinical psychology is a welcome sign of such rebalancing and mixed methods research is becoming a more popular choice amongst clinical psychology doctoral students. Again, it is the combination of quantitative and qualitative that is popular, purely qualitative research designs still being rare within clinical psychology. While this seems to reflect the continued familiarity and trust of quantitative, intellectual knowing within the profession, there is an emerging trust in experiential, personal knowing with the growth of mixed methods research.

In relation to psychology's preference for quantitative research, Miller Mair (2010) called for the profession to engage in research with a new emphasis and direction – he suggested we engage in *search* rather than research, that we seek *understanding* rather than fact finding. He described this new way of searching/researching as being complementary to more traditional research methods within psychology:

*“What ‘searching to understand’ may offer is the possibility of a ‘two-handed’ psychology. With one hand we will be establishing necessary facts and reliable information. With the other hand we will be feeling our way towards personal understandings and personal development. This other mode of inquiry is not **instead of** the approach of ‘standard’ psychology, but there to give depth, colour, qualities and body.”* (p.27, original emphasis).

My intention in my mixed methods research design was to engage in, and offer out to my professional peers, such a two-handed search and research. In the initial survey stage, my hope was that some broad-based understandings could be established about the psychotherapy practice of clinical psychologists. Then, secondly, but its ordering by no means suggesting a lower priority, a deeper and more personal search could be made with my interview participants in this area. My hope and intention in this more in-depth search was that the findings would be illuminating, affirming or stimulating - that a variety of thoughtful or emotional reactions may be brought to life for others in their practice. Mair (1989)

highlighted Carl Rogers' dictum that when we speak most personally we speak most generally too. Similarly, my belief and hope was that other clinical psychologists would access their own sense of personal knowing and truth when given the opportunity to hear my interviewees' experiences and needs.

As my choice of method for analysing the interview transcripts was influenced by political factors, I want to comment on this here in this section. I chose a relatively structured hermeneutic and interpretative approach, Interpretative Phenomenological Analysis (IPA), the same approach I used in my research with psychologists' diary reflections on their therapeutic practice in 2010 (see p.8-9, Vol. 1). Alternative choices for analysing the interview transcripts included using a descriptive rather than an interpretative phenomenological approach (e.g., Giorgi & Giorgi, 2008), a narrative approach such as Langdridge's (2007) Critical Narrative Analysis, or discourse or content analysis (Willig, 2008). However, while any of these approaches would have been valid choices, I was aware that IPA as a method of analysis was a particularly good choice for engaging the clinical psychology community. In their development of IPA, Jonathan Smith and his colleagues (e.g., Smith et al, 2009) have done strong work to make qualitative research more accessible and meaningful to clinical psychologists in Europe. IPA research is now by far the most familiar and popular qualitative methodology amongst clinical psychologists, making this the clear favourite to facilitate communication with my target audience.

4.2. Epistemological issues in mixed methods research

"Better, perhaps, different coats to clothe the children well than a single splendid tent in which they all shiver."

Erving Goffman (1961, p.xiv, quoted in Vidich & Lyman, 1994)

Engaging in mixed methods research raises epistemological concerns about the validity of using starkly different means to access knowledge. When the survey respondents selected a particular "tick-box" response on my questionnaire, did that response represent true information about their values, experience or belief in that area or did such a restricted and non-relational form of communicating their views limit their validity? When my interviewees expressed their opinions over an hour-

long meeting, in an alive relationship with me, did that represent a more valid picture of their experience or did that represent another limitation on their authentic expression? In terms of approaching a “valid” representation of a person’s experience, there are advantages and disadvantages to both methods used in this research. The anonymity of the survey offers an opportunity to express more honest views, particularly in sensitive or personal areas, while within a personal interview there may be a temptation to engage in rhetoric, or to want to display a favourable persona or belief system. On the other hand, the deeper exploration involved in an interview affords the opportunity to open up participants’ beliefs and experiences in relationship and to gain a more nuanced understanding of their reality, valid at that point in time, in that relationship and in that context.

My own world view, or epistemology, is becoming increasingly influenced by my growing, albeit still neophyte, awareness of social constructionism, interpretivism and critical realism. Neimeyer (1998) described the different understanding of research and knowledge offered by postmodern social constructionism compared to positivism:

“The resulting image of psychological ‘science’ is in some respects more humble (aiming only for the production of ‘local knowledges’ that are more bounded and closer to the domain of practice), and in other respects more ambitious (involving more consistent self-criticism and reflexivity) than its modernist predecessor. It is also more disquieting, holding out the promise of only a shifting, fragmentary and constructed knowledge, without the bedrock certainty of firm (logical or empirical) foundations.” (p.136)

Rather than looking for the average and ignoring the specific, as positivists often do, Rubin and Rubin (2005) describe how interpretative constructionists look for the specific and the detailed, trying to build an understanding based on those specifics. While positivism and constructionism are strongly associated with quantitative and qualitative methodologies respectively, Alvesson and Skoldberg (2009) suggest that critical realism offers an alternative and can accommodate both methodologies. Compared to social constructionism, critical realism declares that there is a reality distinct from our conceptions of it, something being real if it has a causal effect, and this including ideas and discourses as well as material objects. Compared to

positivism, these causal relationships are seen as complex, contextual and emergent in changeable societies. Alvesson and Skoldberg quote Danermark et al (2002) as follows:

“While it is evident that reality exists and is what it is, independently of our knowledge of it, it is also evident that the kind of knowledge that is produced depends on what problems we have and what questions we ask in relation to the world around us.” (p.41)

While critical realists are looking to understand reality, they are often also looking to change it, there being a radical, potentially transformative element also (Alvesson & Skoldberg, 2009). This worldview sat well with my objectives during this final project research work, and allowed me more comfort in moving between quantitative and qualitative methods, while working to hold a contextualised understanding of the research findings from both stages of the project.

However, carrying out a mixed methods study was a significant challenge for me, involving a demanding research journey through two completely different processes (as others have observed, e.g., McKiernan et al, 2007). Given this challenge, I was reassured to find a body of literature which endorses the value of marrying such diverse methodologies. Feilzer (2010) believes that mixed methods research offers a valuable response to the *“long-lasting, circular, and remarkably unproductive debates discussing the advantages and disadvantages of quantitative versus qualitative research”* (p.6). She and others (e.g., Creswell & Plano Clark, 2007; Robson, 2002) note that the approach most commonly associated with mixed methods research is pragmatism. Pragmatism, like critical realism, offers an alternative worldview or paradigm to those of positivism/postpositivism and constructivism/intepretivism, focusing on the research problem and its intended consequences. It was Dewey, in 1925, who asserted that pragmatists’ view of the measurable world relates more closely to an *“existential reality”*, an experiential world which has different elements or layers, some objective, some subjective, and some a mixture of the two (quoted in Feilzer, 2010). I value the pragmatists’ acceptance of multiple realities that are open to empirical inquiry, the objective being the attempt to address real-world problems (Feilzer, 2010; Robson, 2002).

Along similar lines, Tashakkori and Teddlie (2010) observe that mixed methods studies are more akin to human problem solving than single method studies: *“everyday problem solvers use multiple approaches (similar to qualitative and quantitative pathways) concurrently or closely in sequence and examine a variety of sources of evidence in decision making”* (p.273). These authors argue that, in offering the potential for broader understanding of social issues, mixed methods research can provide *“more robust opportunities for devising policies and practices to implement positive change”* (Tashakkori & Teddlie, 2010, p.272), which is of evident value to my research work. While a sizeable challenge, I feel it has been both appropriate and meaningful to gather information of both breadth and depth in the attempt to both inform and influence my intended audiences.

4.3 Conclusion

In this chapter I have outlined the mixed methods research design that underpinned my research, exploring some relevant political, contextual and epistemological factors. I believe that my mixed methods design is in tune with a critical realist or pragmatist epistemology and was the most appropriate one given the political and potentially transformative objective of my research. It included a broad invitation to clinical psychologists throughout Ireland to express their views and needs as well as a more personal invitation to a smaller group of clinicians. My hope and intention was that this combination would give range, body and depth to the understanding gained from this research. The next chapter will describe how both stages of the research were planned and carried out, as well as some key ethical considerations.

5. Research methods and ethical considerations

In this chapter, I describe the planning and data collection of both the survey and interview stages of the project, as well as the ethical issues that I considered and addressed during this research process.

5.1 Survey stage

5.1.1 Survey development

I developed the survey (a blank copy is in Appendix 2.1) with a dual purpose – as well as aiming to gather information for this project regarding clinical psychologists and their psychotherapy practice (Psychotherapy study), I also wanted to gather information from a variety of applied psychologists regarding supervision in order to inform the development of a PSI policy on the same (Supervision study, see p.6 and p.34). The survey had three sections. The first section asked questions about supervision attended and confidence in providing supervision. The next section asked questions about psychotherapy, including training, confidence and personal psychotherapy. The final section asked demographic questions and also gave an option to leave contact details for the interview stage of my research. Most of the survey items offered fixed choice response formats, but I also included a number of open response items. Some of the survey information on supervision is relevant to my final project work but I will not be reporting the full range of these results here.

The survey questionnaire was developed over a three month period, going through various stages of piloting and consultation. I developed the first draft of the survey following an initial review of the literature and being informed by responses to a small scale survey I carried out with psychologists in late 2010 (see p.10, Volume 1). I also was guided by what I had observed and experienced in my own practice. One of the survey questions (Q.3, section 4) on experience of clinical supervision was largely adapted from a longer clinical supervision questionnaire developed with nurses (The Manchester Clinical Supervision Scale: Winstanley, 2000). I also reviewed other survey questionnaires used with clinical psychologists in Ireland and the UK (e.g., Gabbay et al, 1999; Golding, 2003; O'Dowd, 2008). However, while some of my questions were similar to these surveys (e.g., question on therapeutic

models), these questionnaires had other objectives (e.g., Golding's survey focused on CPD needs) so I designed the rest of the survey to match my particular objectives and hypotheses (see p.31-2).

During the design stage of the survey, I carried out informal piloting with 4 professionals in December 2010 (3 clinical psychologists and a psychotherapist colleague on the Metanoia doctorate). Also in December, following discussions with the PSI Director of Professional Development, Dr. Katie Baird, I significantly expand the supervision aspect of survey. As a result, I decided to cut back some other areas of the survey (e.g., I reduced the questions on personal therapy) as I was concerned that a lengthy survey would adversely affect the response rate. The final survey took an average of 20-25 minutes to complete.

During this design period, I also consulted with Dr. Stephen Goss on the Metanoia staff, and made some valuable changes following his advice (e.g., aligning my questions more closely to my hypotheses and moving the demographic questions to the end of the survey to allow a more informed choice about sharing potentially identifiable information).

I formally piloted the survey in late January 2011, sending it to 20 clinical and counselling psychologists around Ireland (following Robson's, 2002, recommendation on pilot test numbers). Sixteen of these surveys were returned within 2 weeks. I made a number of changes following the pilot and a test run of statistical analyses, deleting and redrafting questions. I also made changes to the information page of the survey following recommendations from the Metanoia research ethics committee (e.g., I included information on the internet survey's security protocols). As I had made a number of changes, I did a second smaller formal pilot run in February with 5 psychologists, following which I made only two minor changes (e.g., including a definition of clinical supervision). The pilot survey questionnaires and data are included in the CD accompanying this thesis.

I decided to do an on-line survey which would be distributed by email and completed by computer, collected anonymously using the SurveyMonkey company. The main reason for this decision was that I expected a high number of returned surveys as I was distributing it nationwide in Ireland. With an internet-based

survey, the data can be exported directly from SurveyMonkey to SPSS for Windows, overriding the need for the laborious inputting of thousands of items of data. Email surveys tend to have a lower response rate than postal surveys (Couper, 2000; Manfreda et al, 2008) which was a potential downside but I believed the practical benefits of this format outweighed this.

5.1.2 Survey distribution and response rate

The survey was distributed by email through two avenues in March 2011 – through the PSI email membership lists and through the 58 HPSI psychology managers (see the invitation email, Appendix 2.1). Potential respondents were advised that *“this survey will be relevant to you if you are a qualified professional psychologist and have contact with clients as part of your work”*.

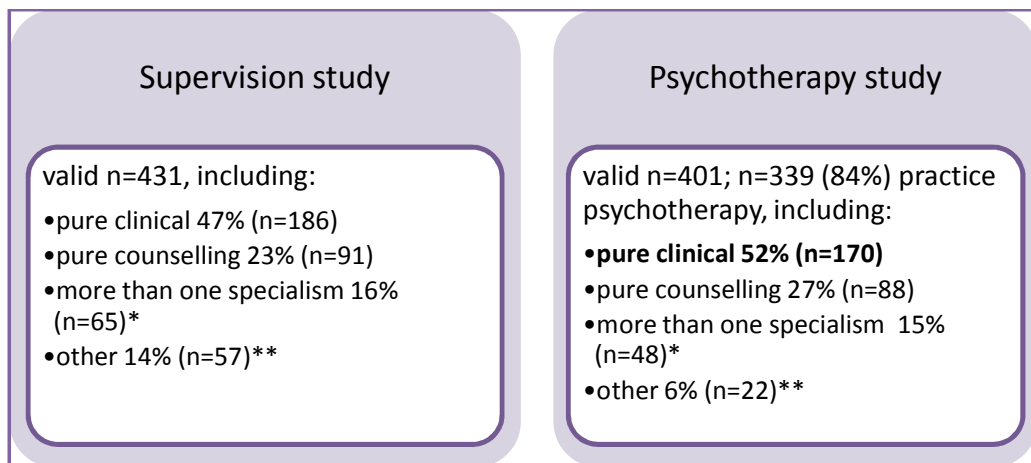
The survey remained open for one month, with approximately once-weekly email reminders being sent through PSI and the HPSI managers. I made concerted efforts to creatively engage participants through the reminder emails. From the mid-point of the survey period, I advised psychologists of the response rate to date per specialism and also relative to the total number of psychologists in the health services. In the final reminders, I advised respondents that I had now set up the survey so that they would get immediate access to some of the survey results when they completed it themselves (see Appendix 2.1 for a sample reminder email).

In total, 447 psychologists returned surveys. Four surveys completed by psychologists still in training were excluded as were 42 surveys which were missing key data for the Psychotherapy study, leaving a total of 401 useable surveys. It was not possible to determine how many of the PSI membership were eligible to take part in the survey (there being no statutory registration in Ireland for psychologists yet) and accurate figures were not received from the HPSI managers regarding numbers of surveys distributed. Thus, a conservative response rate was calculated using the latest nationwide figure of 647 psychologists working in the health services, the predominant work setting for psychologists in Ireland (Breaden & Woods, 2010). Of the 401 valid surveys, about three-quarters (299) worked in health service settings, giving a response rate of 46% of the total Irish population (431 surveys were valid for the Supervision study, with a response rate of 51%).

The other 102 participants worked in non-health service settings (e.g., private practice, academia) but it is not possible to estimate a response rate for this group.

5.1.3 Survey participants

Of the 401 valid surveys for the Psychotherapy study, 339 (84%) were from applied psychologists of various specialisms who indicated that they practised psychotherapy. A number of the psychologists were qualified in more than one psychology specialism. Psychologists with purely clinical training were the largest subgroup of applied psychologists (n=186) and 170 (91%) of these practised psychotherapy. **These 170 clinical psychologists practising psychotherapy are the group studied in this final project work.** Counselling psychologists (n=88) formed the second largest subgroup of applied psychologists practising psychotherapy and some comparative analyses were carried out in this study between the clinical and counselling psychologists. For clarification on the survey data sets, Figure 5.1 depicts both the Supervision study and Psychotherapy study participants. The Supervision study will not be referred to again until discussing the dissemination of my research work in chapter 8.



Note: Information on specialism was available for 399 of the survey participants

* The majority of those with more than one psychology specialism had a clinical psychology qualification: 68% (n=44) of the supervision study; 77% (n=37) of the psychotherapy study

** this group included educational, health, organisational and forensic psychologists

Figure 5.1 All survey participants in the Supervision and Psychotherapy studies

Table 5.1 below offers some information on *the 170 clinical psychologists practising psychotherapy* focused on in this final project work (from here on, this group will

simply be referred to as the clinical psychologists). The clinical psychologists were qualified an average of 12 years (range of 6 months to 35 years). As is increasingly the case in the profession, they were predominantly female (82% female, N=140; 18% male, N=30). This is a slightly higher rate of females compared to the latest Irish nationwide figure for health service psychologists (77% female: Breaden & Woods, 2010), although the survey's full group of applied psychologists matched the nationwide figure exactly.

The majority of the clinical psychologists worked in the HSE (58%) or Voluntary sector (non-statutory health-related services: 30%). As can be seen, their career grade profile was very similar to the nationwide profile and they worked across the major client groups, the most common clients being adults and older adults (39%).

Career grade*	Staff 32% (N=47) [37% nationwide]	Senior 49% (N=73) [49% nationwide]	Principal 17% (N=25) [14% nationwide]	Director 2% (N=3) [1% nationwide]
Work setting**	HSE 58% (N=89)	Voluntary Sector 30% (N=46)	Private practice 16% (N=25)	Other 6% (N=9)
Years practising	5 yrs or less 33% (N=57)	6-10 yrs 21% (N=35)	11-20 yrs 28% (N=48)	20 yrs or more 18% (N=30)
Main client Population	Adult/ Older adult 39% (N=66)	Child/ Adolescent 30% (N=52)	Intellectual Disability 11% (N=18)	Combination of clients 20% (N=34)
% time practising psychotherapy	0-25% of time 25% (N=42)	26-50% of time 41% (N=70)	51-75% of time 23% (N=40)	76%+ of time 11% (N=18)

*based on 148 who answered this optional question. Nationwide percentages are based on HPSI figures (Breaden & Woods, 2010).

**based on 153 who answered this optional question; respondents could choose more than one work setting; the "other" category included academic, private hospital and educational settings.

Table 5.1: Demographic statistics for the survey's clinical psychologists

5.1.4 Survey analyses

The majority of the survey data was analysed using SPSS, version 18, using inferential and descriptive statistics. In reporting the findings, categorical data are summarised with numbers and percentages, the median (Md) is given for ranked data, whereas means (M) and standard deviations (SD) summarise the continuous

data. Chi square tests were carried out to determine relationships between categorical variables, with standardised residuals examined to determine which cells contributed to the overall effect. Differences between groups were examined using either Mann Whitney tests (for ranked data) or independent samples t-tests (for continuous data). Two-tailed significance tests were carried out throughout as a more conservative approach and significance levels were set at $p < .05$ for those analyses that had a priori hypotheses and at $p < .001$ for more exploratory post-hoc analyses. This was to minimise the risk of Type I error (i.e., finding false positives in the data analyses).

Logistic regression modelling was used to predict higher and lower confidence levels in psychotherapy knowledge and skills amongst the psychologists. As this was an exploratory study with no formal theory guiding the modelling, a Forward Stepwise regression was used and the variables entered were guided by a priori hypotheses and by significant findings in the initial analyses. The model was evaluated using both the Nagelkerke and the Cox and Snell estimates of the amount of variance accounted for. In addition, the model's accuracy in predicting which confidence group each psychologist was in was examined. For the predictors in the model, the beta (B) value, standard error (SE), level of significance (p), odds ratio (Exp(B)), and 95% confidence interval for the odds ratio are reported.

With the survey's free response items, I carried out thematic coding analyses (Braun & Clarke, 2006) and an independent validity check of this work was carried out by Dr. David Hevey, from Trinity College Dublin. David also assisted with analysing the survey's statistical data, which was an invaluable support to me in this work. The SPSS raw data and analysis files for the Psychotherapy study are included in the CD accompanying this thesis (any identifying information has been deleted).

5.2 Interview stage

5.2.1 Participant selection

At the end of the survey, participants were invited to take part in the interview stage of the research. There were 22 volunteers and, of these, 15 were eligible for interview based on the following criteria:

1. Trained and practising as a clinical psychologist,
2. Has not done formal psychotherapy training,
3. Practising psychotherapy for at least 30% of their working time,
4. Has not been in a supervisory or therapeutic relationship with the interviewer.

There was a wide range of experience amongst these 15 clinical psychologists, from 6 months to 18 years. This was too broad a range for an IPA study, which works best with more homogenous groups. Five of the group were qualified less than 2 years, four between 6-10 years and six for 14 years or more. I decided to work with the middle group, believing that most people would be settled into their practice as a clinical psychologist after 5 years but still at a key developmental time in terms of their career and confidence. So, I added a fifth criterion:

5. Qualified as a clinical psychologist for between 5 and 10 years.

I contacted the four eligible psychologists, discussed the nature of the study and sent on information and consent forms (see Appendix 2.2). All agreed to take part in the interviews. A profile of the interview participants can be seen in Table 5.2, three being female, all working in the HSE in different counties in Ireland and practising psychotherapy for at least 40% of their time with various client groups.

Participant (pseudonyms are used)	Years practising	Work setting/ client group	Grade	% time practising psychotherapy
Jennifer	10	HSE/adult	Senior	40%
Claire	6	HSE/child & adolescent	Staff	70%
Kate	7	HSE/child & adult	Staff	60%
David	7	HSE/adult	Senior	60%

Table 5.2: Interview participants

5.2.2 Planning, piloting and engaging in interviews

I initially developed a semi-structured interview schedule, with questions on confidence, supervision, personal therapy and psychotherapy training. However, both my academic consultant, Dr. Rosemary Rizq, and my advisor, Professor Maja O'Brien, encouraged me to consider working without a formal schedule, in order to

be more genuinely exploratory and responsive to emerging material in the interview. I realised during an illuminating discussion with Rosemary that I was still caught in a quantitative mind-set from my survey work and I was overly structuring the frame for my interviewees. To be able to engage in a phenomenological analysis with the interview transcripts, I needed to access my participants' own ways of making meaning rather than imposing my own. Smith and Osborn (2003) noted that in IPA research "*there is no attempt to test a predetermined hypothesis of the researcher; rather the aim is to explore, flexibly and in detail, an area of concern*" (p. 53). As a result, I decided to work with just one open guiding question at the start of the interview, asking broadly about the interviewees' experience of practising psychotherapy as a clinical psychologist, and then following their lead into the issues and experiences that mattered for them.

I carried out one pilot interview in April 2011 with a clinical psychology colleague, following an unstructured, responsive interview format. This raised a few issues which informed how I engaged in the subsequent research interviews. For instance, I found that in my attempt to inhabit a more responsive rather than leading interview style, I retreated too much into the background and our conversation did not have enough live engagement and exchange. Our interview also felt too intellectual, having more of a sense of "talking about" rather than "experiencing with", my colleague being cautious about discussing her personal rather than professional experience in this more formal research context. Following this pilot run, I decided to follow an unstructured format for the research interviews but to bring in a little more of my own thoughts and experiences to facilitate a more personal and supported engagement with my interviewees. On this, Fine (1994) wrote inspiringly of "*self-consciously working the hyphen*" between the researcher-researched, highlighting how these "*relations between*" help to get better data (p.71). Being more active in the interviews meant that I had a greater responsibility to be aware of my own opinions, expectations and biases (Rubin & Rubin, 2005). However, Oakley (1981) encouraged such personal involvement, seeing it as "*more than a dangerous bias – it is the condition under which people come to know each other and to admit others into their lives*" (p.58).

I was also interested in engaging with metaphors or images during the interviews. My motivation here was to allow room for more intuitive or emotional exploration, given my awareness of the professional propensity for clinical psychologists to engage in an overly intellectual manner. In relation to this, Barber (2006) noted that: *“social inquiry needs to account for inner experience of life...fantasy and feelings are as strong – if not stronger – determinants of behaviour and meaning than what is conceptualised and intellectually planned”* (p.4). Etherington (2004) also observed that through the use of metaphor we communicate *“that which we perceive or know (tacitly or intuitively) but for which we have no direct translation into words”* (p.135). Again, I initially intended to actively ask for such material but decided to let such material emerge naturally and to follow it if and when it did.

The four research interviews were carried out during May and June 2011, at roughly one-week intervals, each interview lasting between one and one-and-one-quarter hours. I fully transcribed each interview before meeting the next interviewee. While I did largely carry out responsive, unstructured interviews, there was a consistency in the issues I more closely followed up on with the participants, or even more directly asked about at times – these issues being supervision, personal therapy and psychotherapy training. So, although I did not use a pre-set schedule, some internal guiding structure, formed by my three areas of interest in this research, did remain in place during my interviewing.

5.2.3 Participant consent checks and analytic work:

I sent each interviewee their own transcript, asking them to confirm that it was an accurate record of our meeting, to check if there was any potentially identifying material that they would like to have deleted and to re-confirm their consent to be involved in the research project. Each participant asked for some minor details to be deleted from their interviews (e.g., place of clinical training). Also, as agreed with the interviewees, I later sent each of them a summary of my analytic work on their interview before I brought any material into the public domain to ensure that consent to be part of this research was as informed as possible. IPA research is still relatively uncommon within clinical psychology in Ireland and it was likely that the interviewees would not have been aware of the depth of analytic work that would

be carried out on their interview. I was also conscious that the interviewees would be potential consumers of any research articles, so I felt it was fair and respectful to ensure that they would not read analysis of their material for the first time in a published article. All the participants reconfirmed their consent to be part of the study after seeing the analytic summaries and none queried any aspects of the analyses. Those who commented seemed satisfied that their experience had been well represented and two expressed their hope that the findings would encourage more openness and supportive practices in the clinical psychology culture.

Using IPA, I repeatedly read each interview transcript and developed detailed notes on each script at three levels (as advised by Smith et al, 2009) – descriptive (noting content), linguistic (noting the language used or particular linguistic styles, such as repetitions, changes in fluency, etc.) and conceptual (interrogating the data, making more interpretative comments, bringing in more personal reflection). I then identified a number of emergent and superordinate themes for each participant. Following this, I explored connections across the four transcripts in order to develop a table of master themes and subthemes for the full group. The final stage involved developing a narrative to illustrate, discuss and engage in further interpretative work with the themes. Palmer et al (2010) describe developing this interpretative account as involving “*a dialogue between the researchers and the data about what it might mean to have these concerns in this context*” (p. 103).

The IPA approach brings a double-hermeneutic into the research – the researcher’s as well as the participants’ interpretation and meaning-making. Specifically, this involves an empathic hermeneutic (entering into the participant’s meaning-making) and a questioning hermeneutic (standing back, questioning and analysing that meaning making). The developers of the IPA method differentiate their questioning hermeneutic from Ricoeur’s hermeneutics of suspicion in that with IPA the questioning is prompted by close attention to the text rather than drawing in theoretical frames from outside the text (Smith et al, 2009). Incorporating a questioning hermeneutic during the analyses fitted well with my psychodynamic orientation as a psychotherapist and the value I attribute to implicit as well as explicit meaning.

During this process, I had critical and valuable discussions with Dr. Rosemary Rizq, my academic consultant, who has particular expertise in IPA work. My initial analytic forays tended to be too concrete and specific, not capturing the more holistic experiences the psychologists were describing. Rosemary's feedback always helped me to broaden and deepen my interpretative work and to consider the wider human dimension to the psychologists' experiences. I also asked an Irish clinical psychologist with expertise in IPA, Dr. Rebecca Quin, to carry out an independent audit of my work. Rebecca closely reviewed the interview transcripts and my analytic work and verified that the themes that I had identified were credible and justified. However, Rebecca made a couple of suggestions to rename and adjust the priority of some themes. For instance, Rebecca suggested the theme name "Am I good enough?" to capture the interviewees' feelings of insecurity, and I adopted this as one of the themes in the final analysis. Following Rebecca's feedback and a useful discussion with her about the work, I did further work on the theme names which helped to more clearly foreground the participants' central experiences. The accompanying CD includes the four full interview transcripts with my analytic notes, the analytic summaries sent to the participants, the analytic material sent for auditing to the independent researcher, and a copy of her feedback on the analyses (any identifying material in all data has been deleted).

5.3 Ethical considerations

While being informed by the PSI's (2008b) code of professional ethics, I was particularly mindful of the following ethical considerations as I engaged in the design and implementation of this final project research:

1. *Taking every precaution to protect the anonymity of the research participants.*
The Irish clinical psychology community is relatively small so taking particular care with the identities of the interview participants was important, as even a reference to their geographical location could feel potentially exposing to participants.
2. *Having clear procedures regarding the safe-keeping of data and the timescale of destroying the same,* with reference to the Data Protection Acts, Ireland (1988,

2003). As the survey research involved information being collected on the server of an internet-based survey company, I ensured that data was gathered anonymously and that IP (internet protocol) and email addresses were not stored. I also gave directions to participants to access the security and privacy protocols of this company so that they could check how their information was protected and stored (http://www.surveymonkey.com/Monkey_Security.aspx).

3. *Ensuring consent to participate was fully informed*, that participants had access to their own material, and that interview participants were aware of their freedom to withdraw part or all of their material at any time, right up to the point of public dissemination through conferences or published articles. For the interview participants, I had three separate consent checks – before the interview, after viewing their interview transcript and after viewing a summary of my analysis of their interview – to ensure that consent was as informed as possible.

4. *Being aware of the inevitable imbalance of power in research relationships*. In this I was clear at the outset with participants about my objectives and political agenda, my collaboration with PSI in the survey stage of the research, and my plans to publish and disseminate the findings, so that they could consider possible personal and professional implications of their involvement. Bingham and Moore (1959) described interviewing as “*a conversation with a purpose*” (in Burman, 1994) and Burman (1994) reminded us to consider whose purposes the conversation is pursuing. This was also a key learning for me in a professional knowledge seminar on this doctoral programme with Michael Carroll (2010), who advised: “*Rather than just telling participants why you’re doing the research, be tough with them about asking them why they are doing it*”, so that the implicit expectations and needs are explored and negotiated. It was only possible to discuss this with the interviewees. All were motivated by a need for some raised awareness and political change in the clinical psychology profession, particularly a desire for public acknowledgement of their support needs in their work (e.g., the need for regular supervision).

I was particularly conscious of issues of power during the writing up and dissemination of the research work. On this, Taylor (1994) notes: *“writing up is not just a technical matter because it is at the point of representation, the report...that the researcher has most power”* (p.45). I took particular care at that stage of the work, feeling acutely aware of what sometimes felt like a fine line between advocating for and undermining the clinical psychology profession through my use of the research participants’ contributions.

5. *Taking steps to ensure that no participants were disadvantaged or distressed by their engagement in this research*, and that they felt free to contact me both during and following the research process to discuss any arising issues. I also wanted to take this a step further in doing what I could to ensure that participants got something positive out of their involvement in the research. On this, Oliver (2003) recommended that researchers give *“careful thought to ways of maximising the enjoyment, satisfaction and learning gained by participants in the research process”* (p.148). When survey participants completed their on-line questionnaire, I set up the survey programme so that they were given immediate access to a range of up-to-date survey statistics for all participants.

Tindall (1994) asserted the need for caution in giving feedback to research participants, however. He noted that new understandings about the self, while offering an opportunity, may also be threatening, requiring researcher sensitivity. When I shared my analytic summaries with the interview participants, I reminded them of my availability to discuss the analyses with them if they wished to do so. None took up this option and only made more general comments reaffirming their support of the research rather than specifically about their own interviews. I was a little surprised at this in relation to two of the participants as I thought there was some potentially challenging or exposing material that they may have wanted to review with me. I am uncertain about why they did not want to discuss it as I had to respect their choice not to do so. However, I suspect that the attention that both I and these participants had paid to ensuring their interview material was anonymised gave them some sense of protected distance from any potentially exposing material.

6. *Being mindful of potential disability issues which might restrict participants' capacity to take part in this research.* In relation to this, participants were offered the choice to complete the survey questionnaire with me over the telephone, rather than through the internet (one participant chose to do so). In addition, the survey being computerised rather than being a paper survey offered the facility for those with limited vision to enlarge the survey text on screen to whatever size needed.

7. *Remaining conscious of gender and cultural issues and of the potential to operate from an ethnocentric perspective* while gathering and analysing data from this study (see Oliver, 2003). I was aware of my perspective as a female clinical psychologist (the large majority of clinical psychologists being female) and of the advantages of being an “insider-researcher”, such as increased familiarity, credibility and potential trustworthiness for participants. However, there are also limitations with this, such as the lack of an objective, naive perspective and the likelihood of stronger assumptions limiting what is discovered (I discuss this further in chapter 7).

5.4 Summary

In this chapter I outlined the detail of carrying out the two very different stages of my research, a nationwide survey and interviews with a small number of clinical psychologists. Through both stages of the study, I paid close attention to ethical issues in order to make the research process as safe and respectful as possible for the research participants.

While this was a sequential mixed-methods study, moving from quantitative to qualitative analyses, it is worth highlighting that I did choose to gather some qualitative data in the survey also. The majority of survey respondents commented relatively briefly in the open response items but this did offer a valuable personalising and contextualising of the survey statistics. During the analytic stage of my work, this softened the move between the two study stages for me, more meaningfully connecting the larger group of 170 clinical psychologists with the

smaller group of 4 interviewees. The next chapter offers the results of my analytic work in both stages of the study.

6. Results

6.1 Introduction

This chapter is the most substantial one in this final project, a wide range of information having been collected through the two stages of this research. The results are given in three sections here. The first section describes the quantitative results for the 170 clinical psychologists practising psychotherapy who took part in the survey. I also include one reference to a result from the survey's full group of applied psychologists practising psychotherapy, leading into some significant comparative analyses with the survey's counselling psychologists (see p.44 regarding the different survey groups). As is the tradition in reporting quantitative results, I do not engage in interpretative work with the statistical findings until the discussion chapter. In the middle section, I give the results of the clinical psychologists' qualitative open-response items to the survey which were relevant to this project. I have gone into less detail in this section, offering more of a summary overview in order to give more space and attention to the more substantive statistical and interview results. The third section then offers the analytic narrative I developed from the qualitative interviews, giving a richer view into the experience of four clinical psychologists practising psychotherapy.

6.2 Survey results: quantitative data

6.2.1 Therapeutic models trained in and identified with:

When asked which therapeutic models they identified with in their practice (choosing as many as applied), the clinical psychologists most commonly identified with a CBT therapeutic model (73%), followed by an integrative/eclectic model (63%). Most of the clinical psychologists reported gaining knowledge and skills in a CBT model during their psychology training (88%), the next most common model experienced in training being a systemic model (60%). See Figure 6.1 below (please note that all figures and tables in sections 6.2 and 6.3 relate to the 170 clinical psychologists practising psychotherapy).

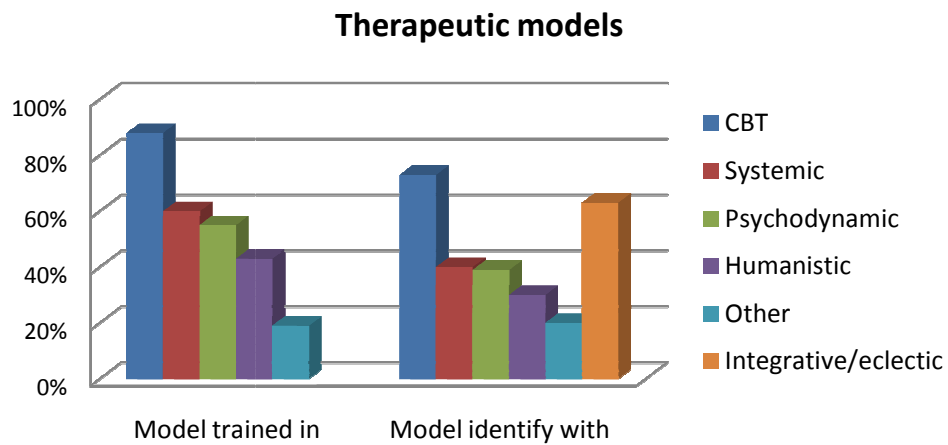


Figure 6.1: Therapeutic models trained in and identified with

6.2.2 Beliefs about qualified psychologists’ professional development needs for practising psychotherapy:

The psychologists were given a list of eight professional development activities and asked to indicate how necessary or valuable each activity was, or would be, for developing qualified psychologists’ psychotherapy knowledge and skills. As can be seen in Table 6.1, the top activities endorsed as necessary by the clinical psychologists were supervision, reading and workshops.

Professional development activity	Necessary	Valuable
Regular supervision	93% (N=158)	5% (N=9)
Regularly reading psychotherapy literature	78% (N=132)	19% (N=33)
Regular psychotherapy theory/practice workshops	67% (N=113)	26% (N=45)
Personal psychotherapy	50% (N=85)	43% (N=73)
Formal training as a psychotherapist	32% (N=55)	64% (N=108)
Training in a therapeutic modality, e.g., CAT, DBT*	29% (N=50)	62% (N=105)
1-2 year “top-up” psychotherapy training	29% (N=49)	53% (N=90)
Joint psychotherapy work with other professionals	22% (N=38)	59% (N=100)

Note: The remainder rated each activity as “useful but not valuable” or “not at all necessary or valuable”.

* Cognitive Analytic Therapy, Dialectical Behaviour Therapy.

Table 6.1: CPD activities rated as necessary or valuable for developing qualified psychologists’ psychotherapy knowledge and skills

6.2.3 What is related to confidence in practising psychotherapy?

In response to the question “Currently how confident are you in your psychotherapy knowledge and skills?” the psychologists selected one of 6 possible responses, ranging from “very low in confidence” to “very confident”. As can be seen in Figure 6.2, the responses were positively skewed towards higher confidence.

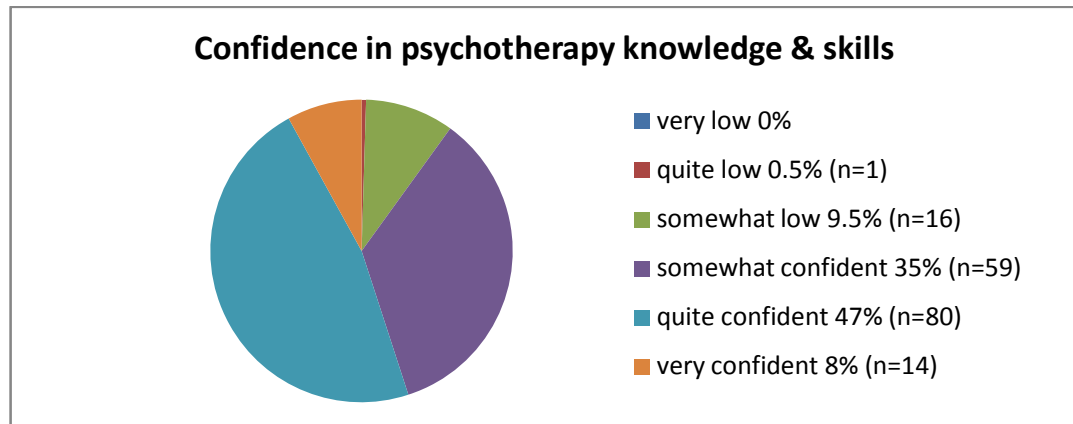


Figure 6.2: Confidence in psychotherapy knowledge and skills

The psychologists were categorised into two confidence groups: the “very” and “quite” confident psychologists together formed the “more confident” group (N=94, 56%) and the two “somewhat” confident groups together formed the “less confident” group (N=75, 44%; excluding one psychologist who selected “quite low in confidence”, this being judged as a qualitatively different level of confidence).

There were eight a priori hypotheses in relation to the clinical psychologists’ confidence and the results of the statistical analyses of these hypotheses follow.

H1: Those with more confidence in their psychotherapy knowledge and skills will have additional formal psychotherapy training

In addition to their clinical psychology training, 18% (N=30) of the clinical psychologists had full training as a psychotherapist and 24% (N=41) had certified training in a mode of psychotherapy (e.g., in CAT, cognitive analytic therapy).

There was a small significant association between having additional formal psychotherapy training and confidence level ($\chi^2 [2, N = 169] = 7.81, p < .05$). Examination of the chi-square’s standardised residuals revealed that the less

confident clinical psychologists were less likely to have full formal training as a psychotherapist and more likely to have no additional psychotherapy training (see Figure 6.3). Further comparison of the odds ratios for the groups showed that the more confident psychologists were significantly more likely to have formal psychotherapy training (OR=2.6, $p<.05$), whereas the less confident group were significantly more likely to have no formal training in this area (OR=2.4, $p<.005$).

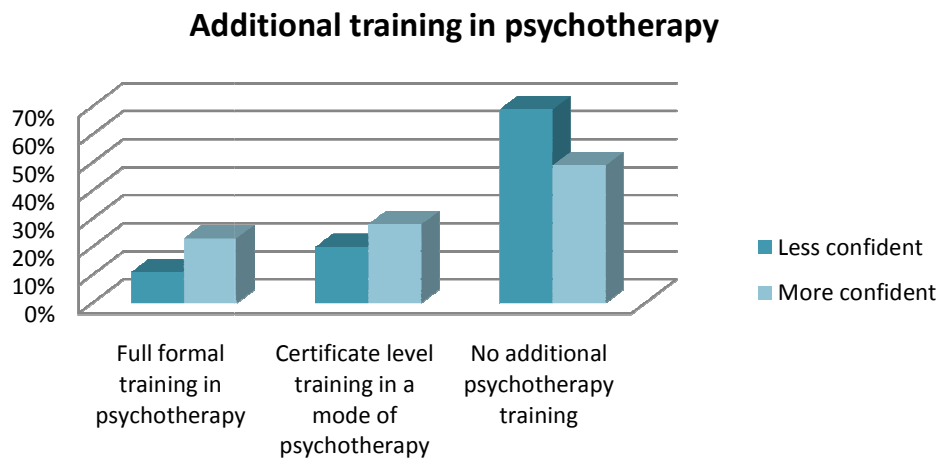


Figure 6.3 Additional formal training in psychotherapy

H2: Those with more confidence in their psychotherapy knowledge and skills will report more frequent engagement in psychotherapy-related personal and professional development activities over the last year

The hypothesis was partially supported. The more confident psychologists reported more often engaging in joint psychotherapy work over the last year (Md=4) compared to the less confident psychologists (Md=6; $z=-2.38$, $p<.05$), nearly twice as many doing so at least once-monthly (40% vs. 21% respectively). Frequency of engagement over the last year in the other four listed psychotherapy-related CPD activities (psychotherapy workshops, personal therapy, clinical supervision, reading psychotherapy literature) did not differ significantly for the two confidence groups.

H3 & H4: Those with more confidence in their psychotherapy knowledge and skills will be more likely to attend clinical supervision and to attend it more regularly

There was no significant difference between the confidence groups in attendance or frequency of attendance at clinical supervision. Nearly all of both confidence

groups reported currently attending clinical supervision (95% of the less confident; 90% of the more confident), nearly half attending at least fortnightly (49% and 48% respectively) and about 80% attending at least monthly (80% and 81% respectively).

H5: Those with more confidence in their psychotherapy knowledge and skills will report greater satisfaction with their current supervisory support

The more confident clinical psychologists were significantly more satisfied with their supervisory support (Md=4 for the less confident group, Md=5 for the more confident group; $z=3.32$, $p<.001$). Compared with the less confident psychologists, nearly twice as many of the more confident psychologists were either very or quite satisfied with their supervision (57% vs. 30% respectively; see Figure 6.4).

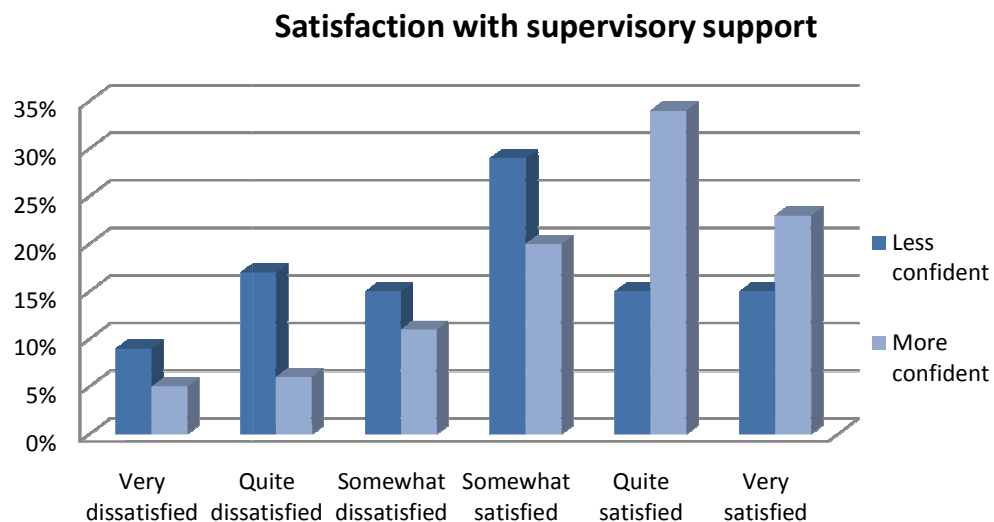


Figure 6.4 Satisfaction with supervisory support

H6: Those with more confidence in their psychotherapy knowledge and skills will be more likely to have attended personal psychotherapy

The difference between the confidence groups in attendance at personal therapy was not significant (80% and 69%, high and low confidence respectively). Overall, the majority (75%) had attended their own therapy, (M=2.8 years, range=0-33 years). However, a post hoc analysis showed that the more confident psychologists had spent significantly longer in personal therapy, for an average of 4 years (SD=5), compared to an average of 2 years for the less confident psychologists (SD=2; $t(127.8) = -3.46$, $p<.001$).

H7: Those with more confidence in their psychotherapy knowledge and skills will spend more time practising psychotherapy

There was no difference between the confidence groups in time spent practising psychotherapy (47% and 44%, high and low confidence respectively).

H8: Those with more confidence in their psychotherapy knowledge and skills will be longer qualified as a psychologist

The more confident psychologists were longer qualified. The more confident group was qualified and practising for an average of 14 years (SD=8.82) compared with the less confident group, who were qualified an average of 9 years (SD=8.61; $t [160.32]=3.17, p<.005$).

Post hoc analyses:

Post hoc analyses were carried out with some of the other variables in the survey. Only two analyses differentiated the confidence groups at the $p<.001$ level: length of time in personal therapy, as noted above, and also, the more confident psychologists were more satisfied with the therapeutic knowledge and skills they gained during their psychology training ($z=3.78, p<.001$). Fifty percent of the more confident group (Md=4.5) compared with 19% of the less confident group (Md=3) were either very or quite satisfied with the psychotherapy aspect of their training (see Figure 6.5).

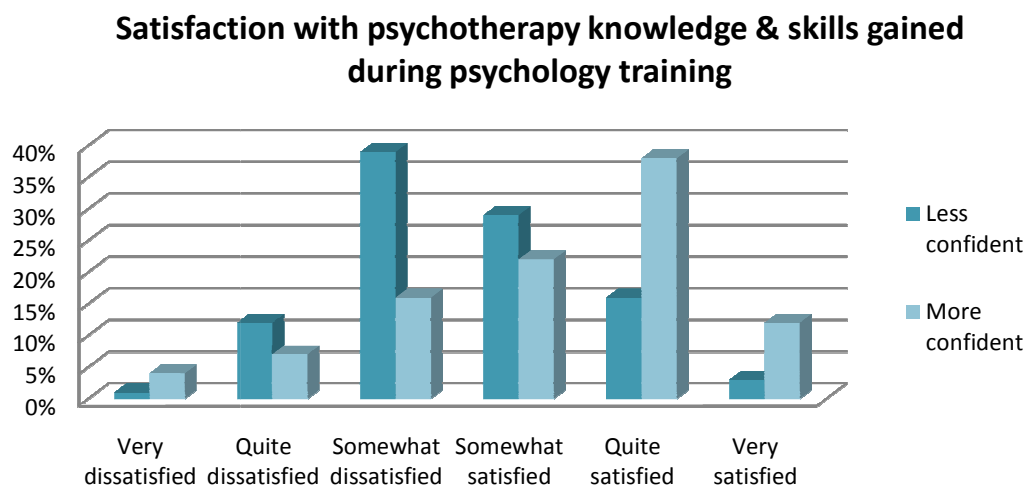


Figure 6.5 Satisfaction with psychotherapy knowledge and skills gained during psychology training

Summary of significant analyses on confidence:

From the above analyses, six variables were found to be significantly related to confidence in psychotherapy knowledge and skills for the clinical psychologists:

- additional formal psychotherapy training (H1)
- engagement in joint psychotherapy work with other professionals (H2)
- satisfaction with supervisory support (H5)
- years of experience as a clinical psychologist (H8)
- length of attendance at personal therapy (post hoc)
- satisfaction with psychotherapy knowledge and skills gained during psychology training (post hoc)

No other variables explored in this study were significantly related to confidence – for instance, the frequency and type of clinical supervision attended or the frequency of engagement in psychotherapy-related CPD over the last year (e.g., reading, attending workshops).

Building a model to predict confidence in psychotherapy:

A logistic regression analysis was carried out to test if a model could be built which would predict confidence levels amongst the clinical psychologists. Conducting a Forward Stepwise regression, the six variables that had been found to be significant were inputted to the model. The final model, derived after 4 steps, was significant: $\chi^2(4, N=169) = 39.65, p < .001$. Estimates of the amount of variance accounted for in the level of confidence ranged between 21% (Cox & Snell) and 28% (Nagelkerke).

Overall, the model accurately predicted 72% of the clinical psychologists as being higher or lower in confidence, the model being better at predicting higher confidence than lower confidence (predicting 77% and 67% respectively).

Having formal psychotherapy training and engaging in joint psychotherapy work with other professionals were not significant independent predictors, so were not included in the final model. Table 6.2 presents the beta value (B), standard error (SE), level of significance (p), odds ratio (Exp [B]) and 95% confidence interval for the odds ratio for each of the four significant predictor variables in the model.

Predictors of confidence	B	SE	p (sig)	Exp(B)	95% C.I.
Satisfaction with therapeutic knowledge & skills gained during psychology training	0.52	0.15	.001	1.68	1.25-2.25
Satisfaction with supervisory support	0.29	0.12	.01	1.33	1.06-1.68
Length of time attending personal therapy	0.18	0.07	.01	1.19	1.04-1.38
Length of time qualified as a psychologist	0.05	0.02	.01	1.05	1.01-1.10

Table 6.2: Significant predictors of confidence in psychotherapy knowledge and skills in the logistic regression model

Controlling for the effect of the other variables in the model, the regression model indicated that:

- each unit increase in satisfaction with psychotherapy knowledge and skills gained during psychology training skills (measured on a 6-point scale) increased the odds of being in the more confident group by 68%;
- each unit increase in satisfaction with supervisory support (again, on a 6-point scale) increased the odds of being in the more confident group by 33%;
- each additional year attending personal psychotherapy increased the odds of being in the more confident group by 19%;
- each additional year's experience as a clinical psychologist increased the odds of being in the more confident group by 5%.

In sum, the logistic regression model showed that more confidence was associated with (in order of importance):

- *being more satisfied with the therapeutic knowledge and skills gained during psychology training,*
- *being more satisfied with current supervisory support,*
- *having had longer time attending personal psychotherapy, and*
- *being longer qualified and practising as a clinical psychologist.*

The presence of these four factors predicted 77% of the more confident clinical psychologists in this study.

6.2.4 Regression model from the survey's full group of applied psychologists and comparisons with the survey's counselling psychologists:

The logistic regression model derived with the survey's full group of 339 applied psychologists practising psychotherapy (see Figure 5.1, p.44) included the same four factors in the clinical psychologists' model, and also included three other independent predictors of confidence: being male ($p < .001$); being a counselling psychologist ($p < .01$); and more time spent practising psychotherapy ($p < .01$). The 7-factor model predicted 85% of the more confident applied psychologists in the larger survey group.

Given the significance to confidence of being a counselling psychologist, **analyses were carried out to explore differences between the clinical and counselling psychologists.** There were a number of significant differences. Compared to the clinical psychologists, the counselling psychologists:

1. were much more confident in their psychotherapy knowledge and skills (92% vs. 56% were more confident; $\chi^2[1, N = 256] = 34.82, p < .001$);
2. were more satisfied with their supervisory support (typically "quite satisfied" vs. "somewhat satisfied"; $z = -3.35, p < .001$); and were more than twice as likely to have external individual clinical supervision (73% vs. 32%; $z = -3.48, p < .001$), with the clinical psychologists being twice as likely to have individual clinical supervision in their workplaces (46% vs. 22%; $z = 3.92, p < .001$);
3. were more satisfied with the psychotherapy knowledge and skills they gained during psychology training (again, typically "quite satisfied" vs. "somewhat satisfied"; $z = 4.54, p < .001$) and were four times more likely to believe that their training fully equipped them to practice psychotherapy (49% vs. 11%; $\chi^2[3, N = 258] = 48.23, p < .001$);
4. were nearly twice as likely to have additional full formal psychotherapy training (35% vs. 18%; $\chi^2[2, N = 258] = 12.00, p < .001$);
5. more often attended psychotherapy workshops (typically one every 2-3 months vs. 2-3 a year; $z = -3.56, p < .001$) and more often read psychotherapy literature (typically once a fortnight vs. once a month; $z = -3.30, p < .001$);

6. were more likely to have attended personal therapy (94% vs. 75%; $\chi^2[1, N = 258] = 14.09, p < .001$), to have been in training where personal therapy was mandated (85% vs. 11%; $\chi^2[2, N = 258] = 135.06, p < .001$), to believe that personal therapy should be mandated during training (92% vs. 42%; $\chi^2[2, N = 258] = 59.36, p < .001$), and to believe that personal therapy is necessary for developing qualified psychologists' psychotherapy knowledge and skills (85% vs. 50%; $z = -5.25, p < .001$).

6.3 Survey results: qualitative data

Turning now to the survey's qualitative data, the results of the two open response items that were most directly related to confidence and capability are reported.

6.3.1 What did the clinical psychologists give as reasons for their level of confidence?

The clinical psychologists were asked to give one main reason for their confidence or lack of confidence in their psychotherapy knowledge and skills. Of the 170, 114 gave comments and these came proportionately from the more and less confident groups (55% and 45% respectively). Overall, four main factors were identified by the group as germane to their confidence: training in psychotherapy, experience, supervision, and client outcomes/feedback. Table 6.3 below lists the 7 top factors identified for all the clinical psychologists, with illustrative quotes from the more confident and less confident psychologists.

As a group, the more confident clinical psychologists commented most frequently on their years of experience (28% of their comments), the significance of the additional or ongoing training work in psychotherapy they had engaged in since their psychology training (25%), the benefits of witnessing positive client outcomes and receiving positive feedback (13%), as well as of having either high quality or long-term supervisory support (12%).

For the less confident clinical psychologists, the most common reasons noted for their lower confidence were having had limited or poor quality psychotherapy training during their clinical psychology training (36% of their comments) and either

poor quality or infrequent supervision (17%). One-fifth (20%) commented on their level of experience, some noting their lack of experience but others noting that their experience contributed to the level of confidence they did feel.

	Reason	No. (%)	Illustrative quotes
1.	Training	56 (30%)	<u>MC</u> : "I received a good grounding in psychotherapy skills in my training and I have continued to attend various training workshops since qualifying" <u>LC</u> : "do not feel my training has fully equipped me to do psychotherapy"
2.	Experience	45 (24%)	<u>MC</u> : "length of years working and knowledge and skills acquired, i.e., learning on the ground" <u>LC</u> : "lack of recent experience as much of my work is assessment driven and time-limited"
3.	Supervision	27 (14%)	<u>MC</u> : "I have a fantastic supervisor which helps enormously" <u>LC</u> : "poor quality clinical supervision"
4.	Client outcomes/ Feedback	17 (9%)	<u>MC</u> : "seeing change in my clients" <u>LC</u> : "lack of adequate...feedback"
5.	Personal therapy	9 (5%)	<u>MC</u> : "I've spent considerable time in personal therapy which has helped enormously in my practice" <u>LC</u> : "I have a certain amount of confidence because of my years experience...and personal therapy"
6.	Confident within limits	8 (4%)	<u>MC</u> : "I only use approaches I feel comfortable with and feel properly trained in" <u>LC</u> : "I feel equipped to deal with some of the issues that occur in the course of my practice but not all"
7.	Reading	7 (4%)	<u>MC</u> : "I continue to do my best to read" <u>LC</u> : "Access to books is somewhat limited and it's difficult to put aside the time to keep up to date"

Note: MC=More confident. LC=Less confident; Other factors, each with just 4 comments or less, included "contact with peers", "still developing", and "not as focused on therapy work".

Table 6.3: Reasons given for confidence in psychotherapy knowledge and skills

6.3.2 What did the clinical psychologists believe would, or does, facilitate greater capability and confidence for them?

The psychologists were also asked to list three things that they believed did, or would, facilitate them to feel more capable and confident in their psychotherapy practice. This gave them the opportunity to comment on what they needed to support their psychotherapy practice currently and into the future, whereas the

question above tapped more into their experiences to date. All but one of the 170 clinical psychologists answered this question, listing 483 comments altogether.

The psychologists most commonly believed (34% of the comments) that further or ongoing training would facilitate greater confidence and capability in their psychotherapy practice. Many noted the need for regular workshops while others specified the value of more formal psychotherapy training.

Supervision was the next most common factor, this making up nearly one-third (30%) of the comments. Many specified their need for more regular and better quality supervision. External clinical supervision was most often named as valued or wanted, peer and group supervision also being named as supportive.

Over one-fifth (22%) of the comments related to the psychologists' need to have more support from their organisations for their psychotherapy practice. They wanted more time, opportunity and financing for training, supervision, networking or reading. Many commented on the high volume and complex nature of their caseloads, as well as the need for more appreciation from their employers of their psychotherapy work. There were a large number of comments on the need for their organisations to separate clinical and line management supervision.

Each of the other factors identified by the clinical psychologists made up less than 10% of the comments and can be seen in Table 6.4 below.

The nature of the factors listed by the less and more confident psychologists were largely similar on this question, with just one main difference in terms of frequency: the less confident psychologists more often commented on their need for more psychotherapy training (39% of their comments vs. 25% of the more confident group's comments). While the differences in frequency were small, the more confident clinical psychologists had slightly higher rates of noting the value of three factors: supervision (38% of their comments vs. 31% of the less confident group's comments) personal work (7% vs. 4% respectively) and time to reflect on their practice (3% vs. 0% respectively).

	Facilitating factor	No. (%)	Illustrative quotes
1.	Training	165 (34%)	<i>“formal training as top-up on existing skills”</i>
2.	Supervision	147 (30%)	<i>“good quality supervision, containing, supportive, challenging”</i>
3.	Organisational Support	107 (22%)	<i>“employer to value the role of psychotherapy practice, there is so much emphasis on quick access and short interventions”</i>
4.	Reading	39 (8%)	<i>“more time for reading articles – access to online journals”</i>
5.	Peer support/ Network	33 (7%)	<i>“access to a support network of similar level peers”</i>
6.	Personal work	26 (5%)	<i>“seeking personal support and using self-care skills regularly to address personal impact issues”</i>
7.	Client outcomes/ Feedback	23 (5%)	<i>“feedback regarding my work from clients and management”</i>
8.	Joint work	17 (3%)	<i>“working alongside like-minded practitioners”</i>
9.	Experience	15 (3%)	<i>“practice!”</i>
10.	Professional recognition	8 (2%)	<i>“recognition from PSI of my psychotherapy training”</i>
11.	Time to reflect	7 (1%)	<i>“time for reflective practice”</i>

Table 6.4: Factors listed by the clinical psychologists that do, or would, facilitate confidence and capability in psychotherapy practice

This finishes my report of the survey results. The results of my analytic work with the interview material are given in the next section, exploring the experience of practising psychotherapy as a clinical psychologist in more depth.

6.4 Interview results

As described earlier (see p.50), I made detailed descriptive and interpretative notes on each of the four interview transcripts, and then developed a list of emergent and superordinate themes for each participant. To illustrate this process, Appendix 2.2 includes Kate’s full interview transcript with analytic notes, as well as a list of the emergent themes and superordinate themes identified in her interview. Following this individual work, I explored connections between the four sets of themes and developed a table of master themes for the group, each with 3 subthemes. Table 6.5 lists the master themes and subthemes, along with the frequency of each subtheme within the group. In the following account I describe and illustrate the themes in some detail, and I engage in broader interpretive work, connecting with the existing literature, when discussing the results in the next chapter.

Master Themes:	Subthemes:	No. participants:
Feeling there’s something missing	<i>Learning in bits and pieces</i>	3 – Kate, David, Jennifer
	<i>Am I good enough?</i>	3 – Kate, David, Jennifer
	<i>Searching for more</i>	All 4
Being able to get in there	<i>Learning from the inside</i>	All 4
	<i>Being able to feel deeply</i>	2 – Kate, Claire
	<i>Moving between head and heart</i>	3 – Kate, Claire, Jennifer
Having somewhere to go	<i>Fighting for support</i>	All 4
	<i>Surviving over the long term</i>	2 – Claire, David
	<i>Fear of opening up</i>	All 4

Table 6.5: Interview master themes and subthemes

6.4.1 Feeling there’s something missing

The experience of professional self-doubt was a persistent undercurrent for three of the clinical psychologists. They felt that they were missing something and that their development as therapists had been piecemeal and fragmented. They also compared themselves with those who had done formal training as psychotherapists, questioning their own capabilities without this training. The

psychologists showed their adaptability to working with what they did have but most expressed their need for more, actively searching for opportunities to fill in gaps in their learning.

- *Learning in bits and pieces*

A significant theme for three of the clinical psychologists was their experience of having developed as therapists in a disjointed, piecemeal way, both during their clinical training and in their post-qualification practice. This was a particularly strong and recurrent theme for Kate, who experienced her clinical training as “haphazard” (12) and dependent on luck in terms of supervisors and placements. She showed her disappointment at being left with fragments that didn’t come together into something of substance for her:

our training, it doesn't really (sigh) make us feel very, very skilled in one area [] you've got loads of bits of everything and you feel like you have not enough of anything really (298-302)

Kate also experienced her ongoing learning as fragmented and lacking cohesiveness:

It would just be lovely to have a very kind of clear framework as well instead of having picked up the skills here and there, from people you've worked with, from bits of training, from reading [] I've had to learn that, really, as I've gone along, you know what I mean? And I suppose I have learned it as I've gone along, but... (332-42)

Again, Kate’s disappointment is strong, her words evoking an image of an adaptable but isolated magpie doing its best to gather what it needs.

Jennifer also shared her experience of being a new, uncertain practitioner after her clinical psychology training. However, she was more satisfied with her clinical training in this area than Kate, believing that her early uncertainty was normal. Like Kate, however, she experienced her ongoing therapeutic development as piecemeal (*I've done bits of training, 118*) leaving her with a feeling that there was something missing:

There's part of me feels like, well, there must be something missing but I don't know what that is, em...I think I feel probably that my approach is a

little bit too eclectic. So there's a little bit too much a little bit from this and a little bit too much from that. I feel, and yet I don't (286-8)

Jennifer's ambivalence is clear here, these "little bits" lacking in substance and cohesion for her but she remains unsure of what may be missing.

David also expressed the feeling that he may have missed something and, while he asserted his competence as a therapist, the piecemeal nature of his learning, both during and after training, again comes through:

do I think that I've had enough training on the basis of all the pieces of work that I've done and all of the placements that I've been on, em, and all of the other formal training that I've done, I would say yes I'm, I'm competent at it (46)

- *Am I good enough?*

Following on from this piecemeal development as therapists, the same three psychologists questioned their capabilities at times, comparing themselves with those who had formal psychotherapy training. Their insecurity was mostly personal, although did include a concern about external judgement, as can be seen in David's comments here:

People can get stuck with an idea that if you don't have an official piece of paper that you're qualified to do something, well then you can't do it, whereas within the clinical psychology qualification it's my belief that for the vast majority of people [psychotherapy] training is encompassed in it, so it's a catch all (52)

While David again asserts his confidence in his psychotherapy training as a clinical psychologist, some insecurity seems to lie behind his words. His use of the term "catch all" brings in a reminder of piecemeal learning and contrasts with the clarity of an "official piece of paper". Although he talks of others being "stuck with an idea", David himself seems to be concerned about his professional standing as a therapist, this being confirmed by his return to this issue later. He expressed a wish for research that would prove his therapeutic work as a clinical psychologist was on a par with that of formally trained therapists:

if there is a need then for external validation, not from me but from somebody else, well I can point to that piece of research and say, you know, I

might not be formally trained but this is the piece of evidence that says that I do an analogous process (288)

This was a significant issue for Kate also, although more of a private concern than a concern about her professional standing. She often compared herself to a psychotherapist colleague, expressing envy at his more substantial psychotherapy training. While at one level she could see the similarities in their work, she had a persistent feeling that he had something that she didn't have:

I probably do have it but I don't really know I have it, if you know what I mean, because I haven't had that kind of formal training [] I always think I don't have it in the way [psychotherapist colleague] does. Now I don't know [] if anybody could observe that in our practice, but it's just in my head really (420)

Kate's description of it being "in her head" echoes David's description of being "stuck with an idea", despite both feeling that their observable practice was probably similar to that of psychotherapists.

Jennifer also raised this issue a few times, feeling "very conscious" (118) that she hadn't done further psychotherapy training. Jennifer felt some insecurity in her work and again had a persistent idea that her training may be the issue:

I'm always going to struggle with that level of competence and confidence and there's always that sort of, the idea of, you know, if I do more training will I be more competent (36)

The clinical psychologists' experience of not having had cohesive or formal psychotherapy training, and their questioning of themselves without such training, seemed to be a persistent issue that fed into their insecurity.

- *Searching for more*

Given their self-doubt and questioning of their training, it follows that the psychologists made ongoing efforts to fill in gaps in their learning and to develop their therapeutic knowledge and skills. While Claire did not express the current self-doubt that the others did, she was clear that she had not gained enough during her clinical psychology training. This had motivated her to do a year-long personal

and professional development course in psychotherapy, her commitment to this additional training being seen in this exchange:

I felt I was going out of my way to develop my skills [] I'm really going out on a limb [] I'm putting myself under pressure [] I would definitely feel that I need that level of training to feel comfortable, em, and to feel competent...

Aisling: You needed more than you got in your clinical training?

OH GOD, YEAH (128-138)

The personal stretch for Claire is clear here, she is pushing herself personally to develop as a therapist, going through a period of pressure and discomfort in order to get to a more comfortable, able place.

Kate also described her ongoing investment in her development as a therapist but she felt that her learning was fragmented, wishing that she had more structure and support for her learning. As she talked about how important her ongoing reading was for her work, there is a sense of the isolation of her search for more:

I don't know where I'd be without it really, you know what I mean. But that's me searching for it myself, again (446)

Jennifer also described her own efforts to develop through occasional training workshops and reading, finding her reading validating and reassuring. However, like Kate, Jennifer wished for more structure and direction:

I feel if I did more psychotherapy training could I become more structured in a sense of direction, a sense of goal (292)

For both Kate and Jennifer, their use of the first person shows the personal nature of their search for more. Kate doesn't know where she herself would be without her reading, rather than expressing the difference it would make to her work. Similarly, it is not that Jennifer's work might become more structured, but that she herself might become so. The essential mix of the personal and professional in practising psychotherapy is captured here – it is not just a case of developing skills, but of developing the self in this work. This can also be seen for David:

I think that with training you can kind of progress [] Then you don't stagnate in that way, like, you kind of keep moving forward a wee bit (90)

The possibilities for David of either progressing or stagnating are personal rather than focused on his work. However, compared to the others who expressed a need for more structured training, David seemed more comfortable adding to his learning in an unstructured and self-directed way. For instance, he described how reading and learning from a colleague with formal psychotherapy training had met some of his needs to develop his therapeutic understanding and skills: *“that’s covered really in other ways now”* (38). The sense of gaps being “covered” and David’s adaptability in using what was available shows his flexibility and resilience. However, the risk of personal stagnation seems to lurk in the background, suggesting that more than covering the gaps may be needed over time, both personally and professionally.

6.4.2 Being able to get in there

The capacity to get into a more personal, emotional place was another major theme for the group, both getting in touch with their own personal experience as well as being able to identify closely with that of their clients. Two of the psychologists had engaged in their own personal therapy and they felt this had been a strong learning experience, deepening their emotional capacity in their work. While self-conscious about not having done their own therapy, the other two psychologists preferred to use clinical supervision as a way to start to open up their more internal, personal process. Three of the group explored their experience of working with the head and the heart in their therapeutic work, commenting on the clinical psychology culture, which they felt valued working more at a cognitive than at a relational or emotional level with clients. They also expressed a need for a more “head-level” theoretical framework for their work, which they felt they had not gained in their clinical training.

- *Learning from the inside*

Kate had done a significant amount of personal therapy work and she felt this experiential learning offered her confidence as well as credibility as a therapeutic guide to others:

I'd say it's been the most important thing for me, you know, in practising. [] I think you just really, really have to know yourself and know what you're carrying yourself. [] how could you work that through with other people if you haven't done it for yourself? (76-8)

Similarly, Claire asserted the importance of personal therapy work for her:

that was really huge learning as well. [] And I feel that's really stood to me in terms of my own work (66-8)

Claire's description of her personal work having "stood" to her gives a sense of the solidity and substance of the experience for her therapeutic practice. Remembering a recent session where a client's issues echoed some of her own personal story, she believed this would have been more difficult for her if she hadn't done her own therapy:

that could have been a red flag for me and not wanting to go there if I hadn't done that work myself (244)

The "red flag" image is a potent one, suggesting the danger and immediate limitation for Claire if personal issues were triggered that she herself had not addressed. Given the strongly valuable nature of their personal work for their therapy practice, Claire and Kate both found it hard to understand how some psychologists did not see the need to do their own personal work. In line with this, the other two psychologists, in different ways, showed some self-consciousness about not having done such personal work. Jennifer brought this up a few times, feeling some sense of pressure that she "should" engage in her own therapy (e.g., *I haven't done any personal work and I'm very conscious that I do need to do that, 118*) but David did not mention this issue at all until asked directly about it over three-quarters of an hour into the interview. He admitted then that he had had some anxiety about being asked about what psychotherapy meant to him personally, as he had not engaged in his own therapy work. His faltering speech here seems to capture his uncertainty in talking about this:

I'm not blind to the idea of there's, there's a, a, a, what do you call it, a contradiction, I suppose, in me expecting clients to be clients and me being a therapist without having done my own therapy (258)

While both David and Jennifer were open to doing personal therapy in the future, neither felt a strong need to do so (*it's more a professional feeling that I should do it than I've ever really struggled*, Jennifer, 126) and they both expressed some uncertainties about engaging in an unfamiliar process (this being discussed later under the subtheme “fear of opening up”). Both did, however, assert the value of tapping into their own personal process in their work and valued clinical supervision as a means of “*opening up what's going on inside of you*” (Jennifer, 124). Clinical supervision seemed to be a more comfortable or familiar route for both Jennifer and David for their personal growth, David feeling that through supervision:

I would be developing myself [] and I know it's a very different thing to go into therapy for yourself but I think that would be enough for me if you like, maybe, I don't know (274)

David shows again his adaptability and willingness to work with less rather than more – he feels process supervision may be enough for him to open up and develop more personally in his work, but it is clear that he lacks personal experience of both options to inform his choice.

- *Being able to feel deeply*

Feeling a strong emotional capacity in their work, as well as an ability to identify with their clients' emotional struggles, was a significant subtheme for two of the interviewees, and they both connected this with having done their own personal therapy. Claire described how emotionally intense and messy psychotherapy work can be at times, recalling a recent session with a father and son:

You have like his emotions, some of my own stuff coming in and some of the Dad's stuff and trying to be able to hold it and manage it and work through it so that you know we can kind of, don't want, you know, anyone to fall apart in it [] that they can all kind of stay kind of solid in it and explore it a bit more (210)

While this work was challenging, from engaging in her own personal work (*I've done that for myself now*, 236) and the ongoing development of her skills, Claire felt a growth in her emotional capacity, solidity and strength:

I definitely feel I can hold myself emotionally. That even though I can empathise, I don't feel as overwhelmed (198) ...I can comfortably explore and go into an issue in more depth with a client (234)

Like Claire, Kate described her capacity to “get in there” at an emotional level with her clients, also seeing this as coming from her own personal therapy experience:

I think I can empathise a lot more [] I really can, you know, get in there and feel for them. I can really, really identify with people's struggles (110)

Through her own experience, Kate felt she developed empathy for herself and this allowed her to connect more deeply with her clients, offering a solid resource that she trusts in her work.

Working at an emotional level did not emerge as a theme in David's interview and Jennifer's experience was of beginning to move into more emotional work, both personally and with her clients, as described in the next subtheme.

- *Moving between head and heart*

Three of the psychologists explored a movement between the head and the heart in their psychotherapy work and how they perceived the clinical psychology culture in this. Jennifer felt that it was safer engaging at a head level within therapeutic work, experiencing the messiness of emotions as difficult for both client and therapist:

I think head stuff is safe, it's attainable, it's important, so it's a place to start...I think the heart stuff can often be messier, it's more confused (176-8)

However, with guidance from her supervisor, Jennifer was becoming more comfortable moving more into her heart in her work, and she, in turn, was guiding her clinical trainees into more relational, emotional work as they progressed through training. Jennifer saw this movement from head to heart as a healthy developmental process for clinical psychologists. While she believed that most people entered the clinical psychology profession wanting to help people, Jennifer saw some tension in the profession's dual nature as both a helping and an academic profession. She recalled advice she was given when applying for clinical training:

don't say you want to do it because you want to help people, say it's because you're interested in people or because people fascinate you and...so I don't know how much you're socialised into becoming more in the head than than in the heart (204-206)

From Jennifer's experience, it seems that intellectual reasons for wanting to be a clinical psychologist are more acceptable within the profession but emotional reasons may be the real motivator.

Claire seemed to have found a satisfying balance between her head and her heart in her work, using a striking turn of phrase when she described what she enjoyed about therapy work:

I'm not afraid to get my hands dirty. [] I don't mind getting stuck in. You know, and that's actually what fascinates me and that's what I love doing (36-40)

Both her head and her heart are engaged here, Claire being both fascinated by and loving her work. The image of getting stuck in and getting her hands dirty gives a strong sense of the messy emotional work that can be involved in growth and healing, images of gardening or even surgery coming to mind - in this, Claire is willing to take her gloves off and feel the reality of her client's internal worlds. Claire's willingness to get in close contact with the messiness of emotion contrasts with Jennifer's caution and lack of safety with this messiness. However, it seems that both are on different stages of the same developmental journey, as Claire talked earlier of not feeling safe with emotions (her "red flag") before she developed a stonger emotional capacity through her own personal work.

While engaging emotionally with their clients was meaningful for three of the group, the same three also expressed the importance of a theoretical framework for their work. For instance, while moving into working more "at a heart level" (124) with her clients had been an important process for Kate (describing the cognitive behaviour therapy skills she had learned in her clinical training as leaving her "cold", 294), she felt she also needed a stronger theoretical framework for her work:

I don't have a very clear framework in my head, it's my own (pointing at her chest), if you know what I mean, that I've brought around (396)

Kate felt she had what she needed in her heart, having developed that from her own personal work, but she was missing a guiding therapeutic framework at a cognitive level. As noted earlier, structure and clarity in terms of direction and therapeutic goals, was also something that Jennifer felt she was missing in her work. Of the four interviewees, Claire was the only one to regularly draw from a therapeutic theory as she discussed her practice and it is of note that she was also the only one not to express self-doubt in her work. Although she had not had formal training, Claire had learned a therapeutic theory that was meaningful for her practice during the year-long personal and professional development group she had attended. It seemed that, compared to the other psychologists, Claire may have met a key need for a theoretical framework through her engagement in this group.

6.4.3 Having somewhere to go

All four interviewees expressed their need to have somewhere to go for support with the personal impact of their often complex and long-term therapeutic work. They most commonly sought supervision for such support but they often had to work hard, and even fight, to get the supervision they wanted. Two of the group emphasised their need to have ongoing supervision for their long-term survival in the work. However, despite their need for support, the psychologists all expressed an awareness of the risks involved in opening up to either supervisors or personal therapists, and they feared judgement in sharing their needs and vulnerabilities.

- *Fighting for support*

All four of the group emphasised their need for supervisory support in relation to their work. However, none had had easy access to supervision in their workplaces, at times having “*fought*” (Jennifer, 56) or travelled long distances for their supervision. Going to such lengths was worth it for these psychologists, however, Claire expressing the importance of supervision for her:

I want to talk about complex cases and maybe my feelings around it and what I'm being left with after sessions and stuff like that or if someone's on my mind a lot during sessions, in between sessions, I want somewhere to go with that as well. [] you will be left with stuff [] you actually need support like that, yeah, to discuss it. I'd end up burnt out otherwise (320-324)

There is a building sense of the pressure for Claire of carrying around feelings and thoughts about her clients, and the need for somewhere to release it all.

As support for her work, Kate described a few significant resources – a long-term personal therapist, an ongoing therapy group for therapists, and her supervision. Although it took a long time, when she found a supervisor she could trust Kate valued how this supervisor helped to settle her self-doubt:

I talk about my fears with, about my work [] I remember bringing that, eventually saying that to my supervisor and she said, Kate, there's a part of every psychologist that thinks she's going to be found out, or, you know what I mean, because we just can't kind of measure what we do and, and we're so stretched as well [] since I've actually had supervision with her that feels much better (234-238)

Kate's relationship with this supervisor has been very important in building her confidence and finding her own personal style in her psychotherapy practice: *"I've moved through into just being more comfortable, I think that is through supervision" (308)*. Kate's movement into feeling comfortable through this supportive relationship offers a contrast to her earlier descriptions of uncertainty and isolated searching for more.

Jennifer talked about how important supervision was for her many times during her interview. Without regular supervision, she experienced things feeling *"haphazard"* and *"a bit more chaotic"* for her, a number of needs being met for her through supervision:

that external view can be helpful even just to confirm what I'm already doing and that sense of validation and, you know, support. Em, and then I guess there's the empowerment, you know, you can actually go that next step with that person (246)

The supportive element of Jennifer's supervision seems to offer a steadying of her footing, so that she can step forward more securely in her work.

The need to fight for supervisory support was a significant and current issue for David. While he had a peer supervision group, it met infrequently and it had been a number of years since he had had individual clinical supervision for his client work:

I think that my last really good experience of supervision was really as a trainee, which is shocking really (280)

David's experience in relation to supervision will be looked at more closely in the next subtheme.

- *Surviving over the long term*

Both Claire and David named a threat to their long term survival in the absence of supervisory support. Without such support, Claire asserted that:

I couldn't survive without good supervision [] I'd say the quality of the therapeutic work I'd be doing would slowly start deteriorating. [] I can't really see how you would do the work we do without having that somewhere (330-336)

David had managed for many years with little supervision, feeling some pride in his capacity to do so but was becoming more aware of the risks of this self-reliance over the long term, issues of "self-preservation" and "survival" now becoming central for him rather than "managing":

I think [clinical psychologists] pride themselves on the capacity [] to manage themselves. I think that that's a dangerous way to work because it's easy to lose sight of whether you're managing yourself or not. [] that's where the external supervision provides a safety net in doing that. [] we're good at being high-wire artists, like, you know, we're good at staying stable up there in the wind (150-162)

While David is conscious of the danger of not having support, his ongoing ambivalence about seeking support, as well as the ambivalence he sees within the clinical psychology culture, is elegantly captured in his choice of metaphor. The high-wire artist in the wind is an isolated, brave image – the attraction being the ability to stay balanced on one's own, even in adverse conditions, and the safety net being needed only if something goes wrong. This metaphor suggests that David still has some attachment to managing alone, with minimal support, rather than appreciating the value or need for either more grounding or for more support alongside him (rather than far below him) while up on the wire in the wind.

- *Fear of opening up*

While all of the interviewees needed and assertively sought out people to go to with the personal impact of their work, opening up to such support also brought up some vulnerabilities for them, with fears of exposure, judgement and stigma.

Kate had had a number of negative experiences with supervisors which had left her cautious about opening up in this context. She described one of her more difficult experiences where she had felt afraid of being judged by a supervisor:

I wouldn't have felt safe talking at a very personal level with her because I don't think that she had kind of dealt with her own stuff. [I felt] that she would kind of pathologise me or something, if I had spoken about anything that I was worried about or fearful about in my work (246)

As Kate described earlier, she had moved on to find a supervisor she felt safe with but this had been a difficult journey for her.

Due to funding cutbacks, Jennifer had changed from attending external clinical supervision to attending her line manager for clinical supervision and she was finding this difficult:

I'm coming to her as a manager and saying [] I'm very competent and everything is very good, and then I'm going in clinical [supervision] saying I'm really struggling here, I'm feeling vulnerable, I'm not, feel like I'm not doing this well because I'm going to bring the cases I'm struggling with more [] I don't want to seem like I'm not confident (308-10)

The tension and discomfort for Jennifer of moving between her vulnerability and her competence in this relationship is strong.

Jennifer also expressed some uncertainty in relation to personal therapy work, as did David and Claire. Jennifer wished that she had had guidance to do personal work during her clinical training, having had some anxiety about it as an “alien” and unknown process then. While therapy was more familiar to her now through her own experience as a therapist, she realised that she didn't “rate personal work high enough” (258) for herself as she had never experienced it and she felt comfortable relying on her familiar resources of family and friends.

Similarly, David had established a way of coping that worked well enough for him and the risk of unsettling that was enough to make him cautious:

I'm reasonably comfortable with the set of skills that I have for managing myself and I don't want them to be either diminished or attenuated [] there's another element of Pandora's box as well like I mean, you know I'm fairly insightful into me but I know I've blind spots, I've probably huge blind spots, and I don't, and sometimes I don't particularly want to go down that road (234-6)

The fear of the unknown seems central for David and being able to freely choose when, as well as why, to go down that unfamiliar road was very important to him.

Claire's fears in relation to her own personal therapy were different to the other two as she had experienced this work and was a strong advocate of its benefits. Her fear was of being judged by her fellow professionals if they knew she had attended therapy:

I just think there's probably a bit of a prejudice and I think people, I'd say there's probably a stigma [] I think that people think that maybe (sigh) if you're doing your own personal work, maybe you're not a good therapist [] Something wrong with you, yeah, maybe you're not coping (280-284)

Within child psychology, Claire had little experience of hearing other clinical psychologists talking about their own personal therapy work, leaving her feeling unsafe talking of her own experience ("you have to kind of protect yourself as well", 394), and only confiding in those she trusted. It is a curious contrast that she had the courage to open up to intense emotional work with her clients, but feared opening up with her professional peers. Claire's fear of being judged for attending her own therapy also contrasts with David's and Jennifer's self-consciousness for not having done so, both experiences showing a sensitivity to what is perceived professionally to be expected or normal. Claire wished for "permission" and "acknowledgement" within the psychology profession of the ordinary humanity in seeking personal support:

I know a lot of it's very private as well but, but I do think there needs to be some acknowledgement, you know, we're all human beings at the end of the day (382)

6.5 Review: the value of both breadth and depth

In this chapter, I have reported a wide variety of information. I first shared the predominantly quantitative, but also some qualitative, data I collected from the 170 clinical psychologists practising psychotherapy who participated in my survey research. I then gave my qualitative analysis of my interviews with four of these clinical psychologists. Despite marked differences in the methods of engagement and in the nature of the resulting information, the two sets of findings complement each other well. I believe that these results offer an invaluable range and depth of understanding of clinical psychologists' experiences and needs regarding their psychotherapy practice. In the next chapter I will discuss the significance of these results and explore their linkages with the existing literature.

7. Discussion

7.1 Overview of results

Remarkably consistent results emerged from both stages of this mixed methods study. Both the quantitative and qualitative analyses showed the central value of three elements for clinical psychologists' feelings of capability and confidence in their psychotherapy practice:

1. ***The importance of satisfaction with initial training in psychotherapy knowledge and skills.*** These professionals felt that they were “missing something” and had developed as therapists in a piecemeal way, both during their training and afterwards.
2. ***The need to have satisfying supervisory support.*** “Having somewhere to go” was something the clinical psychologists had to fight for and was even perceived as essential for their survival over the long-term.
3. ***The value of substantial experience of personal therapy.*** “Being able to get in there”, both in their own personal process and in close relational work with their clients, was experienced as developing the psychologists' emotional capacity in their work.

This chapter will discuss these key results in more detail and how they connect with, and add to, previous literature in the relevant areas.

7.2 Satisfaction with training in psychotherapy knowledge and skills

A strong finding in both stages of this research was the importance of the clinical psychologists' experience of training for psychotherapy practice during their clinical psychology training. In the survey results, ***satisfaction with this aspect of their training was the strongest independent predictor of current confidence in psychotherapy knowledge and skills***, this being true regardless of how long ago the psychologists had done their clinical training. While having additional formal

psychotherapy training was found to be related to confidence, this relationship was not as strong and additional training did not emerge as an independent predictor of confidence. In addition, in line with some past research on confidence and self-efficacy (Glidewell & Livert, 1992; Melchert et al, 1996), the clinical psychologists' initial training experience was more significant for confidence than subsequent experience as a practitioner.

A closer view into this early clinical training experience was gained from the interviews. These clinical psychologists had largely experienced a piecemeal development as therapists and they felt that they were missing a stronger theoretical framework for their practice. They expressed self-doubt and some envy towards formally trained psychotherapists for what they perceived as their more structured or in-depth training.

The self-doubt in the small group of clinical psychologists and the variations in confidence levels for the larger group are consistent with past research which has shown that feelings of self-doubt do persist throughout one's career while engaging in the complex work of psychotherapy (e.g., Thierault & Gazzola, 2005; O'Shea & O'Leary, 2009). Skovholt and Starkey (2010) have argued that "*ambiguity is part of the tattoo of the counselling and therapy professions*" (p.125), and that practitioners have to learn come to terms with uncertainty in their practice. From their extensive research on therapists' professional development, Ronnestad, Skovholt and their colleagues found that many early-career therapists experience disillusionment with their training programme when they realise the real-world complexity of therapeutic work, typically feeling "*if I was better trained, I wouldn't feel so lost and so incompetent*" (Skovholt & Ronnestad, 2003, p.52). In relation to the question I raised earlier (p.29) regarding the relative value of confidence and humility in psychotherapy practice, these researchers observed that more experienced practitioners gain a more realistic sense of the limits in what they can accomplish, leading to a stronger confidence and ability mixed with humility.

These studies offer an important contextualising and normalising of the clinical psychologists' self-doubt and level of dissatisfaction with their training. It also raises the question as to whether the less confident clinical psychologists are going

through a normal professional developmental process of wanting to blame their training for their inevitable limitations in managing complex therapeutic work, or whether there was an actual lack in their training that affects their confidence, and possibly capability, for this work?

While the answer probably involves a combination of both these processes, the clinical psychologists' experience that their learning had been piecemeal, along with their perception that they got less than formally trained therapists did, may leave them in a more insecure position than most therapists when facing the complexities of psychotherapy work. The striking difference in confidence and training satisfaction levels between the counselling and clinical psychologists in my survey research is also relevant here. As a group, the counselling psychologists were far more confident in their psychotherapy knowledge and skills, and were much more satisfied with their psychology training in this area. To my knowledge, there has been no previous research comparing the psychotherapy practice of these two psychology specialisms, and to some extent the differences found here are to be expected given the greater focus on psychotherapy training during counselling psychology training. However, the size of the differences is surprising. It is also of concern as psychotherapy is the main professional activity of the clinical psychology profession, my research further supporting this with a high rate of 91% indicating that they practised psychotherapy for just under half of their working time.

The clinical psychologists' relatively low levels of confidence and satisfaction suggest that there may be real gaps in clinical psychology training in psychotherapy. For instance, the experience of mostly short-term therapy work in clinical training (each of the 6 clinical placements being 4-6 months in Ireland and the UK) is likely to contrast greatly with the experience of working with longer-term chronic issues in their post-qualification practice. Also, I suspect that the fact that clinical psychology training emphasises instruction in the more skills-based, evidence-based therapeutic approaches that "work" (see BPS, 2010) sets up an expectation of the capacity to work effectively with the range of human suffering, rather than a deeper or broader understanding of the complexity of such suffering.

The need for a broader theoretical input in clinical psychology training has been argued in the literature (e.g., Rowan, 2011; Sharpless & Barber, 2006; Zeldow, 2009) and my research offers some support for this. The interviewees' expression of a need for a stronger theoretical framework suggests that this may be a particular gap in the clinical training. While Betan and Binder (2010) affirm that relationship skills are of primary importance in psychotherapy practice, they have strongly argued that having a conceptual framework and theoretical understanding offers greater confidence in the work, providing "*meaning and structure to the often ambiguous and nuanced array of clinical information*" (p.144). These authors describe a process of "*metabolising the theory*" (p.144), when practitioners make their theoretical understanding their own, theory becoming a deep structure that guides more expert, intuitive psychotherapy practice. In her post-qualification training, Claire had gained, and often referred to, a personally meaningful theoretical framework for her practice and this seemed to distinguish her from the other three interviewees in the lack of self-doubt during her interview. Her confidence also seemed grounded in an appreciation of the emotional demands and complexity of the work, suggesting that she has elements of the confident humility Skovholt and Ronnestad (2003) have referred to.

7.3 The need to have satisfying supervisory support

Both stages of this research showed that ***having safe and satisfying supervisory support was a dominant and central issue for the clinical psychologists***, was significantly related to confidence in their psychotherapy practice, and was not something that was easily or reliably available to them. Having satisfying supervisory support was the second most important predictor of confidence in psychotherapy knowledge and skills, with nearly twice as many of the more confident psychologists being either quite or very satisfied with their supervision. Thus, my research adds to the growing body of literature endorsing the strong value of supportive supervision to those practising psychotherapy (e.g., Grant & Schofield, 2007; Lavender & Thompson, 2000; Vallance, 2005).

Against my expectation, the psychologists' level of confidence was not associated with attendance, or frequency of attendance, at clinical supervision. Nearly all of

the clinical psychologists reported currently attending clinical supervision, which compares very favourably to previous research on attendance (see Gabbay et al, 1999; Golding, 2003; O'Dowd et al, 2008) and indicates that clinical supervision seems to be increasingly available to, and used by, clinical psychologists. Previous research studies have not normally gathered information on the frequency and quality of clinical psychologists' supervision, however, which I felt was quite crucial to assessing the reality behind what could potentially be nominal supervision arrangements. While what constitutes an adequate frequency of supervision meetings will vary depending on the quality and quantity of one's workload, one session per month has been named as a minimum standard by the BPS for clinical psychologists (BPS, 2006). The majority of this survey's clinical psychologists do have supervision at this low minimum rate, but a sizeable one-fifth reported attending clinical supervision less than once-monthly or not at all. When asked what did, or would, contribute to their confidence and capability in their psychotherapy practice, supervision was named by the clinical psychologists as a top factor for them, second only to further training. They made repeated comments about their need for supervision or for more regular supervision, indicating that many of these psychologists did not have the frequency of supervision they needed.

However, despite my concerns about frequency and the psychologists' comments about the need for more supervision, the less confident and the more confident clinical psychologists in this study did have clinical supervision of similar frequency. It was their level of satisfaction with their supervision that was found to strongly relate to their confidence in their psychotherapy practice. This is in tune with Poulin and Walter's (1993) research which found that it was only the experience of *supportive* clinical supervision that related to reduced levels of professional burnout. Nearly one-third of the clinical psychologists in my survey were at least somewhat dissatisfied with their supervisory support. This is only a slightly better rate than that in Gabbay et al's (1999) study, where 42% reported dissatisfaction with their supervision, despite a higher priority being given to supervision by the clinical psychology profession in recent years (e.g., Fleming & Steen, 2004). As a point of comparison, Grant and Schofield (2007) found that only 8% of counsellors

and psychotherapists in their Australian study were dissatisfied with their supervision.

Some understanding of the relatively high rates of dissatisfaction for clinical psychologists may be found in the interviewees' experience. While they had had good, supportive supervisory experiences, they also had experienced difficulty accessing safe and supportive supervision, and had some fears of being judged by their supervisors. For clinical psychologists, their clinical supervisors are often their line managers, limiting the safety in being open in such a dual relationship. As an illustration of this, Jennifer described in her interview how she wanted to feel confident rather than vulnerable during clinical supervision with her line manager. Jennifer's experience also raises a broader issue regarding the clinical psychology culture, which seems to be only gradually moving on from a legacy of autonomous, self-reliant practice. For instance, Walsh and Cormack's (1994) early, but I believe still relevant, research found that clinical psychologists feared being judged from showing a need for support. O'Connor (2001) also described psychologists' need to appear competent and hide vulnerability:

"In our professional comportment, we strive to display expertise and competence...Emotional openness and vulnerability are the exception in most professional arenas." (p.347)

I believe that David's metaphor of clinical psychologists as *"high wire artists"* captures the ambivalence towards seeking support within the clinical psychology culture beautifully, illustrating the investment and pride we can feel in our capacity to work independently but also the risk and pressure associated with that. On this tendency to self-reliance, Barnett and Cooper (2009) have argued that psychologists need to work harder to develop a culture of self-care that is integrated into their professional identities.

The interviewees also expressed an awareness of a tension between working with the head and the heart within the clinical psychology profession, of being both a helping and an academic profession. The profession's ambivalence as to whether their role is to objectively understand (assess, research) or to offer help has been commented on over the years (e.g., Eysenck, 1949; Pilgrim, 2003). However, three

of the interviewees felt that there was a healthy progression into working more with the heart, for themselves in their development since their clinical training, and also within the clinical psychology profession. However, this movement still seems relatively new and may still have vulnerabilities associated with it when opening up emotionally in supervision.

It is also worth noting that while many studies have shown the positive effects of supervision for therapists, some have also described more difficult supervisory relationships and unsatisfying experiences that have affected therapists' confidence (e.g., Gray et al, 2001; Ramos-Sanchez et al, 2002). Just as the relationship has been found to be the central factor in successful psychotherapy (Wampold, 2001), the quality and strength of the supervisory relationship is emerging a central factor for successful and satisfying supervision (Watkins, 2011). The more extensive data from my Supervision study also endorses the strong importance of the supervisory relationship for the clinical psychologists' satisfaction with their support (see the Supervision research report in Appendix 2.4).

7.4 The value of longer experience of personal therapy

The third central finding in this final project research relates to the clinical psychologists' experience of personal therapy. Three-quarters of the clinical psychologists in this study had attended their own therapy, this validating a similar rate reported in a recent unpublished Irish survey (Moore-Corry, 2008). It seems that Irish clinical psychologists are on a par with their US counterparts in their investment in personal therapy (75% rate: Orlinsky et al, 2005) and less akin to their UK clinical psychology colleagues, with their low rates of attendance at therapy (e.g., 41% rate: Gabbay et al, 1999; although we lack more up-to-date, reliable figures for UK clinical psychologists).

Despite this high attendance rate, experience of personal therapy was not found to be significantly related to confidence in psychotherapy practice for the clinical psychologists, although there was a trend in that direction. This trend did translate into a significant finding for the full survey group of applied psychologists, though, more of the more confident psychologists having attended their own personal

therapy. What did come through as significant for the clinical psychologists was that ***longer attendance at personal therapy was strongly associated with more confidence in psychotherapy practice***, the more confident attending an average of two years longer than the less confident psychologists (an average of 4 years versus 2 years, respectively; the same result being found for the larger survey group). This finding offers further support for the now extensive literature reporting positive benefits from attending personal therapy (e.g., Bike et al, 2009).

The significance of length of personal therapy to therapeutic confidence is interesting and only one other study seems to have reported findings related to this issue. Sandell and colleagues (2006) found a curvilinear relationship between the therapist's training therapy duration and their client outcome, the rate of client change being best with those therapists who had attended their own therapies for 7-8yrs (being at its lowest with those with therapies of 13-14 yrs and in the middle with those of 3-4yrs). It is relevant here that the majority of this study's participants were practising and engaging in more long-term psychodynamic psychotherapy. The authors of this study discussed various possible interpretations of this finding but were essentially left uncertain about the reason for this outcome. In my own study, the relationship was straightforward, longer experience of personal work being simply and directly related to greater confidence in psychotherapy knowledge and skills. It confirms that *significant* personal development is of value in psychotherapy practice and that it is not just a case of developing skills for therapeutic practice, but of developing the self in this work, as many other researchers and theorists have noted (e.g., Skovholt & Starkey, 2010).

It was noteworthy, however, that personal work was seldom named by the survey's clinical psychologists when commenting freely on the reasons for their confidence, the survey's counselling psychologists giving more acknowledgement to the value of their personal work to their confidence (commenting on personal work at least twice as often as the clinical psychologists). Overall, the clinical psychologists had less experience of personal therapy compared to the counselling psychologists, saw it as less important in terms of developing qualified psychologists' psychotherapy

knowledge and skills, and were much less likely to believe that personal therapy should be mandated during psychology training.

The interview results offer some insight into the mixed feelings that clinical psychologists seem to have in relation to personal therapy work. For the two interviewees who had done their own personal work, they believed it had been a strong and essential learning experience, deepening their emotional capacity in their therapeutic work. They felt able to get in more deeply at a heart level in their work, manage strong emotions in themselves and also empathise more intimately with their clients. This corresponds well with previous research, which has frequently found that therapists' empathic capacity is enhanced through experience of personal work (e.g., Murphy, 2005; Peebles, 1980; Rizq & Target, 2008a).

For all four of the interviewees, however, the issue of personal therapy was a significant one for them. The two clinical psychologists who had not done their own personal work were self-conscious about this, feeling some professional pressure that they should do so, as well as some fear of the unknown (the "Pandora's box") of engaging in therapy. They were more comfortable using clinical supervision to open up their personal process and this use of clinical supervision to develop self-awareness is indeed a valid one, having been reported to be one of the positive effects of supervision (e.g., Borders, 1990; Raichelson et al, 1997). However, as Jennifer observed in her interview, it is likely that these psychologists do not really know what they are missing, not having experienced the positive benefits of personal work. This also brings us back again to the clinical psychology culture, where personal therapy work has not traditionally been part of the training, and still is not normally mandated. It is only recently that personal therapy (as well as clinical supervision) is being publicly advocated for within clinical psychology in Ireland and the UK (e.g., Hughes & Youngson, 2009) so some reservations about using this form of support and personal development may still remain within the profession, as David's and Jennifer's fears showed. Claire's concerns about being judged for attending her own personal work also suggest that there may still be an uncertainty and lack of public acknowledgement within the

clinical psychology culture about the value of personal therapy work (the tradition of self-reliance within the profession discussed earlier being relevant here too).

Support for this interpretation can be found in the mixed views that the clinical psychologists had about mandating personal therapy during clinical training. Less than half of the survey's clinical psychologists believed it should be mandated, compared to nearly all of the counselling psychologists supporting such a mandate (although an additional 44% of the clinical psychologists did believe it should be recommended during training). There has been much debate in the literature on the relative merits and ethical concerns of mandating personal therapy during training (e.g., Atkinson, 2006; Grimmer, 2005; Holland, 1986; Kumari, 2011; McLeod, 1993; Rizq, 2011). A number of years ago, Norcross and his colleagues (1988) observed that this issue has been "*shrouded in mystique, defensiveness and anxiety sometimes bordering on the irrational*" (p.37). Offering a balanced view, Grimmer (2005) suggests that it may not ultimately be a case of finally proving it one way or the other but of "*recognising and understanding the different theoretical and philosophical traditions...and deciding one's own position.*" (p.286).

Both stages of my research strongly indicate that personal therapy work contributes to confident psychotherapy practice, suggesting that such personal work is an appropriate part of training to practise psychotherapy. The experience of the two interviewees who had not done personal therapy work indicated that it may be harder to engage in personal therapy as they move on in their careers and personal coping strategies become more established. Similarly, Norcross et al (2008) found that (along with time constraints) having sufficient coping skills and other sources of adequate support were the main reasons therapists gave for not engaging in their own therapy. These findings offer further support for personal therapy to be required as part of initial training so that its value as a personal resource, as well as a professional development resource (the two being intertwined), is experienced at an early stage.

7.5 Other factors related to confidence and capability

Two other factors were relevant to confidence and capability for the clinical psychologists in this research – their experience and the level of organisational support they had for their psychotherapy work. While the amount of time spent practising psychotherapy was not related to confidence, those clinical psychologists who were longer qualified were more confident in their psychotherapy knowledge and skills, experience understandably and appropriately being related to confidence. The interviewees commented on the value of experience over time for their practice and, within the survey, experience was the second highest factor noted by all the clinical psychologists as a reason for their level of confidence. This corresponds with Norcross' (2005) finding that client experience was one of the top three sources of positive professional development for psychologists (along with supervision and personal therapy). It is also of note that the less confident psychologists, who were unhappy with their training in psychotherapy and with their supervision, often named their experience as contributing to the level of confidence they did feel.

When it came to commenting on what factors would, or do, contribute to confidence and capability in their practice, organisational support was the third most important factor for the survey's clinical psychologists (after training and supervision). Many of the clinical psychologists, particularly those who were less confident in their psychotherapy practice, expressed needs for their organisation to support them through giving funding and time for further training and supervision, through having more resources to facilitate a reduction in their waiting lists, and through showing more appreciation of the value and complexity of psychotherapy work rather than prioritising short-term interventions. Organisational concerns were also often present as a context to the interviewees' experience of practising psychotherapy in the HSE. It has often been noted in the literature that the clients that present to clinical psychologists in the health services often have intransigent and long-standing problems (e.g., Barnett & Cooper, 2009; Gudjonsson, 1989). The clinical psychologists in my research were very aware of the complexity of their

client work and the limited supports and resources they had in their services for this work.

7.6 Some strengths and limitations in this research

There are some strong points in this research that deserve highlighting here, as well as some issues that may limit the validity of the findings.

7.6.1 Survey participation rate

The relatively high participation rate in the survey part of this research is a strong feature of this research. While I calculated a response rate of 46%, which is an acceptable and average response rate for survey research, this is a very conservative estimate, using the full nationwide figure for health service psychologists, and not including one-quarter of the participants who were non-health service psychologists. A valid response rate of 40% is by far the largest participation rate to date in an Irish survey with practising psychologists (e.g., of Irish nationwide surveys carried out since the 1990's, the numbers of qualified psychologists taking part have ranged from a low of 73 [O'Dowd, 2008] to a high of 159 [Moore-Corry, 2008], researchers reporting response rates of between 30% and 45%). Also, in contrast to other Irish surveys, this research included psychologists in a greater variety of work settings, including private practice, business, and academic settings rather than being limited to health service related settings as is commonly the case.

The demographics of the survey respondents also matched closely to the nationwide demographics for health service psychologists, indicating that this was a representative group of clinical psychologists. This level of response from clinical psychologists practising in Ireland gives a welcome credibility and weight to the research findings.

7.6.2 Mixed methods design

I believe that the strongest feature of this research is its mixed methods design. Mixed methods designs are still relatively rare within clinical psychology, as indeed

are purely qualitative designs, although these are increasing. The survey part of the research has immediate credibility in terms of its familiarity for clinical psychologists, carrying some political leverage for communicating with psychology service managers and advocating for needs. However, the equal inclusion of the qualitative interviews brings a necessary substance and personal life to the survey numbers, giving voice to the clinical psychologists' needs and experiences.

The mixed methods design also matched well with my overall aims to explore and identify needs, as well as influence awareness and policy. The findings from both stages of the research complement each other well and offer a more detailed and persuasive message. Often, a quantitative research report leaves the reader with questions about why a particular finding emerged, the meaning and context being unclear. With a qualitative research report, the findings often offer a rich experiential perspective, but here the reader is left wondering if the findings generalise to the wider population from which the small number of participants was drawn. While engaging in this mixed methods research was demanding of my resources, the excitement for me was in finding the synchronicities between the two study stages. For instance, the reader does not have to question whether the experiential theme of strongly valuing having somewhere to go with the impact of their therapeutic work is unique to the small group of clinical psychologists interviewed in this research, or if clinical psychologists more generally feel this. The survey part of the research offers the answer that having satisfying supervisory support is strongly related to the therapeutic confidence of a large, representative group of clinical psychologists. While these are clearly quite different ways of accessing and describing the clinical psychologists' experiences and needs in relation to supervision, these two findings complement and reinforce each other well.

7.6.3 Being an insider-researcher

An issue worth noting as both a strength and a possible limiting or confounding factor in this research was the fact of my being an insider-researcher as a fellow clinical psychologist. This issue is more relevant to the interview stage of the research as there was a personal engagement here between me and the

participants. Being an insider-researcher offers benefits in that the researcher can seem less threatening and more sympathetic, and a common language and implicit conceptual framework can exist for both researcher and participants (Rubin & Rubin, 2005). While this offers a clear advantage in helping interviewees to relax and be more natural, it also brings in the possibility again of the range of issues being discussed being limited or not expanded enough. There may be too many shared assumptions about what is being discussed and naive questions may not be asked. I do believe that this was the case at times in the interviews as I often felt I understood the psychologists' experiences from my own experience, and at times even finished their sentences for them (as can be seen at times in Kate's interview transcript in Appendix 2.2).

In addition, while the four interviewees largely seemed comfortable with me and seemed to appreciate that I was a clinical psychologist interested in advocating for the profession's needs, I wonder about the impact of the fact that I had done an additional training as a psychotherapist. Specifically, I wonder would the decision I had made to engage in additional formal training have been experienced as an implicit criticism of clinical psychologists' therapeutic capability without such extra training. For two of the interviewees in particular, I felt that there was a defensiveness and self-consciousness in how they talked about not having done extra formal training. The fact that these psychologists spontaneously and repeatedly made comments about their training suggested that this was a significant issue for them regardless of my part in this, but it is possible that my additional professional identity as a psychotherapist may have raised the level of their self-consciousness and self-doubt about being good enough without such training.

7.6.4 Reliance on self-report data and on the construct of confidence

As noted earlier (p.27), I did not attempt to assess actual capability in psychologists' psychotherapy practice but rather relied on my research participants' own judgements of their confidence and capability. While therapist confidence has been related to client progress (e.g. Clemence et al, 2005), the reliance on self-report data is a clear limitation in this project. In addition, the cross-sectional data

gathered in this study did not access changes in confidence over time and in different circumstances: as one survey participant noted in relation to their confidence: “it depends on the day you ask me...”.

The validity of the construct of confidence can also be questioned given that feelings of insecurity and professional self-doubt are an integral part of psychotherapy practice, my research adding to the evidence for this. As already observed, it may actually be a combination of confidence and humility that underpins effective and resilient psychotherapy practice (Skovholt & Ronnestad, 2003).

7.6.5 Researcher preconceptions and political agenda

The main limitation I see in this research is the extent of my preconceptions and biases and my strong hope to gather information which would influence policy and practice in relation to the clinical psychology profession. I set up the survey to explore the three areas I wanted to explore – supervision, therapeutic training and personal therapy. While the interviewees arguably had the freedom to express whatever was important to them in their experience of practising psychotherapy as a clinical psychologist, for at least two reasons they were highly likely to pay attention to these three areas. Firstly, they had already taken part in the survey, so they were already primed to these as relevant issues in my research. Secondly, while I started the interviews with a broad, open question about their psychotherapy practice, I did at times ask more focused questions about supervision, personal therapy or therapeutic training, and was inclined to follow up on these issues given my interest in them. However, in both the survey and the interviews, the value of client experience also emerged as a significant issue for the psychologists, as did the limitations of the organisational context of their work. If I had been more invested in exploring these issues or other potentially relevant aspects of the clinical psychologists’ resources or support systems, such as family relationships, hobbies or spirituality, other factors may have emerged as more relevant to their therapeutic confidence. I did not actively explore or follow up on these issues, both during the research work and in my discussion of the results, as they did not have immediate implications for developing clinical training or

supports for clinical psychologists' practice. While significant and valuable findings emerged in relation to my three primary areas of focus, it is important to note that the centrality of my political investment in promoting change for the clinical psychology profession limited my attention to other factors.

7.7 A brief review

In this chapter, I have reviewed and discussed the findings of this final project research. This mixed methods research study highlighted the importance for clinical psychologists' therapeutic confidence and capability of feeling satisfied with their initial psychology training in psychotherapy but also their experience of piecemeal development as therapists; the significance of having satisfying supervisory support but the reality of having to fight for supervision at times and the difficulty feeling safe opening up to support; and the value of having longer experience of personal therapy for developing emotional capacity in the work, as well as the vulnerabilities and fears that can be involved in engaging in such work. In the next chapter, I will discuss the implications of these findings for clinical psychologists' training and practice and how I am working to bring these findings out into the public domain.

8. Implications, recommendations and future directions

8.1 Introduction

In this chapter, I consider how my research has added to the literature on psychotherapy practice and the implications of the findings for psychotherapists generally, as well as more specifically for clinical psychologists' training and practice in psychotherapy. I then outline the recommendations I am making to key stakeholders in the clinical psychology community. In considering the application and dissemination of my research and development work, I review the various products of my doctoral journey, including those completed, ongoing and in process. I also note some future directions that could usefully be followed to build on my research findings.

8.2 Implications for training and practice

8.2.1 Key findings and implications for professionals practising psychotherapy

My research findings add to the general literature on psychotherapy practice, both confirming and developing our understanding. Some key findings are highlighted here, along with their applied implications.

- *Importance of satisfying initial training in psychotherapy for career-long confidence*

There was little research on the significance of quality of training in psychotherapy so my research offers some useful information in this area. My survey research showed that satisfaction with initial training in psychotherapy was of primary importance for confidence in practice, more so than any later training or experience in this area. This endorses Melchert et al's (1996) finding that longer time in training contributed more to counselling self-efficacy than subsequent experience. The implication is that the quality of this initial, early-career training is particularly significant for developing a strong foundation of confidence as a therapist.

- *Importance of having satisfying supervisory support to enhance confidence in practice*

My research adds to the growing body of research that endorses the value of supervision for therapists' practice (Watkins, 2011). Both the interview and survey stages of my research highlighted the significance of supervisory support for the clinical psychologists' practice. However, this supervisory support was only related to confidence in psychotherapy practice when it was perceived as satisfying, my results offering validation of a similar finding by Poulin and Walter (1993). This indicates the importance of finding the right personal fit in terms of the supervisory relationship, format and style, this being more significant than frequency of supervision in my study (these issues were explored further in my Supervision study, see Appendices 2.3 and 2.4).

- *Value of longer engagement in own personal therapy to enhance confidence and emotional capacity in psychotherapy work*

Both the survey and interview stages of my final project work add to the literature endorsing the professional benefits of engaging in personal therapy. As has been a consistent finding in past research (e.g., Murphy, 2005; Rizq & Target, 2008a), the perceived growth in emotional capacity through personal therapy work was shown in my interview study. The interviewees who had done their own personal work experienced a greater capacity to identify with their clients' emotional experiences. They also felt a greater ability to enter into emotional material without feeling overwhelmed, expanding the range of work they felt able to engage in with their clients.

My survey results have also added some useful information to the existing literature in this area, as it was found that longer experience of personal therapy was significantly related to greater confidence in practising psychotherapy. One past study (Sandell et al, 2006) found a curvilinear relationship between length of therapists' therapy attendance and client outcome but there has been little research on this issue. My study indicates the value of substantial engagement in personal therapy in the fulfilling but personally demanding work of psychotherapy.

- *Professional self-doubt as part of psychotherapy practice, endorsing the need for ongoing support and development*

The two pieces of research work I engaged in during this doctoral journey, my research in 2010 with clinical psychologists' reflexive journaling on their psychotherapy practice (McMahon, 2012) and the interview stage of my final project work, both provide further evidence of the significant presence of professional self-doubt for those practising psychotherapy (as shown in past research, e.g., Mehta, 2006; Thierault & Gazzola, 2005). This finding points to the complexity of the work with human suffering and its personal impact on therapists, underscoring the ongoing need for professional support and development in this work.

8.2.2 Implications for clinical psychology training

While the above findings are of value for all professionals practising psychotherapy, they have significant implications for the training and practice of clinical psychologists. As clinical psychology training by its very nature is a broad training, the time given to psychotherapy training is of necessity more limited than it is in psychotherapy or counselling psychology training. The BPS (2010) have noted that there will always be a need for further development and specialisation of skills after clinical psychology training and they emphasise the importance of post-qualification CPD to achieve this. However, a key finding in my research was the primary significance of satisfaction with initial training in psychotherapy knowledge and skills for confidence in psychotherapy practice. Post-qualification CPD, and even further formal training in psychotherapy, were not found to be independent predictors of confidence. It seems that this initial training experience lays a crucial foundation for confidence.

Analysis of the interview material in my study showed that these clinical psychologists experienced the psychotherapy training within their clinical training as fragmented and piecemeal, and they were left feeling that something was missing for them relative to those with more formal training. This fragmented learning continued on into post-qualification practice, the psychologists describing

engaging in patchy self-directed reading and attendance at workshops when they could find the time. While the BPS (2010) have asserted that developing skills and specialisation through such ongoing CPD is a valid route, it seems clear that this was not enough for the clinical psychologists in my research. The interviewees expressed their need for more, including more structure and theory.

Clinical psychology training relies strongly on clinical placement experience under the supervision of senior clinical psychologists. About 3,000 hours of clinical experience is gained over 3 years of training, this comprising at least 50% of the time in clinical training (BPS, 2010). The rest of the time involves academic input and research work. While the clinical placement experiences are of central value to the trainees' learning and development, and experience in psychological therapies is required in all placements, the degree and quality of their learning in psychotherapy will vary depending on particular placements and supervisors (as the interviewees in my research noted). Hall and Marzillier (2009) have also observed that most psychologists in the health services are eclectic therapists (health service psychologists most commonly being placement supervisors), meaning that development of a conceptual framework about the process of therapy may not develop from learning under supervision. Clinical trainees also move placement every 6 months, so it is the training institution and staff that provide the consistent structure to the training. This is also where the trainees will have theoretical input on psychotherapy, alongside other inputs in a broad programme. My research findings indicate the need for improvement of the psychotherapy aspect of clinical psychology training in at least two important ways – the need for a more cohesive, structured training experience and for more theoretical input on psychotherapy.

Another implication of my research is the significance of the personal development of the clinical psychologists for this work. It emerged from the survey that the majority of these Irish clinical psychologists have engaged in their own personal therapy. Given the relatively high numbers of attendance overall, actual attendance at personal therapy was not found to be significantly related to confidence for the clinical psychologists in my study (although attendance was significant for the full group of applied psychologists). However, longer experience of personal work was significantly related to more confidence in psychotherapy

practice. The issue here is that personal therapy has not traditionally been mandatory for clinical trainees, although some movements towards this have been occurring, two of the Irish clinical doctorates mandating a small amount of personal therapy hours. While this issue has been debated over the years, my research offers further confirmation of the strong professional value of engaging in personal therapy, and the difficulty justifying personal work not being an integral part of training for psychotherapy practice. Furthermore, my research indicates that *early* engagement in personal therapy is to be strongly recommended for two reasons: it can become harder to initiate engagement in therapy as coping styles become more established; and longer experience of personal work is of significant benefit to confident practice. As such, my research indicates the strong value of including a requirement for personal therapy work as part of clinical training.

8.2.3 Implications for clinical psychology practice

While improvement in the theoretical and personal development aspect of clinical psychology training programmes is needed, the reality of such a broad range being covered in the training will still mean that substantial time or in-depth attention cannot be given in any one area. As such, even if there are needed improvements in the clinical training, additional and ongoing input will be needed in post-qualification practice, as the BPS (2010) recommend. However, two important issues were highlighted in my research regarding ongoing development for qualified clinical psychologists. One is in the area of CPD. In the survey stage of my study, the frequency of engaging in psychotherapy workshops or reading in this area over the last year had no relationship to confidence in psychotherapy practice, despite these being activities highly rated by the psychologists as ways to develop their psychotherapy knowledge and skills. The interview results showed that such occasional CPD work seemed to perpetuate the experience of piecemeal, fragmented learning in this area. The one interviewee who had engaged in a structured, year-long personal and professional development programme in psychotherapy had a different experience to the other three, and did not experience her ongoing learning as fragmented. Also within the survey results, having additional formal training in psychotherapy did have a small but significant

relationship to confidence in practice (albeit of less significance than their initial clinical training in this area). Not having additional formal training was significantly related to less confidence in psychotherapy practice, corresponding with the interviewees' experience that they may be missing something relative to those with formal training. Thus, the lack of additional formal training seems to feed into professional insecurity as a therapist. This indicates the need for structured training options in psychotherapy for qualified clinical psychologists, ideally at an early stage post-qualification to reduce feelings of insecurity and lack of confidence. The value of *structured* learning seems to be of key importance, and of the development of a *theoretical framework* for their practice within such learning (as indicated by the interviewees), rather than the typical format of occasional attendance at CPD skills workshops and self-directed reading.

A second major implication for clinical psychology practice from my research is the importance of having satisfying supervisory support for confidence in psychotherapy practice. My research showed that a significant proportion of Irish clinical psychologists are not satisfied with their supervision. The interview results provided further evidence that accessing safe and satisfying supervision was not easy for the clinical psychologists and that having such a resource felt essential for them. The survey results also indicated that once satisfying supervision is found, that is what is of central value, rather than its frequency or type (e.g, work-based or external). There is a significant push on within the clinical psychology profession to position regular supervision more centrally in career-long practice (e.g., Bernard & Goodyear, 2009; Fleming & Steen, 2004) and my research provides further support for the value and necessity of supervision for confident and supported practice.

8.3 Recommendations for the clinical psychology profession

At this point, I am highlighting three fundamental areas that my research indicates need development in order to support clinical psychologists practising psychotherapy – and they can be shown graphically as follows:

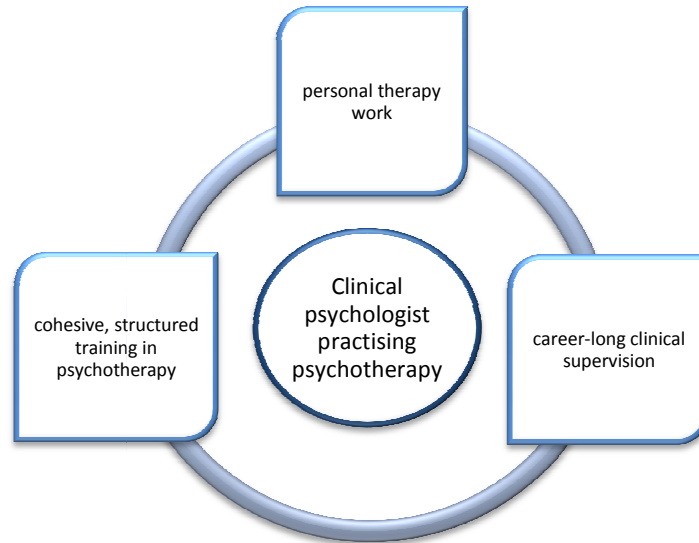


Figure 8.1 Areas in need of development for clinical psychologists practising psychotherapy

Following on from my research, I am in the process of making recommendations to key stakeholders in the Irish clinical psychology community. I am also submitting articles to British journals in order to widen the potential impact of these findings to clinical psychologists in other jurisdictions.

My three main recommendations from this research are as follows:

- I recommend that clinical psychologists have *more structured, cohesive input in psychotherapy skills and knowledge development during clinical training*. Given the breadth of clinical training and the limits on how much extra input can be given to the psychotherapy aspect of the training, I recommend that structured post-qualification training in psychotherapy, with a strong theoretical component, is also developed and supported by co-operation between psychologists' training sponsors and subsequent employers (predominantly health service managers) and the training universities.
- I recommend that *personal therapy work is required during clinical psychology training and that this is financially subsidised as a core part of the training programme*. I propose that a minimum of 40 personal therapy

sessions is mandated, as this allows a substantial year-long experience of personal work, but still leaves some freedom to choose the timing and readiness for such work within the 3-year training programme. I recommend that clinical trainees are facilitated to find accredited, reputable therapists given the anxieties for some in initiating such personal work.

- I recommend that *qualified clinical psychologists attend career-long supervision and are facilitated to find the best possible personal fit so that their supervision is experienced as appropriately satisfying and supportive.* This requires policy development at national level (PSI) as well as within employing organisations, such as the HSE, so that supervision is firmly established as a central feature of clinical psychology practice. I also recommend that time and resources are given to training supervisors as my Supervision study indicated that a significant proportion of psychologists providing supervision have received no training in this area, despite an expressed need for the same.

8.4 Dissemination of findings and doctoral products

My research work has resulted in some substantial and significant findings in relation to clinical psychology training and practice in psychotherapy. While I have started disseminating the findings, I believe that this is going to be a somewhat lengthy process and that the impact of this research will take time to unfold. In this section, I include: a review of dissemination and professional development work that I have already done within the clinical psychology community during this doctoral process; my continuing work in this area; work that I am currently in the process of completing; as well as work that I am planning for a later stage.

8.4.1 Professional journal and peer-reviewed journal articles

I have had four articles published in the last few years in relation to psychotherapy practice. Three were professional psychotherapy and psychology journal articles in which I explored aspects of psychotherapy process in some detail (McMahon, 2009a, 2009b, 2010c; see Appendix 1.1). The fourth article has just been published in the peer-reviewed journal, *The Irish Journal of Psychology*, this being my

exploratory IPA study with the journals of clinical psychologists practising psychotherapy (McMahon, 2012; see Appendix 1.3).

I have three articles in the final stages of preparation for submission to international peer-reviewed journals (the journals I am targeting are high impact British journals of interest to psychologists: *Psychology and Psychotherapy: Theory, Research and Practice*; *Clinical Psychology and Psychotherapy*; and the *British Journal of Clinical Psychology*). One article is on factors related to confidence in psychotherapy from the survey research (written with Dr. David Hevey), and one is on the experience of practising psychotherapy as a clinical psychologist from the interview research. The third article reports on factors associated with satisfaction with supervision and with confidence in providing supervision from my Supervision study (written with Darina Errity). I plan at a later point to write two further articles focused on particular aspects of my research, one on psychologists' personal psychotherapy and one on clinical psychologists' training in psychotherapy. I plan to write one of these articles with the psychologist who provided an independent audit of my interview analyses, Dr. Rebecca Quin. I also intend to write a review paper for *The Irish Psychologist*, Ireland's professional psychology journal, once the peer-reviewed articles have been published, so that my findings can reach as many Irish psychologists as possible. I am initially prioritising publication internationally so that the research will have a wider reach and influence than the Irish clinical psychology community.

8.4.2 Teaching and training work

As described in Volume I (p.6-7), I designed and ran training workshops for practising clinical psychologists in Ireland in psychotherapeutic theory and practice as part of my developing specialism in this area during this doctorate. I initially ran three sets of four workshops throughout 2010 (see Appendix 1.2), as well as a workshop at the 2010 Annual PSI Conference on the theory and practice of psychodynamic psychotherapy (McMahon, 2010b; see Appendix 1.5). Since then, I have been running psychotherapy workshops at the invitation of HSE services. I ran 6 workshops in 2011, for the North East and South East HSE psychology services, and I am running 4 more in the North East HSE in early 2012. I get queries from

time to time from individual practitioners about running more psychodynamic workshops and do plan to run another set later in 2012.

I have also been doing psychotherapy training work with trainee clinical psychologists since starting this specialist doctoral work. I have been running a once-monthly therapeutic practice module for final year clinical psychologists in training in Trinity College Dublin (TCD) since 2010 (see Appendix 1.6). This continues to run well, with good feedback from the trainees and staff, and is a significant addition to the psychotherapeutic training on this clinical programme. The fact that it is a year-long module rather than an isolated input is significant, and I believe that it offers the trainees a more cohesive, structured input in psychotherapy, fitting with my research findings.

8.4.3 Conference and AGM Presentations

During this doctoral process, I have created and taken up opportunities to share my research findings with the Irish clinical psychology community in formal settings. As I described in Volume 1 (p.9-10), I was a guest speaker at the 2010 PSI Clinical Division AGM (McMahon, 2010a), sharing my research with clinical psychologists' journals on their psychotherapy practice (see Appendix 1.4).

From my final project research work, I presented two papers at the 2011 Annual PSI Conference, one on the Psychotherapy study (McMahon & Hevey, 2011) and one on the Supervision study (McMahon, 2011; see Appendix 2.3). There was a good level of engagement from the psychologists present at my papers, two issues in particular being discussed. The psychologists were pleased to see the significance of supervision being validated by both my Supervision and Psychotherapy studies, those at senior level expressing their difficulties getting organisational support for supervision. I have had a few requests from senior clinical psychologists in the HSE to send on a copy of my Supervision study presentation so that they could use my research to support their need for supervisory support. The second issue picked up by the conference participants was that of personal therapy. A couple of psychologists noted that there seemed to be a shift in the Irish clinical psychology culture, with a greater expectation that personal therapy would be engaged in. However, the psychologists debated how to safely talk about needs for personal

therapy or supervision, feeling vulnerable to judgement from professional peers and management in expressing such needs (fearing judgement from all disciplines, not just psychology).

In terms of future plans for formal presentations in relation to my research, I have been invited by a senior psychology colleague, Dr. Maeve Nolan, to present as part of a symposium she is planning to run on IPA research for the 2012 Annual PSI Conference. I welcome this as a useful opportunity to encourage more qualitative research in clinical psychology.

8.4.4 Research reports for key stakeholder groups in the Irish psychology community

Based on both my Supervision and Psychotherapy studies, I have written, and am in the process of writing, a number of tailored research reports for different groups in the Irish psychology community. The reports for different groups are as follows:

1. Research report for clinical psychology training directors & PSI Director of Professional Development: *Practising psychotherapy as a clinical psychologist: Recommendations for clinical training* (focused on the clinical psychology data; see Appendix 2.4).
2. Research report for HPSI managers & PSI working group on psychologists specialising in psychotherapy: *Practising psychotherapy as a psychologist: Training and continuing professional development needs* (broader focus on data from all applied psychologists practising psychotherapy and addressing training and post-qualification needs).
3. Research report for PSI supervision policy group: *Irish nationwide survey: Psychologists' supervision practices and needs* (a detailed report to inform the policy development work of this group; see Appendix 2.4).
4. Research report for HPSI managers: *Irish nationwide survey: Psychologists' supervision practices and needs* (less detailed than that for the policy group).

Initial feedback from my reports has been positive, particularly from the members of the PSI supervision policy working group, who welcome having this detailed information for our work, and from my learning signatories, Professor Alan Carr and

Dr. John O'Connor, in relation to supporting their programme development work on the clinical training doctorates. I am offering these different groups the option of following up my research report with a presentation of the findings so that I can go into the results and their implications in more detail. I hope that this will open up some debate and discussion about possible ways of using these findings to improve initial training and career-long supports for psychologists.

8.5 Future directions

I can see a number of leads into future research and professional development work arising from my study, some of these being as follows:

- *Researching how psychologists and therapists talk to professional peers and managers about attending personal therapy or supervision, and their needs for the same.* I believe that this is a useful issue for advocacy work as well as further research.

- *Development of structured post-qualification psychotherapy training options for clinical psychologists, ideally with collaboration between training universities and employers.* In this, there could be the possibility of some collaboration with other disciplines who have psychotherapy training as part of a broader training, such as social workers and psychiatrists. A difficulty here is the possible dilution of a psychotherapy training model, which appropriately includes significant personal development and supervised practice during engagement in theoretical training. Any developments here would need to link in with the work of the PSI working group on psychologists specialising in psychotherapy, which is working closely with EFPA (European Federation of Psychologists' Associations) in its development of accreditation certificates for psychologists' specialisation in psychotherapy.

- *Complementary research with the British clinical psychology community* would be of value. Ireland and Britain have historically followed the same model of training and practice but it seems that there may be some divergences occurring. For instance, my research shows that Irish clinical psychologists are

investing significantly in their own personal therapy work in the way that British clinical psychologists do not seem to be doing, although up-to-date figures are needed on this. There seems to be a culture developing within the Irish clinical psychology community that expects practitioners to do their own personal work.

- The strong *significance of satisfaction with initial training in psychotherapy* in my research is worth exploring further. For the clinical psychologists, as well as for the wider group of applied psychologists in my research, this initial training was more important than any other factor for their confidence. Exploring further what elements in training result in satisfaction or dissatisfaction would be useful.
- It would be interesting to do exploratory research with *later-career clinical psychologists*, to look at their concerns and needs in relation to their psychotherapy practice at that stage. It would also be of value to do a *longitudinal study*. Clinical psychologists have a particular work environment, often having a chronic and heavy therapy caseload, in the midst of other responsibilities (Gudjonsson, 1989; O'Connor, 2001). Research with either diary records and/or repeated interviews would be of value to more deeply explore this experience.

8.6 Review

In this chapter, I have considered how my research has added to the literature on psychotherapy practice and, more specifically, to our understanding of clinical psychologists' needs in this area of practice. I have outlined my recommendations based on this research and the work I am doing to bring my research findings out into the public arena, as well as noted some interesting future directions for research and professional development. The next, and final, chapter offers my reflective review of this doctoral journey.

9. Reflective review

9.1 Introduction

In this final chapter, I describe my personal and professional journey through this doctoral process. I review my initial expectations and some of the surprises and satisfactions along the way. I also describe the key areas of growth and challenge for me over the last couple of years, concluding my thesis with some reflective comments on the clinical psychology profession.

9.2 Expectations, satisfactions and surprises

At times during this doctoral process, I felt that the work I was engaged in had its own natural force and direction. Once I initiated something and brought myself into the public domain in some way, new opportunities invariably presented themselves for developing my work. For instance, the psychotherapy training workshops I developed and ran with clinical psychologists led to a demand and interest in more training from a few sources – individual practitioners, HSE psychology services and a training university. Also, my final project research plans linked in with PSI's plan to develop a supervision policy and their wish to have research to inform this. While I made active choices to run with these opportunities, it has been demanding to keep up with the momentum of this process while still remaining engaged in my regular work and full family life. However, it has been a very welcome and validating experience to have a ground-level interest and engagement in my work from within the Irish psychology community over the last couple of years.

When I started on the Metanoia doctorate I was not sure what area I wanted to research or develop a greater specialism in, having a number of thoughts and possibilities competing for attention in my mind. It was the experience of a disappointment in my work around that time that helped me to realise the direction my heart wanted to follow. An invitation in September 2009 to do teaching on psychodynamic psychotherapy and to run a personal development module on the Galway clinical psychology doctorate did not come to fruition at that time (a committee was established to develop changes to the doctoral programme,

so new modules are still “in planning” over two years later). I was surprised at how excited I felt about the invitation when I received it, and at how disappointed I felt when it disappeared into a bureaucratic process. The opportunity to contribute to the development of clinical psychologists felt personally meaningful to me for reasons I have described earlier (see p.1-4, Vol. 1, and p.1-4 in this volume). I realised that this was a direction I was very interested in taking, and one that I felt would be of value to my profession, so I decided to take my own initiative to step into this work. This was when I started developing and running my psychodynamic workshops for practitioners in early 2010 (see p.6-7, Vol. 1). I have not looked back since then, each piece of work stimulating another piece (interestingly, as I described earlier [p.11-12, Vol. 1] I got offered an opportunity to do psychotherapy training work with clinical trainees on a different doctoral programme, this coming into effect more quickly, and the work is as enjoyable as I expected).

I had clear opinions at the beginning of this journey about what I felt needed development for clinical psychologists in their training and practice, specifically the need for personal therapy work, for regular clinical supervision, and for more substantial training in psychotherapy. As can be seen in the last two chapters, my main research findings strongly support my initial opinions. I have been particularly pleased with how the findings from the two stages of the research, the survey and the interviews, complement each other so well. While it is important to note that my preconceptions and political agenda sharpened my focus onto participants’ experiences of training, supervision and personal therapy, my research does seem to have offered an opportunity for needs to be expressed that were ready and waiting to be heard. I am heartened by the quality of the material I have, of both breadth and depth, as I engage in my dissemination work to advocate for these needs amongst the clinical psychology community.

There have, however, been some surprises in the finer detail of the research findings. As has often been described (e.g., Smith, 2007), some of my preconceptions only came to light when I encountered something that surprised me. For instance, I did not expect how important their initial training experience would be to psychologists’ confidence in their psychotherapy practice. In my survey development, I asked more about post-qualification psychotherapy training

and CPD work than about psychology training experience in this area. I fully expected this later training work to be important for confidence (as it was for me in my journey) as it is only after initial clinical training that some in-depth specialisation occurs. However, the foundation of this early training experience is more central and critical than I realised.

I was also surprised at the strength of the needs of senior clinical psychologists. When I started running my practitioner workshops, I expected only early-career psychologists to attend, expecting that this would be the time of most need for further input as these psychologists did not have the benefit of experience. However, most of the workshop participants were senior clinical psychologists, including some principal grade psychologists of up to 30 years' experience. It became clear that these experienced practitioners needed this reflective-dialogical space to engage with psychotherapy theory and with the complexities of their therapeutic work with clients. Many of these senior psychologists were also lacking the supervision they needed and wanted for their practice, this coming through in the final project research too. Of course, the needs of senior practitioners make perfect sense to me now, as it is often only with experience that we realise the complexity of our work and our essential limitations. I am reminded of David's metaphor of the "*high-wire artist*" to represent clinical psychologists. This metaphor seems to elegantly capture the illusion the clinical psychology profession can create of being able to manage all sorts of work with alacrity and without the need for support. Early-career clinical psychologists may remain under the influence of this illusion until they realise that such unsupported artistry will not sustain them over the long term, as David described.

Another, and very pleasant, surprise was the high investment in personal therapy work amongst Irish clinical psychologists revealed in my research. The need and value of this personal work is not discussed openly amongst clinical psychologists and there seems to be some anxiety about being judged for revealing such a need. I am genuinely delighted to be able to report this result and hopefully create more security in talking about personal therapy as a typical and valuable activity for clinical psychologists.

Probably the biggest surprise for me has been the size of the political dimension of this research work on clinical psychologists' psychotherapy practice. I have struggled with at times feeling more like a traitor than an advocate in my work. My first and most startling brush against this political edge was when presenting my research proposal to my doctoral cohort. I was pleased that my peers (nearly all psychotherapists, there being no other psychologists in the group) were so supportive of my research plans. The shock came when I realised that it was their *negative* opinions about clinical psychology that underpinned their support. The psychotherapists had an understandable resentment at the dominance clinical psychology had in the health services as managers of psychotherapy services, feeling that this status was undeserved with the profession's lack of in-depth training in psychotherapy. While I understood their position and they offered it in a balanced, respectful way, I felt an acute sense of disappointment in myself, feeling that I had let my fellow clinical psychologists down. I had been so tuned in to my concern to speak out about the gaps in clinical psychology training and practice that I hadn't done anything to speak up for the vulnerabilities, concerns and genuine personal engagement of many clinical psychologists practising therapy.

From this experience of presenting my research plans to my peer group, I felt quite unsettled about the possible divide and conflict that might arise from my research work, rather than what I hoped would be a supportive, developmental piece of work. During the writing up of articles and research reports from my research I have been very conscious of the advocate/traitor duality that may be present in what I am revealing in terms of clinical psychologists' needs. Apart from my conference presentations of my research and my initial distribution of my research reports within PSI and the clinical training staff, which have been well received so far, I have yet to see the impact of my research work. In my ongoing dissemination work, I hope that I manage to show and engender respect for authentic needs rather than judgement of limitations. It has been, and continues to be, important to discuss my work with others during this process. I have particularly appreciated guidance from my "critical friend", Teresa O'Mahony, whose experience as a principal psychology manager in the HSE keeps her closely in touch with the

political nuances of the clinical psychology profession and Irish health service management.

9.3 Key areas of personal and professional challenge and growth

9.3.1 Becoming a more sophisticated practitioner-researcher: the importance of process, context and praxis

As I described in my Professional Knowledge paper, I have come to realise through this doctoral journey that there is nothing straightforward about research and the “knowledge” it produces. The context and process of arriving at any knowledge are quite central, as well as the context and process of disseminating such knowledge. I had been quite naive about these issues, having had only quantitative research training during my clinical psychology training, so it has been a valuable induction into a broader understanding through the research and professional knowledge seminars during the doctorate.

Portwood’s (2010) description of an ongoing cycle of knowledge offered a guiding framework for my research journey. He described this as moving from pre-understanding, through reflection, social engagement, praxis, and post-understanding, this latter then becoming the new pre-understanding. Having an awareness of this cycle was quite freeing, as I felt less pressure to design the “perfect” project and find absolute answers. I felt more able to trust that I did not have to prove or disprove something but could illuminate from certain perspectives, offering potential explanations and insights. I also have been able to view this doctoral work as the beginning of my specialist work and not an end in itself, allowing room for the potential of the work to unfold further into the future.

Barber (2006) asserted that in practitioner research *“the questions we form are more important than the results we defend”* (p.24). This feels particularly relevant as I reflect on my development during this research journey. My broad questions regarding what it is like to practice psychotherapy as a clinical psychologist and what facilitates capability in this work need to remain the central focus as I disseminate my findings. My research results show that these are live questions for many Irish clinical psychologists, with some needs being shown and some useful

indications emerging regarding the way forward to enhance confidence and capability. However, my investment in promoting change for the clinical psychology profession caused me to hold a relatively concentrated focus as I engaged in this research and interpreted the findings. I realise now that taking too strong a position in relation to my research findings, interpreting them as unqualified indicators of the need for change in clinical psychology training and practice, may undermine the credibility and value of my research. While I am excited by the potential implications of my research, it is important that I work to hold and offer a balanced position which openly considers the findings, the focused context of my research, and the many other factors influencing therapeutic confidence and capability not addressed in this research. I realise that it is bringing my original questions, as well as the knowledge gained from my research, into a process of dialogue with some key stakeholders in a shared search for answers that is an important stage of this work. This I understand as engaging in praxis, putting energy into bringing the knowledge gained from my research into applied action.

9.3.2 Befriending the research “wall”

Before starting on this professional doctorate, I had not engaged in formal research for nearly 20 years. I would like to include an entry from my research journal from November 2009 to illustrate where I was at that stage:

I want to overcome my block at the idea of data analysis - whether it be a qualitative or quantitative method or, ideally, both...I hit a blank wall and a deep sigh when I think of qualitative or statistical analysis. I want to learn and to experience this territory so that I can move forward with my work and career feeling more knowledgeable and comfortable in research work, with a sense of “I can” not “I can’t and I don’t even know where to start”.

Even though that was only a little over two years ago, I have come a long way since that time and have exceeded my expectations in terms of my learning and confidence in both quantitative and qualitative research work. I have worked hard to get to the point of “I can”, my study and countless hours of trial and error being instrumental in that. However, the key process for me was that the wall I had been hitting became less “blank” and more textured, with well-positioned footholds, this happening through the help of some important guides in my journey through

statistical analysis and IPA methodology: Dr. David Hevey, Dr. Rosemary Rizq and Dr. Rebecca Quin. The collaborative nature of this doctorate has been highly valuable to me in this way. I still have a lot to learn and I am conscious of where I could have done better during this research. For instance, I could have designed some of the quantitative questions in my survey to offer better choices in how they could be analysed statistically, giving me more power to uncover meaningful relationships. Within my interview work, my capacity to inhabit a phenomenological interviewing style was variable, as I engaged in more conceptual discussions at times, and at other times responded to my interviewees in a containing, therapeutic way rather than being more exploratory. There was strong learning in that process which will help me in any future research interviewing.

Overall, I have found engaging in applied mixed-methods research a variously demanding, satisfying, exciting and exhausting process. While undoubtedly challenging, I found it refreshing and stimulating to be able to move between the different layers of knowledge in my study. When the dryness and lack of personal life in statistical data sets was draining my spirits, I would spend time with my interviewee transcripts and touch into what mattered at a personal level to individual clinical psychologists. Conversely, when feeling concerned that my conversations with my interviewees were too individualised and personal to have enough impact or political weight within my profession, I found it exciting and validating to find a connection between a qualitative theme and a statistical finding in my quantitative work.

However, at times during this research process I wished I had had a more concentrated area of inquiry in both the survey and the interviews, focusing in on experiences and needs regarding supervision, for instance, rather than exploring the wider field of overall experience of psychotherapy practice. Reflecting on it now, I was operating in what I see as the classic mode of the stereotypical clinical psychologist – working with breadth rather than depth, working to meet many needs (*“that needs doing, yes I can do that”*) but feeling an internal stretch in capabilities in doing so. It makes me smile to realise this now, and to see how deep my clinical psychology roots run in me. However, I also trust that this broader

exploration of what it means to practice psychotherapy as a clinical psychologist has been meaningful. I see it as offering a more holistic, holding frame of attention around what my research has shown can be a fragmented and piecemeal development for clinical psychologists in their therapeutic practice – I am glad that I didn't just focus on one of the pieces and miss the broader picture.

9.3.3 Going public: claiming my ground and finding my voice

When I consider how private my working life was before starting this doctorate and how much public engagement I have had with my profession over the last couple of years, I am a little stunned at the contrast. While I had done teaching work in the past, such as once-yearly inputs with clinical trainees, and teaching days with prison officer recruits, I had never developed and run my own training workshops for practitioners in the general public. While this was something I was energised about doing, it also brought up significant vulnerabilities for me, as a research journal entry from before one of my early workshops shows:

Will I be enough? Will I let people down? Will I get lost – and publicly so?...part of me feels scared and unable. I'm working to consciously relax and ground myself – I have done a lot of preparation, I can rely on that and need to trust that the rest will follow and that I will be good enough (March, 2010).

The rest did follow, and kept on following, as I ran a second and then a third set of these workshops through 2010 and have been running workshops at the invitation of HSE psychology services since then, as well as doing regular teaching work with clinical trainees over the last couple of years. Also between 2010 and 2011, I ran a workshop and presented two research papers at two PSI Annual Conferences (McMahon, 2010c, 2011a, 2011b), and presented at a PSI Clinical Division AGM (McMahon, 2010b). Even though I am now 20 years qualified as a clinical psychologist, within these last couple of years I have moved from being a relatively unknown professional into being quite visible and active within my profession in Ireland.

Two things have been quite central in enabling my movement into this work. The first was finding and establishing a clearer ground in my own professional identity

and practice. I trained as both a clinical psychologist (the therapeutic training being mostly CBT) and a humanistic and integrative psychotherapist, but at the beginning of this doctorate I hadn't consciously claimed a preferred therapeutic orientation. While reflecting on my own beliefs during early project work on the doctorate, I more strongly claimed my affinity with psychodynamic psychotherapy, and recognised more clearly how my therapeutic practice fitted with some of the more relational psychodynamic models of growth, particularly some object relations theories. A large element of my integrative psychotherapy training was psychodynamic but I have since developed my reading and knowledge in this area, even more so since deciding to be involved in offering psychotherapy training to others. In this, I was aware of how psychotherapy outcome studies have shown that the most effective therapists are those who believe in their particular form of therapy and make it their own (e.g., Wampold, 2001), or who experience their work as a *"mechanism for self-expression of [their] deeply held view of the human condition"* (Simon, 2006, p.343). I believe that this also follows through for effective teaching or training work. My clearer inhabiting of a particular orientation and understanding of life and growth has allowed me to feel more grounded in my beliefs and it has also enabled me to offer a clearer territory to move around in for those attending my training workshops. It seems that this theoretical clarity is also something my interview participants are seeking in their practice.

The second has been a willingness and readiness to work with my vulnerability rather than being held back by it. I have always been much more comfortable in small group or one-to-one settings, speaking out within a larger group feeling like quite an exposed and unsupported position for me. I had been glad to leave my occasional teaching work behind me when I moved into private practice. However, with more experience, and having developed a more accepting relationship with my anxiety and vulnerability through my personal therapy work, I felt ready to move into more of this work again. When I started my first set of workshops, I had no idea that this would become a regular part of my work. However, it has become something I really appreciate as a way of engaging with my own experience and knowledge as well as connecting with, and offering a space to develop, the knowledge and abilities of my professional peers.

9.4 In closing: the stereotypical clinical psychologist and the room for growth

From my experience working alongside, training, supervising or offering personal therapy to other clinical psychologists, I have observed some emotional/relational patterns that I often see in those in my profession, and where I feel development towards more balance needs to occur. These are:

- *Over-reliance on the head, the cognitive* - needing to move more into the emotional, towards *more balanced integration of head and heart*.
- *Fear of not knowing*, relying on the solid, the known and knowable - needing to move into giving self permission to not know, to be lost and developing comfort *moving between the known and unknown*.
- *Valuing competence*, a strong competence developed and exhibited, usually across an impressively wide range, but often holding and protecting an insecure or not deeply enough grounded base in any one area - loosening the grip on the expert, competent role, allowing mistakes, confusion, uncertainty, exploration, and leaving *more room for shared or evolving discovery*.
- Valuing *independence and self-reliance*, favouring situations where in control and the leader, feeling uncomfortable with weakness, dependency or need for support - letting go of some control and compassionately meeting own needs to *depend, rely on and trust others more*.

I also personally share these emotional/relational patterns and while they have offered me the capacity to be relatively successful, competent, and well regarded within my profession, I have also worked hard over the years to develop a healthier intellectual-emotional-interpersonal balance for my own sake and for those I work with. In line with my own observations and development, it is interesting that the theme of moving between the head and the heart was a significant one for three of my research participants. Similarly to me, Jennifer commented about the clinical psychology profession:

that's where the professional development is to come, less from the head and it's moving more down to the heart (160)

My research findings strongly indicate the value of an early re-balancing of these patterns for clinical psychologists in training, rather than professionals having to work on their own after training to develop such a balance.

In tune with research with other therapists, the clinical psychologists in my research also expressed their professional insecurity, as well as their need for ongoing support. This suggests that there is, at least privately, a loosening of the stereotypically competent and autonomous clinical psychologist persona. However, there may still be some pride in being seen to be *"high-wire artists...stable in the wind"* (David, 162), making it difficult to openly acknowledge needs and vulnerabilities. I believe that the dissemination of my research findings is important in normalising and validating a more rounded persona, which includes and values both strengths and vulnerabilities.

In terms of dissemination work and the intention to create change and development, Barber (2006) suggested considering how the *"innate intelligence of the system"* might be worked with (p.21). Similarly, on a professional knowledge seminar in Metanoia, Dr. Kathryn May (2010) spoke of the value of gentle exploration and sowing seeds for change, asserting how people need to be attracted to move towards something rather than being pushed into change. I find both May's and Barber's thoughts extremely useful and in tune with my own personal style and beliefs. Leadbeater (2008) also offers the concept of *"witness"*, arguing that sustainable change more reliably occurs by working with the status quo and offering motivation to change and develop from within. The fact that I am a clinical psychologist exploring my own profession's needs offers me more credibility and I hope that may reduce potential defensiveness to change. So far, there seems to be a welcoming of the needs and issues being voiced in my research, and a readiness within the clinical psychology profession for change.

Final project word count: 40,912 (excl. contents page, references & appendices)

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RAL 5 Appendices, Volume 1

Appendix 1.1:

Front pages of articles published in Irish professional journals on psychotherapeutic practice issues, and examples of past written work

ARTICLE

The Fear of Change: Understanding and Working With Client Resistance in Psychotherapy

Aisling McMahon

Aisling McMahon is a Senior Clinical Psychologist and Humanistic and Integrative Psychotherapist working in private practice in Lucan, Co. Dublin. She is a Registered Member of PSI and an accredited member of the Irish Association of Humanistic & Integrative Psychotherapy. Correspondence may be sent to the author by email at aislismahon@gmail.com

The unenlightened are always anxious. Like the man in the river who doesn't know how to swim. He becomes frightened. So he sinks. So he struggles to keep afloat. So he sinks even deeper. If he dropped his fear and allowed himself to sink, his body would come to the surface on its own.

Anthony de Mello (1989, p. 166)

Introduction

Clients attending psychotherapy struggle with opposing needs and wishes – while wanting personal change, they can also be fearful and resist inhabiting it. Holmes and Bateman (1995) describe resistance as referring to: “the myriad of methods a patient uses to obstruct the very process that he [or she] is relying on to help him [or her]” (pp. 163–164). Resistance is apparently a counter-productive process, but most psychodynamic therapists also see it as a valuable focus for a “transformational psychotherapy” – an absence of resistance possibly signalling a “stagnant or lazy therapy” (Davy & Cross, 2004, p. 18). Thus, while working to facilitate client change, movement and growth, as therapists we can benefit from an understanding of how to work with client resistance, fear and desire for stasis.

Psychotherapists and psychologists have highlighted different aspects of resistance during therapeutic work. Many have described how resistance is fuelled by a wish to avoid psychic and emotional pain (e.g., Bateman, Brown, & Pedder, 2000). Yalom (2001) notes how resistance can

occur through fear of intimacy or exposure to another's rejection, abandonment or exploitation. Bugental (1987) asserts that resistance is: “the impulse to protect one's familiar identity and known world against perceived threat” (p. 175). To deepen our knowledge of this central issue, this article explores the insights for both understanding and working with resistance as offered by four major psychodynamic theoretical frameworks: psychoanalytic, object relations, gestalt and body-oriented psychotherapies. In the author's experience, drawing from more than one theoretical framework offers a greater range and depth of potential understanding of each particular client's history, current concerns and future personal development. In addition to the benefits of drawing from a wide theoretical base, a theme running through this article is the importance of the therapist entering into an authentic, empathic relationship with the client, while encouraging and supporting the client to work with resistance to change. To help ground some of the theory, two client examples will be used as illustrations. Their names and identifying information have been changed to protect their anonymity.

Psychoanalytic Theory

It was Freud (1916–17) who originally pointed out how, throughout treatment, the client: “meets us with a violent and tenacious resistance” (p. 327). He named five types of resistance: three types having their source in the ego, one in the id, and one in the superego (Freud, 1926).

The first ego resistance Freud called “repression resistance” – keeping anxiety-provoking drives out of consciousness. The second, “transference resistance”, is the person's repetition of the past, without memory or conscious awareness. Third is the ego resistance caught up in the secondary gains of being “ill” (e.g., meeting dependency needs).

Resistance from the id is believed to be caused by the libido's adhesiveness, which remains compulsively attached to its objects (i.e., the external objects or people from which the person sought infantile gratification). These intense attachments fuel the repetition compulsion, where the individual replays his or her early relational experience in current relationships, including the therapeutic relationship.

Freud believed resistance from the superego involves unconscious guilt and the need for punishment, as an attempt to ease the guilt. Although essentially seen by Freud as obstacles to be overcome, he argued that resistances, through their repetition in the transference:

“include so much of the most important material from the patient's past and bring it back in so convincing a fashion that they become some of the best supports of the analysis if a skilful technique knows how to give them the right turn” (Freud, 1916–17, p. 332).

Freud believed that our clients need to move from acting out their repressed early conflicts in the transference relationship into remembering and working through those conflicts. This is done through interpretation of unconscious material to the client, bringing the client from contemporary symptoms and concerns back to their early origins.

In relation to Freud's rule that the client has to be led from acting out to remembering, from the contemporary to the infantile, Reich (1972) added that before this takes place, what has been “chronically stultified” has to attain “a new living reality in the contemporary transference” situation (p. 85). In other words, the client needs to become emotionally engaged in re-experiencing his or her early conflictual or unsatisfying relational experience in the here-and-now relationship with the therapist. Then, we have the opportunity for experiential insight and change rather than intellectual insight

* McMahon, A. (2009). The fear of change: understanding and working with client resistance in psychotherapy. *The Irish Psychologist*, 35, 352-356. Reproduced with permission of the editors of *The Irish Psychologist*.

UNDERSTANDING RESISTANCE IN PSYCHOTHERAPY: the paradox of both wanting and fearing change

by **Aisling McMahon**

"The unenlightened are always anxious. Like the man in the river who doesn't know how to swim. He becomes frightened. So he sinks. So he struggles to keep afloat. So he sinks even deeper. If he dropped his fear and allowed himself to sink, his body would come to the surface on its own."

Anthony de Mello (1989, p.166)



Introduction

Facilitating others in making significant personal changes, helping them open out into freer and more spontaneous lives from a history of trauma or restriction, is fundamentally a very satisfying way to make a living. However, the path of personal growth is rarely a smooth one. As therapists, and indeed as clients ourselves, we have all experienced the conflicted reality of wanting personal change while also being fearful and resisting moving towards that change. Holmes and Bateman (1995) describe resistance as referring to: "the myriad of methods a patient uses to obstruct the very process that he is relying on to help him" (p.163-4). However, while resistance is apparently a counter-productive process, most psychodynamic therapists agree that it can provide a valuable focus for a "transformational psychotherapy", an absence of resistance possibly signalling a "stagnant or lazy therapy" (Davy & Cross, 2004, p.18).



* McMahon, A. (2009). Understanding resistance in psychotherapy: the paradox of both wanting and fearing change. *Eisteach*, 9(4), 9-13. Reproduced with permission of the editors of *Eisteach*.

The Value of Allowing Space to Receive and Work with the Client's Idiom

by Aisling McMahon

Introduction

As psychotherapists we are called upon to enter into our clients' phenomenological worlds, to bear witness to their personal experience in a way that can affect us at various levels - cognitively, emotionally, somatically, spiritually. Much of the resonating that occurs within us when with our clients happens outside our conscious awareness and the richness of the knowing that is available to us can be missed or unrecognised unless we give it the space and attention it needs. In this article I would like to offer an illustration of some valuable work that can take place when we open up our awareness of how we are affected by the client's unique voice, relationship style or idiom and offer some of that awareness back to our clients.

In my practice as a clinical psychologist and integrative psychotherapist, I work with individual adult clients over varying lengths of time - some people come for only a short period of work, having a more pragmatic focus or a defined piece of exploration that they want to do, and others come for, or end up staying for, deeper, more long-term or substantial work. As my original training is as a clinical psychologist, I am relatively well known within that field and more people come to me or are referred to me within that role, often having an expectation of more short-term, cognitive work. I, of course, will readily meet with people at that "head level" but will also invite them to connect with themselves and with me at deeper levels too, even in short-term work - this invitation being gentle and respectful of the readiness and vulnerability/strength of the client. I have become increasingly aware that, even in short term work, the client's idiom is strongly present and strongly communicated to the therapist, often even from the first session, and that aspects of this can usefully be received, partly digested, articulated and offered back to the client to be worked with, and more fully chewed on together.

The client's idiom and the therapist's countertransferential knowing

A definition of "idiom" from the New Penguin English Dictionary (2002) is: "a characteristic style or form of artistic expression...from Greek *idioma* individual peculiarity of language, from *idios* one's own, private." (2002:696). Christopher Bollas (1987) brought the term into the

psychotherapeutic field by talking of the client's idiom and his or her idiomatic use of the therapist, the client creating a unique interpersonal environment. To understand and come to know the client's idiom, Bollas richly describes the value of therapists exploring and respectfully working with their countertransference in the therapeutic relationship. Similarly, David Sedgwick (1994) offers wonderful illustrations of working with layers of inner experience that are evoked in the therapist in relation to clients. In relation to working with the countertransference, Robert Young (1994) writes of the interactive, phenomenological or dialectical space between therapists and clients, where meaning is mutually constructed and where both the therapist and client learn most through evocative knowledge - that is, by what we evoke in each other. I am only lightly touching on a few theoretical references here as I want to give most space to describing my work with a client, Deirdre, to offer a fairly simple but meaningful illustration of how an important aspect of the client's idiom can come into, and be worked on, in the therapeutic relationship. The client's name has been changed and she has given permission for our therapeutic experience to be described here.

An illustration

Deirdre came to see me for six sessions at her workplace's request as she had remained on sick leave for many months following a bereavement. While therapeutic work was new to Deirdre and she was initially unsure if this was what she wanted or was comfortable with, she in fact settled into the work quite quickly and Deirdre showed good engagement with me and with her emotions. While I felt very welcoming of Deirdre and I felt comfortable offering her a safe space to work through her grief, I found another layer of judgement as I reflected on our first session together. After I had taken note of the main themes in her life and in relation to her grief, essentially the content of our work together, I asked myself how I received Deirdre, how I felt about her and what fundamental statement she was making to me about herself or what statement I was making to myself about her. I then noticed a critical voice in me, a judgment that Deirdre was "just" a mother, "just" an office worker, that she didn't have that much to say that was deeply interesting, that at some level I was dismissing her as someone whose range and depth was limited.

In the following few sessions, as we worked on Deirdre's bereavement and on the impact of her loss on her other relationships and her own sense of meaning and worth, I had an evolving sense in each session that Deirdre had

* McMahon, A. (2010). The value of allowing space to receive and work with the client's idiom. *Inside Out, The Journal of the Irish Association of Humanistic and Integrative Psychotherapy*, Vol. 60 (Spring), 16-20 (online: www.iahp.org). Reproduced with permission of the editors of *Inside Out*.

- *Contents page and summary of recommendations from policy document I wrote on behalf of Psychology Department, 1996:*

DEPARTMENT OF JUSTICE CLINICAL PSYCHOLOGY SERVICE

**SUBMISSION ON THE MANAGEMENT OF DRUG ABUSE AND
ADDICTION IN THE PRISONS**

March 1996

TABLE OF CONTENTS:

Section		Page no.
1	Policy statement: A co-ordinated approach to drug abuse and addiction in the prisons.	1
2	Prevention	
	2.1 Goals of prevention	2
	2.2 Supply and demand reduction	2
	2.3 Information and education	2
	2.4 Drug free units	2
3	Intervention	
	3.1 Heterogeneity of the population	3
	3.2 Model of behaviour change	4
	3.3 Co-ordination of prison-based initiatives	6
	3.4 Models of intervention	7
	3.5 General issues regarding drug programmes	9
4	Rehabilitation	12
5	Summary of Recommendations	13
	Bibliography	14

SECTION 5

SUMMARY OF RECOMMENDATIONS

The following points have been highlighted in the text of this document and are summarised here as the main recommendations of the Department of Justice Clinical Psychology service regarding the management of drug abuse in the prisons:

- 1. A general strategy needs to be articulated to guide the development of substance abuse programmes in the prisons.**
- 2. The preparation and implementation of a co-ordinated strategy regarding drug addiction and abuse within prisons should include the following principles: prevention, intervention and rehabilitation.**
- 3. Professional expertise, a PR company, should be engaged to produce notices that will be effective in preventing drug abuse.**
- 4. All categories of offenders should have the right to serve their sentence in a drug free unit and drug free landings/units need to be planned for every major institution.**
- 5. A survey to be carried out by Dr. Paul O' Mahony has been proposed to provide an update on the level of drug use and addiction within the prisons. This survey will provide essential information for matching the different strategies needed to the various target groups.**
- 6. Treatment initiatives must reflect the fact that each known addict will be at a different stage in readiness to change to a drug free lifestyle.**
- 7. It is recommended that a system of categorisation is developed which allows the identification of appropriate target groups for different intervention strategies. To this end, it is proposed that the Prochaska and DiClemente model of change forms the basis for such a categorisation.**
- 8. Different treatment options need to be available to facilitate choice on behalf of the offender, thus fostering a greater commitment to initiating and sustaining change.**
- 9. It is recommended that a steering committee be formed at Department level, made up of the specialist services in this area - psychology, probation and welfare, and medical services.**
- 10. As well as a specialist Departmental committee, it is recommended that a multidisciplinary team be appointed in each institution to plan, co-ordinate, implement and evaluate current and new initiatives.**
- 11. There is a need for training to develop awareness regarding drug addiction amongst staff.**
- 12. Measures need to be developed to ensure accountability to both short-term and long-term programme objectives.**

➤ **Letter from Director of Psychology regarding early auditing work, 1993:**



Hospitaller Order of St. John of God
Child and Family Centre

Telephone 977596
Fax 967423

59, Orwell Road,
Rathgar,
Dublin 6.

September 2, 1993

Ms. Aisling McMahon, M.A. M.Psych.Sc
Clinical Psychologist
Cluain Mhuire Family Centre
Newtownpark Avenue
Blackrock
Co. Dublin,

Dear Aisling,

I wish to thank you for your recent audit of the work you have completed over the past six months. It is an excellent example of the issues we have discussed recently at our psychology department meetings.

The detail of the report and the analysis of the information as well as the conclusions and recommendations drawn will be very helpful in planning for the future of the services in Cluain Mhuire.

Thank you for this and for the high quality of the other work which I know you are doing in the service.

Sincerely,

Patrick Walsh Ph.D
Director of Psychological Services

Appendix 1.2:

Therapeutic practice training workshops for psychologists and some past training work

➤ **Information sheet for workshops:**

**A Series of Four One-Day Workshops for Clinical Psychologists
in the Theory and Practice of Psychodynamic Psychotherapy
with Adults**

**Workshop facilitator: Aisling McMahon, Reg. Psychol. Ps.S.I., MIAHIP,
MIACP**

Senior Clinical Psychologist and Integrative Psychotherapist

About the workshop facilitator:

Aisling is an experienced clinical psychologist and psychotherapist. She qualified from UCD as a clinical psychologist in 1992 and has worked for nearly two decades in various settings, including community care services for children and adolescents, community-based adult psychiatric services, the Irish prison system, private practice and a psychiatric hospital setting. She trained as a humanistic and integrative psychotherapist in the Dunlaoghaire Institute of Creative Counselling and Psychotherapy, qualifying in 2005. Aisling is currently engaging in a Doctorate in Psychotherapy at the Metanoia Institute in London.

Rationale and format for the workshops:

Since her clinical psychology training, Aisling has always found therapeutic work to be the most interesting, satisfying, and also challenging part of her work. From personal experience, Aisling has realised the fundamental value of incorporating three essential strands to support and develop one's practice as a therapist, whatever one's theoretical orientation, and whatever the client group:

- *Personal process work*, ideally including experiential learning and personal development work through both individual and group therapy. This does not need to be ongoing but therapeutic work demands a lot of the person of the therapist - the deep support and personal learning from one's own experience in therapy offers a rich base from which to do therapeutic work with others.
- *Regular process supervision* (as distinct from case- or work-load management), this being an essential aspect of good professional practice as a therapist, both to develop one's personal resources and competence and to enhance the client work.
- Engaging in opportunities for both *theoretical and skills development in therapeutic work*. This can include a wide range of work from regular reading to attending skills development workshops to engaging in full training as a psychotherapist.

These workshops aim to address the third area above, ***offering the opportunity for both theoretical and skills development in therapeutic work, the focus being on therapy with individual adults***. The workshops are particularly addressed to clinical psychologists. The broad clinical training we engaged in offered us a wonderful array of competencies and knowledge across the life span, with client groups of differing abilities and needs, with skills in multidisciplinary work,

consultancy, teaching, assessment, and various forms of intervention. We are the quintessential “Jacks-of-all-trades”, our adaptability and flexibility in addressing service and client needs being our real strength as clinicians and team members. However, therapeutic work is often a substantial part of our work as clinical psychologists and, even though we follow best practice and continue to learn through our clinical experience, our ongoing reading and our CPD work, the lack of a broader or more in-depth training in this area can leave us at times feeling less equipped than we would like. For those clinical psychologists who do a significant amount of therapeutic work with clients, there can be great value in taking part in some further training in this area.

These workshops do not attempt to substitute for formal psychotherapy training but they do offer the opportunity for guided discovery and skills development in some fundamental and valuable areas. The expectation or goal of these workshops is that they will facilitate some expansion of the theoretical and personal resources available to workshop participants in their ongoing therapeutic work with clients. Each workshop follows a main theme, reflected in its title (please see below, these titles having been selected by clinical psychologists surveyed in November as the ones of greatest interest). There will be some initial teaching to offer a theoretical grounding and framework for the day’s work, which will include discursive engagement within the group with the theory and its illustration with client examples (participants will be encouraged to bring in client material for theoretical discussions and for role plays). Each group will then progress onto more practical and experiential skills development through a combination of experiential role play, facilitator modelling and, where relevant, use of video material.

The workshops will be run *with a maximum of 12 participants* for each group. Learning and skills development will be done in a respectful, bounded and supportive way. In anticipating taking part in experiential learning, it is worth noting that there may be some ambivalence about the potential exposure involved in front of peers. In these situations, we often put ourselves under pressure to perform well and to showcase our experience and skills. However, this training offers the opportunity for participants to let go of that pressure and to allow themselves the freedom to explore and discover new aspects of their therapeutic work.

There will be a *process of evaluation and development of these workshops* as they are being delivered so participants will be asked to fill out some brief questionnaires and for their permission to anonymously use some of their workshop material as part of this process of evaluation. Taking part in the evaluation is not a requirement of attending and participants are free to opt out of this, or indeed to later withdraw permission. Further details about this will be available at the workshop and can be explained further on booking if desired.

Some advance reading material will be sent to participants before each workshop. Participants will also be asked to engage in some specific exploration and reflection on a relevant aspect of their client work before each workshop - this advance work will enhance learning on the day.

➤ **An example of a completed pre-workshop questionnaire:**

Psychodynamic workshops: pre-workshop questionnaire

I would appreciate you filling out this questionnaire before you come to your first psychodynamic workshop so that I can have some understanding of the work and therapeutic background of the participants. This will be of great help when evaluating these workshops.

Are you trained as a clinical psychologist **or a counselling psychologist**
_____?

How long have you been working as a qualified psychologist?

Less than 5 years: ; 6-10 years: _____; 11-15 years: _____; 16 years or more:
_____ *5½ yrs*

Have you had any other formal therapeutic training? Yes _____ No If yes, please specify:

Approximately how much of your working time do you spend with clients in psychotherapy (including individual, couple, family and group therapy)?

Less than 20% _____; 20-40% _____; 41-60% _____; 61--80% ; 81-100%

In which of the following areas, if any, do you have previous experience of psychodynamic theory or practice? Tick more than one if relevant:

Personal psychotherapy Supervision received _____ My supervisory work _____

Client work Reading Previous training events (please specify length/amount of

training _____ None

Other, please specify

How would you identify your practice as a psychotherapist? Please tick the relevant one(s) below:

Psychological therapist Cognitive-behavioural therapist

Systems/family therapist _____ Psychodynamic therapist _____

Gestalt therapist _____ Humanistic therapist _____

Integrative therapist (please note the main forms of therapy you have integrated): _____

Psychodynamic workshops: pre-workshop questionnaire

Eclectic therapist (please note the main forms of therapy you draw from): cbt, dbt,
attachment informed work, mindfulness-based
interventions

Other (e.g., cognitive-analytic, attachment theory based, Jungian, etc.), please specify:

Have you attended your own personal individual psychotherapy? Yes No:

If yes, for approximately how long altogether to date?

Less than 6 mths 6mths-1 yr 1-2yrs 2-3 yrs more than 3
years

Now, I'd appreciate hearing something of your expectations in relation to these workshops.

Which aspect of the forthcoming workshop(s) are you particularly interested in? (**please rank order** according to your strongest interest, 1 being the strongest, leave blank if not interested):

Theoretical input 2 Recommended reading material 1 Experiential skills training
1

Peer discussion 2 Exploration of client material 1

What prompted you to apply for the workshop(s)?

I would welcome the opportunity to increase my understanding
of, and ability to work effectively with, the complex dynamics
of the therapeutic relationship which in turn, will hopefully
impact positively on both client and my own satisfaction within
the encounter. Realising more and more how fundamental working
at this level is and of my need/wish to upskill in this regard

At this point, what do you believe would cause you to feel disappointed in the workshop(s)?

If after the workshop, I didn't feel that I was reflecting
or had any greater understanding of, or greater ability to
be aware of and work with, both my own and client's
reactions within the therapeutic relationship

And finally, at this point, what key things or experiences would need to be present for you to feel satisfied in the workshop(s)?

Case discussion. Time for reflection re own practice
Opportunity to hear from facilitator re own experiences in
terms of working with clients dynamically!

➤ **A sample of completed feedback questionnaires on psychodynamic workshops:**

**Feedback questionnaire on Psychodynamic Workshops:
1. The therapeutic relationship, 26th February, 2010**

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's workshop.

The workshop met my expectations.

Not at all Very much so

1 2 3 4 5 6 7

The workshop was interesting and informative.

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the theoretical aspects of the workshop:

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the experiential-skills development aspects of the workshop

Not at all Very much so

1 2 3 4 5 6 7

The best thing(s) about today's workshop was/were:

Feedback from the mini therapy sessions. It helped me to understand my clients better & gave me more confidence & trust in the therapeutic process.

To improve this workshop, I would have liked if there was more, or less, of:

I think it was great. I can honestly not name a single thing that I would change.

Feedback questionnaire on Psychodynamic Workshops:
2. Transference and countertransference, March 26th, 2010

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's workshop.

The workshop met my expectations.

Not at all Very much so
1 2 3 4 5 6 7

The workshop was interesting and informative.

Not at all Very much so
1 2 3 4 5 6 7

I was satisfied with the theoretical aspects of the workshop.

Not at all Very much so
1 2 3 4 5 6 7

I was satisfied with the experiential-skills development aspects of the workshop.

Not at all Very much so
1 2 3 4 5 6 7

The best thing(s) about today's workshop was/were:

I really enjoyed the experiential (personal) parts of this workshop today. Felt v. energized - day flew or bi-annually
Would you consider any sort of quarterly workshop/process support group on an ongoing basis

To improve this workshop, I would have liked if there was more, or less, of:

It was perfect!
Look forward to the next one -
I think the personal experiential work while forgetting is extremely powerful

➤ **Examples of completed feedback questionnaires on hospice volunteer counselling skills training workshops, 1997 & 1998:**

EVALUATION OF COUNSELLING SKILLS TRAINING

Using the following scale, please rate how useful the sessions on counselling skills were to you:

0 1 2 3 4 5 6 7 8 9 10

✓

What aspects of these sessions were most useful?

Roleplay was very helpful to me, they made me more confident and was able to role my mistake
Open discussion very helpful, and discussions with each other interesting

What aspects of these sessions were least useful?

None

Have you any suggestions for how this part of the course could be improved?

Shorten break, more time for Roleplay
Ending at 4.30 INSTEAD of 4 pm.

General comments:

Very enjoyable day, it passed too quickly
Arlene was more than helpful and an excellent teacher, kept us working all the time so helpful with the Role-Play.
Created such a friendly atmosphere & encouraged covered so many items us so well.
Many thanks for taking the time to complete this. We learnt a lot.

EVALUATION OF COUNSELLING SKILLS TRAINING

Using the following scale, please rate how useful the sessions on counselling skills were to you:

0 1 2 3 4 5 6 7 8 9 10

What aspects of these sessions were most useful?

- ① Role play with discussion afterwards
- ② Handouts ← How to
- ③ Putting words on non verbal skills and closely examining verbal skills.
- ④ Basically everything!

What aspects of these sessions were least useful?

Have you any suggestions for how this part of the course could be improved?

More counselling skills sessions.

General comments:

Coming from a background of non counselling skills, I took everything on board and found these sessions the most useful of the entire course.

Many thanks for taking the time to complete this.

Appendix 1.3:

Phenomenological research with psychologists on their therapeutic practice

Consent form for evaluation of psychodynamic workshops

These one-day workshops on the theory and practice of psychodynamic psychotherapy are being evaluated by the facilitator, Aisling McMahon, as part of her current work on a Doctorate in Psychotherapy with the Metanoia Institute and Middlesex University.

As part of this evaluation, Aisling is requesting permission for the anonymous use of some of your workshop material. This anonymous material will be used professionally and respectfully in any representation of it which may arise from the evaluation of these workshops - e.g., in any published work, such as professional journal articles.

The material that will be used for this evaluation includes:

A pre-workshop questionnaire for participants on therapeutic practice, training and experience, and expectations of the workshops;

A reflexive journal completed by participants at the beginning and end of each workshop.

Your name will not be written on any material that is used for the evaluation. If you are doing more than one workshop in this series of four workshops, you will be asked to record in the same reflexive journal - to protect your identity, your journal will be given a symbol, which you will be asked to remember.

Aisling will give feedback to participants on the outcome of this evaluation work when it is completed. Please tick here if you would like to be included in receiving this feedback.

You are in no way obliged to take part in this evaluation work as part of your attendance at these workshops and you are free to decline to take part without there being any prejudice to your involvement or participation in the workshops.

If you give your consent now to take part in this evaluation, you are still ***free at any time to change your mind*** and to withdraw permission for your material to be used in the evaluation of these workshops.

If you want to discuss any of this further or would like further information, please contact Aisling at 087-2617188 or at aislismcmahon@gmail.com

Name: (in block capitals) _____

Signed: _____

Date: _____

Countersigned: _____

Aisling McMahon, M.A., M.Psych.Sc., Dip.Psychotherapy
Senior Clinical Psychologist, Humanistic & Integrative Psychotherapist

➤ ***First page of article submitted for publication to journal of
Clinical Psychology and Psychotherapy***

**“It’s hard to feel on the ball”: Practising psychotherapy as a clinical
psychologist**

Aisling McMahan

Aisling McMahan is a Senior Clinical Psychologist and Humanistic and Integrative Psychotherapist working in private practice in Lucan, Co. Dublin, Ireland. She is a Registered Member of PSI and an accredited member of IACP and IAHIP. Correspondence may be sent to the author by email at aismcmahan@gmail.com

Abstract

This article presents a qualitative phenomenological study of the reflections of psychologists practising psychotherapy. The journals of 25 psychologists (20 of whom were clinical psychologists), which were completed at psychotherapy practice workshops, were subjected to a thematic analysis, and 7 of these journals, all by clinical psychologists, underwent a closer phenomenological analysis with Interpretative Phenomenological Analysis (IPA). Ten recurring themes in relation to their psychotherapy practice were identified and were subsumed under two super-ordinate themes – ‘impact on the self’ and ‘professional needs’. The results, with illustrative quotes of the ten themes, and including a more individualised view of the experience of three of the clinical psychologists from the IPA analysis, are described. The implications for the initial training and ongoing professional development of clinical psychologists practising psychotherapy are discussed.

Key words: clinical psychology, psychotherapy, training, continuing professional development, qualitative analysis, thematic analysis, interpretative phenomenological analysis (IPA)

Introduction

Working as a clinical psychologist is an engaging and demanding enterprise. During training we develop a wide breadth of competencies and skills, we engage with individuals of various ages and abilities, and we work with families, carers and with teams in a number of different organisations and services. Once qualified, we often take positions of leadership and advocacy in teams and services, carry out comprehensive assessments and systemic interventions, while also engaging intimately with the concerns and needs of our clients in our therapeutic work. O’Connor (2001) has highlighted the multiplicity of psychologists’ roles, saying that: “Psychologists may be teacher, administrator, researcher, therapist, mediator, entrepreneur, crisis counsellor and referral source all in the course of a day, sometimes changing roles by the hour” (p.346).

While there are varying responsibilities, a core part of the workload of most clinical psychologists is psychotherapeutic work. Aherne et al (2001) found that 88.5% of clinical

Appendix 1.4:

PSI Clinical Division AGM presentation and example of past committee work



DIVISION OF CLINICAL PSYCHOLOGY

ANNUAL GENERAL MEETING

DATE:	FRIDAY 8 th October 2010	
TIME:	AGM	9:30 - 10.00
	Resilience in practising psychotherapy	10.00 - 11.15
	Break	
	Developments in Psychology	11.45 - 1.00
	Lunch	1.00 - 2.00

VENUE: **Aisling Hotel, Dublin** (near Heuston Station)

SPEAKERS: Aisling McMahon, Senior Clinical Psychologist and Integrative Psychotherapist will speak on 'Resilience and vulnerability in practising psychotherapy: needs, challenges and opportunities'.

Gerard Perry, Clinical Director of Psychology will speak on 'Developments and reflections on Psychology in Ireland today'.

REGISTRATION: 9AM – 9.30

CPD POINTS AWARDED FOR ATTENDANCE

➤ *Format of Clinical Division AGM presentation, 2010:*

Resilience and vulnerability in
practising psychotherapy:
Challenges, needs and opportunities

Aisling McMahon
Senior Clinical Psychologist &
Psychotherapist
Clinical Division AGM
Oct 8th, 2010

Practising psychotherapy as a
clinical psychologist

Reflective piece – what burdens me and supports
me in my therapeutic work?

Qualitative research with Irish
psychologists practising psychotherapy

Brief look at the literature

Review and discussion

➤ Example of completed survey form at Clinical Division AGM, 2010:

Anonymous survey on aspects of self-care, development and support for clinical psychologists' therapeutic practice, Clinical Division AGM, October 2010

Have you attended individual personal therapy?

Yes, currently _____ Yes, in the past _____ No

If not, are you likely to attend personal therapy in the future? Yes _____ No

If yes, for what main reason(s)?

If no, for what main reason(s)?

Never felt a need - feel that I get the support / space to process with family / friends

Do you attend individual process supervision? (as opposed to line management/workload/service management meetings) Yes, currently Yes, in the past _____ No _____

max of process + casework

If, yes, do you or did you do this internally in your workplace or externally? Internally

If externally, did you get your workplace's support in:

time _____ financing _____ both time & financing _____ neither _____

Do you attend a peer supervision group? Yes, currently _____ Yes, in the past No _____

How do you update/refresh/affirm/get validation for your therapeutic knowledge and skills?

Reading articles or books: How often? (e.g., weekly, monthly, every few mths..) _____

Attending practice or theory workshops: How often? No of times a year if finances allow

Working with other therapists (e.g. group work, family work): How often? weekly with 4 colleagues

Please note any other ways:

Can you list the most important and useful things you do to look after your own needs as a psychologist who practices psychotherapy? (e.g., sport, meditation, time with family or friends, personal therapy, supervision, reading, attending workshops, music, etc.....)

1. Reading + discussion with 4 colleagues
2. Supervision
3. Running + walking
4. Time Alone
5. Cooking nice meals + eating them w family, friends - wine!

With very grateful thanks for your time in completing this survey, Aisling McMahon – if you wish to contact me in relation to this survey or any issues within it, please do at 087-2617188 or aismcmahon@gmail.com

- *Example of past work done at professional body level: results of a survey I carried out with Irish clinical psychologists, 1996:*

CLINICAL DIVISION NEWS: RESULTS OF QUESTIONNAIRE

The Clinical Division are pleased to report an overview of the results of the questionnaire which we developed to help us review the work of the Division, with the aim of more clearly representing the needs of Clinical Psychologists. The questionnaire was available for Clinical Psychologists to complete at the 1996 PSI Conference and it was also circulated to Clinical Psychologists around the country. In all, 91 questionnaires were returned and we are grateful for the time people took to give us their comments and suggestions.

When asked *what Clinical Psychologists wanted from the Clinical Division*, nearly three-quarters of respondents prioritised two main needs. One is for the Division to organise workshops and seminars for skill/knowledge development in areas of clinical practice. A second priority is for the Division to provide representation for Clinical Psychologists, in the face of changes in the profession and in allied professions, regarding statutory registration and career structure, and on issues of continuing professional development.

When faced with an open-ended question on *how the Clinical Division could improve*, the responses were varied and informative. The most common suggestion (made by over one-third of respondents) was for the Division to work on increasing its profile through better communication with members and within PSI generally. Concrete suggestions on this included starting a Division newsletter for members, and developing a clear agenda for the work of the Division, shared by the profession, through more involvement of members. A consistent message from many respondents was that the Division needed to "sell" its wares more and prove to Clinical Psychologists that it is worth joining the Division. Other suggestions included a focus on running training workshops, monitoring training and employment criteria for Clinical Psychologists, and work on increasing the profile of Clinical Psychology generally in the public arena.

Of the respondents, 75% were not members of the Clinical Division. Of those individuals, the most common *reason for not being a member of the Division* was an intention to join that had just not been acted upon (noted by 42%). A significant number commented that they did not know what the benefits of joining would be, being unsure of the activities of the Division, again showing the need for a heightened profile. An interesting and welcome outcome of the questionnaire was a high rate of interest in joining the Division from respondents, two-thirds of non-members requesting that membership application forms be sent out to them.

The Clinical Division Committee are actively beginning to implement the suggestions of respondents and we feel more clearly mandated to follow certain strategies in our work. The good turnout at this year's AGM and the lively debate on a number of issues has also given us plenty of substance to work with over the year to come. We will continue to communicate more regularly with Clinical Psychologists generally through this news item in the IP. We also will be circulating a regular newsletter to our members. We also plan to follow the advice of involving our membership more in the Division, rather than trying to do too much work on our own as a small committee. We intend to tackle some of the important issues above, on which Clinical Psychologists are seeking representation, by setting up small working groups within our membership. We will also continue to organise workshops for Clinical Psychologists, our next event being organised for the PSI Conference in Ennis this year.

Many thanks again to those of you who helped to put some fire in our veins - we hope to continue to grow as a Division and to be seen as an effective representative body for the Clinical Psychology profession - remember, we need your ongoing help and involvement to allow this to happen!

Aisling McMahon,
Secretary, PSI Clinical Division.

Appendix 1.5:

PSI Annual Conference Workshop

Psychological Society of Ireland

Annual Conference 2010



Saturday 13th November 2010

Registration: 8.30am – 9.00am

Session A	Session B	Session C	Session D	Session E
<p>9.00am – 10.30am Individual Papers in Clinical Psychology</p> <p>Mark Smyth Early and short-term intervention for recent onset anxiety in children</p> <p>Pauline Beegan Depathologising dissociation</p>	<p>9.00am – 10.30am Symposium Novel Approaches to Cognitive Disorders in Acute Hospital Settings</p> <p>Andrew Magee, Gillian Fortune, Niall Pender, Teresa Burke, et al. A retrospective review of patients with Non-Epileptic Attack Disorder</p> <p>Gillian Fortune, Brian Lamont, John Thornton, Mark Mulrooney, et al. The Wada Test: A child-centered approach</p> <p>Mark Mulrooney, Niall Pender & Andrew Magee “Effort”: A new index</p> <p>Mark Mulrooney, Niall Pender, Teresa Burke & Helen Maher Best Test: “The best a man can get”</p>	<p>9.00am – 10.30am Individual Papers in Educational Psychology</p> <p>Aisling Murray & GUI Study Team Effect of parenting style on academic achievement</p> <p>Barbara Caska Measuring student attitudes toward attendance: Development and assessment of the AT CLASS Scale</p> <p>Gráinne Ní Dhómhnaill Absent from school: The psychology of non-attendance</p> <p>David McLroy, Louise Marshall & Val Todd Secondary level achievement: The role of personality and ability</p> <p>Emma Harkin & Howard Smith Investigating the levels of stress, self-esteem, psychological well-being and academic self perception of fifth- and sixth-year leaving certificate and leaving certificate applied students</p>	<p>9.00am – 10.30am Individual Papers in Behaviour Analysis</p> <p>Ita Forde, Jennifer O'Connor & Julie Brosnan A dyadic analysis of the functions of language emitted by children with autism compared to typically developing children across settings, communicative partners and spontaneity of language</p> <p>Clodagh Mary Murray & Olive Healy Outcomes of a home-based behavioural intervention programme for a 7-year-old boy with traumatic brain injury</p> <p>Michelle Kelly Pica: A review of behavioural interventions</p> <p>Laura Moran, Ian Stewart, John McElwee & Siri Ming The training and assessment of relational precursors and abilities: A preliminary analysis</p>	<p>9.00am – 10.30am Workshop</p> <p>Aisling McMahon Psychodynamic psychotherapy: Engaging with insight, emotional immediacy and authentic relationship</p>

10.30am – 11.00am

Tea/coffee served in the Siege Suite and the Burke Suite 2

Session A	Session B	Session C	Session D	Session E
<p>11.00am – 12.00pm Individual Papers in Clinical Psychology</p> <p>Aisling White, Yvonne Quinn & James McFadden What, if anything, is different about primary care psychology?</p> <p>Alexandra Diana & John O'Connor Interpersonal relations, sexuality development and sexual fantasies of men who engage with child pornography: An exploratory study</p> <p>Claire Barrett & Paul D'Alton BRCA gene carriers: An understudied population with significant psychological distress</p>	<p>11.00am – 12.00pm Individual Papers in Intellectual Disability</p> <p>Marie Walsh, Audrey Pidgion, Geraldine Cregg & Niamh O'Dowd Development and evaluation of a stay safe, personal development and relationships training programme for people with severe and profound intellectual disabilities</p> <p>Marian O'Gorman & Suzanne Guerin Exploring the development and use of equine-assisted personal development for adults with a mild/ moderate intellectual disability</p> <p>Eileen Dukas Consultation with</p>	<p>11.00am – 12.00pm Individual Papers in Health Psychology</p> <p>Emily Bloxham & David Hevey Relationships among self-objectification, body esteem, self-esteem, reasons for exercise and exercise experience in Irish fitness centre members</p> <p>Sharon Mary Cruise, Fiona Alderdice, Maria Lohan, Carolyn Corkindale, et al. Examining the factor structure of the Idealisation of Pregnancy and Parenthood Scale among Irish and Australian adolescent males</p>	<p>11.00am – 12.00pm Individual Papers in Forensic Psychology</p> <p>Mary Walker & Margaret O'Rourke Sex Offenders in Ireland: Reviewing systems and safety</p> <p>Michael Nopprapun & John Bogue Response latency as a cue to deception: Support for the activation-decision- construction model of lying</p> <p>Daniel Boduszek & Christopher McLaughlin The role of antisocial peers, recidivism and personality in development of criminal attitudes of ex-offenders</p>	<p>11.00am – 12.00pm Workshop</p> <p>Stephen McBride Functional Family Therapy: Its implementation for at-risk youth in a disadvantaged community in Dublin</p>

➤ **Samples of completed feedback questionnaires:**

Feedback questionnaire on Psychodynamic Workshop:
PSI Conference, November 2010

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's workshop.

The workshop met my expectations.

Not at all Very much so

1 2 3 4 5 6 ⑦

The workshop was interesting and informative.

Not at all Very much so

1 2 3 4 5 6 ⌀

I was satisfied with the theoretical aspects of the workshop.

Not at all Very much so

1 2 3 4 5 6 ⌀

I was satisfied with the experiential aspects of the workshop.

Not at all Very much so

1 2 3 4 5 6 Ⓞ

The best thing(s) about today's workshop was/were:

Very 'User friendly'
Made emotional engagement in
exercises very easy & non threatening
insightful & enjoyable.

To improve this workshop, I would have liked if there was more, or less, of:

Just fine - well done

Feedback questionnaire on Psychodynamic Workshop:
PSI Conference, November 2010

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's workshop.

The workshop met my expectations.

Not at all Very much so

1 2 3 4 5 6 7

The workshop was interesting and informative.

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the theoretical aspects of the workshop.

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the experiential aspects of the workshop.

Not at all Very much so

1 2 3 4 5 6 7

Scary!

The best thing(s) about today's workshop was/were:

Very clear Powerpoint & exposition.
The experiential exercise
Good management of the time
Your very personal, accessible style - stillness

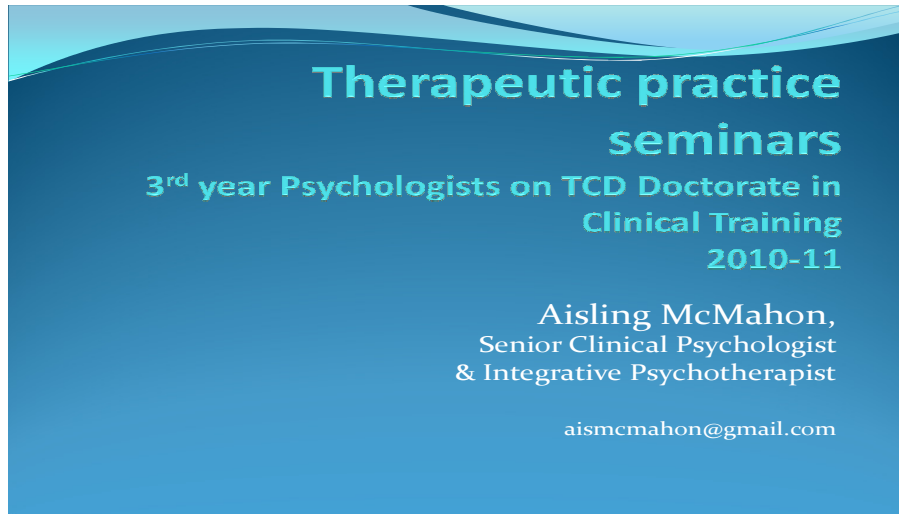
To improve this workshop, I would have liked if there was more, or less, of:

Time!

Appendix 1.6:

***Therapeutic Practice Seminars for Clinical Psychologists in Training
and example of past teaching work with trainees***

➤ *Format of therapeutic practice seminars for trainees:*



Therapeutic practice seminars
3rd year Psychologists on TCD Doctorate in Clinical Training
2010-11

Aisling McMahon,
Senior Clinical Psychologist
& Integrative Psychotherapist

aismcmahon@gmail.com

Aims of seminars

- A series of therapeutic practice seminars within a psychodynamic framework
- Developing personal presence, availability & resilience as a therapist
- Exploring following aspects of therapeutic work:
 - working with the therapeutic relationship
 - working with developmental issues, transference & countertransference
 - working with emotion
 - working with resistance
 - working with intuition, fantasy, metaphor, dreams

Session 1

- Overview of psychodynamic practice & efficacy
- Working with the therapeutic relationship
- Client reflection & experiential role play with client material
- Discussion

➤ **Samples of completed feedback questionnaires on therapeutic practice seminars for trainees:**

Feedback questionnaire for TCD trainees on therapeutic practice session with Aisling McMahon: November, 2010

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's session.

The session met my expectations.

Not at all Very much so

1 2 3 4 5 6 7

The session was useful and informative.

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the theoretical aspects of the session.

Not at all Very much so

1 2 3 4 5 6 7

I was satisfied with the experiential-skills development aspects of the session.

Not at all Very much so

1 2 3 4 5 6 7

The best thing(s) about today's session was/were:

The space to talk/hot about process issues and reflecting on the relationships with clients. The role play was incredibly useful in terms of exploring emotional - relational issues & putting me in place of client.

To improve this session, I would have liked if there was more, or less, of:

I don't expect a strong theoretical focus, it's more useful to focus on content similar to today, but it may be helpful to have reinforcement on readings as I feel I could do with a stronger theoretical foundation. Thank you for today!

Feedback questionnaire for TCD trainees on therapeutic practice session with Aisling McMahon: November, 2010

I'd appreciate it if you would anonymously rate the following statements and answer the following questions based on your experience of today's session.

The session met my expectations.

Not at all Very much so
1 2 3 4 5 6 7

The session was useful and informative.

Not at all Very much so
1 2 3 4 5 6 7

I was satisfied with the theoretical aspects of the session.

Not at all Very much so
1 2 3 4 5 6 7

I was satisfied with the experiential-skills development aspects of the session.

Not at all Very much so
1 2 3 4 5 6 7

The best thing(s) about today's session was/were:

experiential piece + use of reflection was excellent.

To improve this session, I would have liked if there was more, or less, of:

a little bit more of the theory but this would probably need to be explored in a longer session!!

➤ **An early example of teaching work with clinical psychology trainees, 1995:**

M. PSYCH. SC. COURSE IN CLINICAL SPECIALISATION

Adult Orientation Programme February 1995

Tuesday 14th February 9.30am - 12.30 pm	A.M. Preparation for Adult Placement	Dr. Richard Booth, St. Patrick's Hospital
2.15 pm - 5.15 pm	P. M. Interviewing and History taking	Michael del Monte U.C.D./St. Patrick's
Wednesday 15th Feb. 9.30 am - 5.00 pm	Working with adults	Dr. Richard Booth Mr. Tony Bates, St. Patrick's & St. James
Thursday 16th February 9.45 am - 5.00 pm	Assessment Procedures	Aisling McMahon, Dept. of Justice
Tuesday 21st February 9.30 am - 12.30 pm	Working with couples.	Dr. Richard Booth, St. Patrick's Hospital
2.00 pm - 5.00 pm	Assessment Procedures	Aisling McMahon St. Patrick's Hospital
Wednesday 22nd Feb. 9.30 am - 5.00 p.m.	Working with adults	Dr. Richard Booth Mr. Tony Bates St. Patrick's & St. James'
Thursday 23rd February 9.30 am - 12.20 pm	Basic skills in Cognitive Behaviour Therapy	Mr. Tony Bates St. James' Hospital

M. Psych. Sc. Course: First Year

Adult Orientation: Assessment Skills

* Please assemble in waiting room and ask the desk to notify Aisling when everyone has arrived.

PROGRAMME:

1) **COGNITIVE ASSESSMENT**

Intellectual, memory and screening neuropsychological functioning:
WAIS-R+, WMS-R+, NART-2, SCHONELL, BENDER-BIP,
KENDRICK, REY AVLT, FAS.

2) **VOCATIONAL ASSESSMENT**

Aptitudes and personality: DAT, MYERS-BRIGGS,
ROTHWELL-MILLER.

3) **MOOD/ADJUSTMENT/PERSONALITY: SELF-REPORT MEASURES**

MMPI-2+, STAI, BAI, BDI, BHS, EDI, IES, PADUA INV.,
MAUDSLEY INV., FEAR QUEST., 16PF, ROTTER, GRIMS,
GRISS, MARITAL SATISF. SCALE, SADD.

+ Most time will be given to the use and interpretation of these assessment techniques. A basic introduction will be given to the other techniques.

Final Project Appendices, Volume 2

Appendix 2.1:

Survey material

This includes: Print-out of the online survey questionnaire

Email invitation to the survey and a reminder email

➤ **Initial email invitation for online survey, 7.3.11:**

Dear Colleague,

You are invited to take part in an **anonymous on-line survey** which is exploring two major areas of practice for applied psychologists: **experience of supervision** and **of psychotherapy practice**.

The PSI (Psychological Society of Ireland) currently has a working group in place to develop **a policy on supervision for all applied psychologists**. Your responses to the supervision part of this survey will be immediately used to help inform the development of this policy so this is a key opportunity to have **your experience and views about supervision heard and acted upon**.

The survey is also exploring psychologists' **experience of confidence in practising psychotherapy** in order to increase awareness of what facilitates career-long capability in this satisfying but demanding area of work.

This research is being carried out by Aisling McMahon, Senior Clinical Psychologist and Integrative Psychotherapist, as part of a Doctorate in Psychotherapy, in collaboration with Dr. Katie Baird, Director of Professional Development of PSI. If you would like to discuss any aspects of this study, Aisling can be contacted at 087-2617188 or aislismahon@gmail.com or Katie at the PSI office at 01-4749160 or katie.baird@psihq.ie

It is estimated that it will take **about 20-25 minutes to complete the full survey or about 10-15 minutes to complete the supervision part of the survey** (if you do not practice psychotherapy as part of your work). To complete the online survey, please click on the link below (you will also see some additional information about the study on the first page):

<http://www.surveymonkey.com/s/surveylink.....>

If you would prefer to complete this survey over the phone rather than over the internet, please leave a message for Aisling at 087-2617188 and she will be happy to organise a time to do so with you.

With many thanks in advance for your participation and support,

Aisling McMahon and Katie Baird.

➤ **Example of survey reminder email: sent to PSI Clinical Division members, 25.3.11:**

Many thanks to those of you who have participated in the Supervision & Psychotherapy practice survey. ***I will be closing the survey down shortly and I am keen to encourage as many people as possible to take part in this research before I do so.*** You may be interested to see the response rate so far for the different psychology specialisms:

<i>Clinical</i>	<i>143 (56.3%)</i>
<i>Counselling</i>	<i>72 (28.3%)</i>
<i>Educational</i>	<i>28 (11%)</i>
<i>Organisational</i>	<i>17 (6.7%)</i>
<i>Health</i>	<i>12 (4.7%)</i>
<i>Neuropsychology</i>	<i>7 (2.8%)</i>
<i>Forensic</i>	<i>3 (1.2%)</i>

As you can see, ***the clinical psychology grouping is the largest group, but it still is less than 25% of clinical psychologists practising in Ireland*** - so the response to date is far from representative and I am hopeful that you will be able to help to improve this.

The response rate from the Clinical Division membership also remains very low - ***only 34 members have completed the survey (again, less than 25% of the 150 full members)***. Invitations to the survey have gone out through two routes: HPSI (Heads of psychology services of Ireland) and PSI. If you are a member of the Clinical Division but you have completed the survey through the HPSI invitation, a brief email to aismcmahon@gmail.com to say so would be greatly appreciated to track accurate response rates.

The survey link is here again - please do remember that ***you can start the survey, but leave it and re-enter at any time***, so this may make the 20-25 minute time commitment more possible for you in smaller units of time: [...[surveymonkeylink](#)...]

As an extra incentive, I have now set up the survey so that ***you get instant access to the survey results on supervision once you complete the survey*** and click "Done" at the end. Due to limited space, the SurveyMonkey system is unable to share results for the full survey with respondents so most of results for the psychotherapy part of the survey aren't included but you may find it interesting to see how your own experience and beliefs regarding supervision compare with your peers (your more personal open written responses are not shared through this forum). (If you are a Clinical Division member and have already completed the survey, you can access the results by entering the survey again through the same PC and scrolling through the pages to the end - enjoy!)

I do hope you will be able to find time to take this final opportunity to inform the development of the PSI supervision policy and also to develop our understanding of clinical psychologists' experience of practising psychotherapy.

With very best wishes, and many thanks for your support,

Aisling McMahon

Appendix 2.2:

Interview material

This includes:

- Interviewee information sheet and consent form*
- One full interview transcript (Kate) with analytic notes*
- Kate's emergent themes and superordinate themes*

➤ **Interviewee information and consent sheets**

Aisling McMahon, Clinical Psychology, Psychotherapy & Supervision Service
Reg.Clin.Psychol. Ps.S.I., M.I.A.H.I.P., M.I.A.C.P.

Rooms and correspondence address:

2 Abbeydale Crescent,
Lucan, Co. Dublin.

Phone: 087-2617188
email: aismcmahon@gmail.com

Participant Information Sheet for Individual Interview Date: _____

Practising psychotherapy as a clinical psychologist: What facilitates capable practice?

Name of researcher: Aisling McMahon (please see contact details above)

Supervisor's Name and contact details: Professor Maja O'Brien, Metanoia Institute, 13 North Common Rd., Ealing, London W52QB, ph: 0044-2085792505

You are being invited to take part in a research study. Please take time to carefully read the following information about the study, why it is being done and what it involves. Feel free to contact me by phone or email to ask about anything that is not clear or to ask for further information about any aspect of the study.

Purpose of the study:

I am a clinical psychologist and psychotherapist and I am carrying out this research as part of a professional doctorate in psychotherapy with the Metanoia Institute and Middlesex University. I am interested in exploring clinical psychologists' experience of practising psychotherapy and what supports confidence and capability in that practice. Through this research, I hope to influence awareness, policy and practice about what clinical psychologists need to support such capable practice from initial training and throughout their careers.

This study is being done in two stages – as you are aware, the first stage involved a survey questionnaire which was sent out to psychologists around Ireland. The survey explored psychologists' experience of supervision, of professional and personal development work, and how

these related to capable and confident psychotherapeutic practice. You are now being invited to take part in the second stage of this research, which involves individual interviews with a small number of qualified practising clinical psychologists.

The interview will last for between 45-75 minutes and together we will take this time to explore your experience of practising psychotherapy as a clinical psychologist. The interview will be largely unstructured in format, with just a few guiding questions, and will aim to explore your own experience quite closely and in some depth, rather than following a pre-determined set of questions.

The interview will be audio-recorded and transcribed and I will be analysing the transcript using Smith's Interpretative Phenomenological Analysis (IPA), a qualitative research methodology. This form of analysis explores participants' experiences in some depth and offers a rich description and interpretation of themes in each interview.

There are no anticipated direct benefits or risks to you in taking part in this study. However, one possible benefit may be the personal satisfaction in contributing to the understanding of the experience and needs of clinical psychologists in their psychotherapeutic practice, or you may derive benefit from the opportunity to explore in some depth your own experience and beliefs in this area. *If you do in any way become upset or disturbed by your involvement in this interview, I will be available to offer support immediately after the interview and can also be contacted at any stage after the interview by email or phone to discuss any concerns.*

My intention through this survey and interview research is to explore and highlight what facilitates capable and confident psychotherapeutic practice for clinical psychologists. I will be writing up this research as part of my doctoral dissertation as well as writing up the findings for publication in professional journals. I also plan to write recommendations based on the findings to relevant people within PSI (e.g., the Director of Professional Development) and within the training universities so that our professional body and clinical training directors may be informed of any identified training and CPD needs.

Your involvement in this research and all information that you give will be kept strictly confidential. While excerpts from your interview may be used in subsequent reports and articles, your name and any identifying information will be removed from all documentation, all efforts being made to ensure that you cannot be identified. All data will be stored, analysed and reported in accordance with the Irish Data Protection Acts, 1988 and 2003, and will be destroyed within 12 months of the completion of the study.

Taking part in this study is entirely voluntary. If you do decide to take part you will be given a copy of this information sheet to keep and asked to sign the following consent form. Also, if you decide at this point to take part, *you are still free to withdraw at any time without giving a reason. You are also free to decide not to answer any question I might ask you in the interview or to request that certain answers are deleted from the transcript.*

If you would like to be sent a copy of the transcript of your interview, please give your email or home address here:

If you would like to be sent a copy of the results of this research, please also indicate that here:

Yes, I would like to be sent a copy of the research results: _____

This study has been reviewed and approved by the Metanoia Research Ethics Committee.

With many thanks for taking the time to consider taking part in this research.

Aisling McMahon, Clinical Psychology, Psychotherapy & Supervision Service
Reg.Clin.Psychol. Ps.S.I., M.I.A.H.I.P., M.I.A.C.P.

Rooms and correspondence address:

2 Abbeydale Crescent,
Lucan, Co. Dublin.

Phone: 087-2617188
email: aismcmahon@gmail.com

Participant Consent Form for Individual Interviews

Participant ID no.: _____

Title of Project: Practising psychotherapy as a clinical psychologist:
What facilitates capable practice?

Name of researcher: Aisling McMahon

Please initial the boxes beside the statements:

I confirm that I have read and understand the information sheet dated _____ for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.

I understand that my interview will be audio-taped and subsequently transcribed.

I agree to take part in the above study.

I agree that this form that bears my name and signature may be seen by a designated auditor.

Name of participant

Date

Signature

Name of researcher

Date

Signature

➤ ***One full interview transcript (Kate), with analytic notes***

➤ ***Emergent and superordinate theme development with Kate's interview***

Kate's Emergent Themes:

Haphazard/fragmented experience

Luck/Agency

Significance of relationship – supervisor, having someone to go to, to bring stuff to/On own

Knowing and not knowing – knowing/learning from the inside/size of the learning/not knowing as unsafe

Risks and benefits of opening up

Fear of being judged

Comparing self to others

Managing

Feeling able

Being comfortable

Wanting more/Seeking more/Not having enough/Missing something /Security of having something

Wanting structure/Movement between structure and process

Engaging with the heart

Survival with the head

Personal-professional overlap

Being a psychologist (competitive, insecure, unaware)

Kate's Superordinate Themes:

Having somewhere to go (to bring stuff to)

On own

Significance of relationship – supervisor, having someone to go to, to bring stuff to

Luck and agency (finding right supervisors)

Fear of being judged / Risks and benefits of opening up (experience of unaware supervisors/psychologists)

Knowing from the inside (head and heart)

Knowing and not knowing – knowing/learning from the inside, powerful learning

Engaging with the heart (can get in there, willingness to take risks) / Survival with the head

Personal-professional overlap

Needing more (wholeness, structure) – feeling fragmented, missing something

Haphazard/fragmented experience

Managing /Feeling able /Being comfortable

Wanting more/ Searching for more on own / Not having enough / Missing something

Comparing self to others (envying others having more)

Wanting structure / Movement between structure and process

Appendix 2.3:

Conference presentations, 2011: Psychotherapy study and Supervision study

Appendix 2.4:

Research reports: Psychotherapy study and Supervision study

**Practising psychotherapy as a clinical
psychologist: recommendations for clinical
training**

**Research report for Clinical Psychology Training
Directors & PSI Director of Professional Development**

January, 2012

Aisling McMahon, Reg.Clin.Psychol.Ps.S.I., M.I.A.H.I.P., M.I.A.C.P.

1. The research context and participants

This report describes research carried out in 2011 by Aisling McMahon as part of a professional doctorate with the London Metanoia Institute and Middlesex University. **The study explored clinical psychologists' psychotherapy practice and identified factors associated with confidence in this practice.** It is believed that the research offers valuable information for those running and accrediting clinical psychology training programmes.

An Irish nationwide survey for all applied psychologists was followed by a small number of qualitative interviews with clinical psychologists. Of 401 participants in the survey, three-quarters (299) worked in health service settings, representing 46% of all Irish health service psychologists (as per HPSI, 2010, figures). The other 102 participants worked in non-health service settings (e.g., private practice, academia). Excluding workforce surveys, **with over 400 participants, this was the largest response for a survey with Irish psychologists.**

The survey participants were predominantly clinical and counselling psychologists, many being qualified in more than one specialism. Psychologists with purely clinical training were the largest subgroup (47%, n=186) and 170 (91%) of these practised psychotherapy. **These 170 clinical psychologists practising psychotherapy are the focus of this report.** Counselling psychologists (23%; n=91) were the second largest subgroup.

The clinical psychologists were qualified an average of 12 years (6 months-35 years) and were predominantly female (82%). The majority worked in the HSE (58%) or Voluntary sector (30%). Their career grade profile matched the nationwide profile and they worked across the major client groups, most commonly with adults (39%). Practising psychotherapy involved 46% of their work time.

The survey's clinical psychologists were invited to take part in follow-up interviews exploring their psychotherapy practice. The four selected for interview were HSE staff practising psychotherapy for between 40-70% of their working time, were between 5-10 years qualified and did not have formal psychotherapy training. Three were female and one male, two Senior and two Staff grade, and they worked with child and adult client groups.

2. Research results¹

What is related to confidence in practising psychotherapy for clinical psychologists?

Based on their own rating of their current confidence in their psychotherapy knowledge and skills, the survey's clinical psychologists were classified as *more confident* (those who rated themselves as either "very confident" or "quite confident"; 56%) or *less confident* (those who rated themselves as "somewhat low in confidence" or "somewhat confident"; 44%).

¹ Dr. David Hevey assisted with statistical analyses and provided an independent validity check of the coding of the survey's open response items; Dr. Rebecca Quin provided an independent audit and validity check of the interview analyses

Listed in order of strength at predicting confidence (all were significant to at least the $p < .005$ level), it was found that those who were more confident:

- **were more satisfied with the psychotherapy knowledge and skills they gained during their clinical psychology training** (see Figure 1 below);
- **were more satisfied with their current supervisory support**;
- **had attended their own personal therapy for longer; and**
- **were longer practising as a clinical psychologist.**

While they did not emerge as independent predictors of confidence and the associations were not as strong ($p < .05$), greater confidence was also related to:

- having additional formal psychotherapy training, and
- engaging in joint psychotherapy work with other professionals.

No other factors explored in this study were significantly related to confidence – for instance, the time spent practising psychotherapy, the frequency and type of clinical supervision attended, or the frequency of engagement in psychotherapy-related CPD over the last year (e.g., reading, attending workshops).

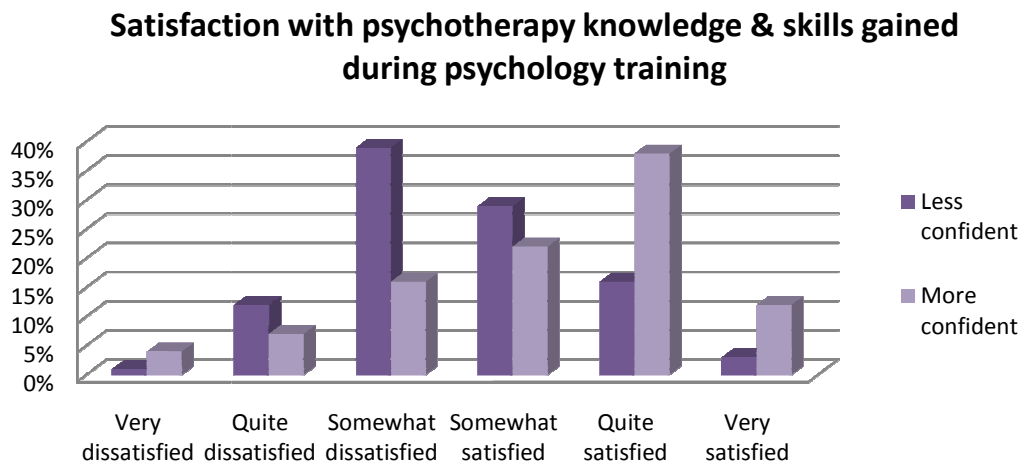


Figure 1: The strongest predictor of confidence: satisfaction with psychotherapy knowledge and skills gained during clinical psychology training

Comparing the clinical and counselling psychologists practising psychotherapy who took part in this survey, a number of significant differences were found (at the $p < .001$ level), a few relevant ones being reported here. The counselling psychologists:

- were much more confident in their psychotherapy knowledge and skills (92% were more confident vs. 56% of the clinical psychologists);

- were more satisfied with the psychotherapy knowledge and skills they gained during psychology training (typically “quite satisfied”); and
- were more likely to have attended personal therapy (94% vs. 75%), to have been in training where personal therapy was mandated (85% vs. 11%), and to believe that it should be mandated during training (92% vs. 42%).

Within the survey, the psychologists were asked to give **one main reason for their confidence or lack of confidence in their psychotherapy knowledge and skills**. Table 1 lists the 5 top factors identified by the clinical psychologists, with illustrative quotes from the two confidence groups.

	Reason	No. (%)	Illustrative quotes
1.	Training	56 (30%)	<u>MC</u> : “I received a good grounding in psychotherapy skills in my training and I have continued to attend various training workshops since qualifying” <u>LC</u> : “do not feel my training has fully equipped me to do psychotherapy”
2.	Experience	45 (24%)	<u>MC</u> : “length of years working and knowledge and skills acquired, i.e., learning on the ground” <u>LC</u> : “lack of recent experience as much of my work is assessment driven and time-limited”
3.	Supervision	27 (14%)	<u>MC</u> : “I have a fantastic supervisor which helps enormously” <u>LC</u> : “poor quality clinical supervision”
4.	Client outcomes/ Feedback	17 (9%)	<u>MC</u> : “seeing change in my clients” <u>LC</u> : “lack of adequate...feedback”
5.	Personal therapy	9 (5%)	<u>MC</u> : “I’ve spent considerable time in personal therapy which has helped enormously in my practice” <u>LC</u> : “I have a certain amount of confidence because of my years experience...and personal therapy”

Note: MC=More confident. LC=Less confident; Other factors, each with just 8 comments or less, included “feeling confident within limits”, “reading” and “contact with peers”.

Table 1: Reasons clinical psychologists gave for their level of confidence in their psychotherapy knowledge and skills

The more confident clinical psychologists commented most frequently on their years of experience (28% of their comments), the significance of additional or ongoing training work in psychotherapy they had engaged in since their psychology training (25%), the benefits of witnessing positive client outcomes and receiving positive feedback (13%), as well as of having either high quality or long-term supervisory support (12%).

For the less confident clinical psychologists, the most common reasons noted for their lower confidence were having had limited or poor quality psychotherapy training during their clinical psychology training (36% of comments) and poor quality or infrequent supervision (17%). One-fifth (20%) commented on their experience, some noting a lack of

experience but others noting that their experience contributed to the level of confidence they did feel.

Exploring clinical psychologists’ psychotherapy practice in more depth:

In-depth interviews carried out with four of the clinical psychologists offered a more personal insight into the experience of practising psychotherapy as a clinical psychologist. The interviews were analysed using Interpretative Phenomenological Analysis (IPA) and three master themes were identified, each with three subthemes, as can be seen in Table 3. A summary overview of the master themes with some illustrative quotes is offered below.

Master Themes:	Subthemes:
Feeling there’s something missing	<i>Learning in bits and pieces</i> <i>Am I good enough?</i> <i>Searching for more</i>
Being able to get in there	<i>Learning from the inside</i> <i>Being able to feel deeply</i> <i>Moving between head and heart</i>
Having somewhere to go	<i>Fighting for support</i> <i>Surviving over the long term</i> <i>Fear of opening up</i>

Table 3: Interview master themes and subthemes

Feeling there’s something missing

A professional insecurity in relation to their psychotherapy practice was a significant undercurrent for the clinical psychologists. They felt that they were missing something and that their development as therapists was piecemeal, dependent on training supervisors and occasional workshops and reading. They compared themselves with those who had done formal training as psychotherapists, envying their more structured, in-depth training and questioning their own capabilities without this training. Kate wondered about the impact of the broad clinical training on confidence:

Maybe it is partly about our training, that it doesn’t really (sigh) make us feel very, very skilled in one area, you know what I mean? I kind of always envy these people who have their sand tray therapy...or their play therapy, that they’ve really trained up in that, or their psychotherapy or whatever. I kind of envy them, where we can

just get kind of bits and pieces of everything...and you feel like you have not enough of anything really (Kate²)

The psychologists showed their adaptability to working with what they did have but most expressed their need for more, actively searching for opportunities to fill in gaps in their learning.

Being able to get in there

The capacity to work at an emotional level, both in terms of their own personal process and being able to connect empathically with their clients, was another major theme for the clinical psychologists. The psychologists commented on the clinical psychology culture, which they felt valued working more at a cognitive than at a relational or emotional level with clients. However, with the experiential learning from either personal therapy or process supervision, the psychologists described a greater ability and comfort working at a “heart level” with their clients, and they valued this development in their therapeutic work. Two of the interviewees had done their own personal therapy work and they felt this deepened their capacity to engage at an emotional level, as Claire described:

I definitely feel I can hold myself emotionally. That even though I can empathise, I don't feel as overwhelmed...I can comfortably explore and go into an issue in more depth with a client

For the two psychologists who had not done their own personal therapy, they showed more difficulty connecting into their own personal process and working at an emotional level, relying on supervision to start to open this up. In their interviews, the psychologists also expressed a need for more structure, direction and a stronger theoretical framework for their work, which they felt they had not gained in their training to date.

Having somewhere to go

All of the clinical psychologists expressed their need to have somewhere to go for support with the personal impact of their often complex and long-term therapeutic work. They most commonly sought supervision for such support but they often had to work hard, and even fight, to get the supervision they wanted. Two of the group emphasised their need to have ongoing supervision for their long-term survival in the work. However, David also expressed his own ambivalence, as well as the ambivalence he saw within the clinical psychology culture, towards seeking out support:

I think [clinical psychologists] pride themselves on the capacity...to manage themselves. I think that that's a dangerous way to work because it's easy to lose sight of whether you're managing yourself or not...that's where the external supervision provides a safety net in doing that....we're good at being high-wire artists, like, you know, we're good at staying stable up there in the wind

The clinical psychologists also expressed an awareness of the risks involved in opening up to either supervisors or personal therapists, fearing judgement in sharing their needs and

² Pseudonyms are used

vulnerabilities. They variously talked of a fear of being “*pathologised*” if they opened up to supervisors, of “*feeling vulnerable*” but wanting to feel confident with supervisors who were line managers, of opening up a “*Pandora’s box*” if they engaged in personal therapy, and a fear of being judged as “*not coping*” by other professionals if they were known to be doing their own personal therapy.

3. Review of results and recommendations for clinical training

Psychotherapy practice is a dominant activity for clinical psychologists and yet this research indicates that a high proportion (44%) of these professionals do not feel confident in this area of work. Their confidence in this area falls far below that of their counselling psychology colleagues. Some difference in confidence is predictable given the broad clinical psychology training and the more in-depth counselling psychology training in this area, and the expectation has been that clinical psychology graduates will build on the foundation they received through their post-qualification CPD. However, this research indicates that ***this early foundation-level training is central for psychologists’ confidence in practising psychotherapy, more so than any later specialised training or clinical experience.*** Given the clinical psychologists’ lower confidence levels and the high rates of dissatisfaction within the full clinical group with their training in psychotherapy (35% were dissatisfied, and another 25% were only somewhat satisfied), this research shows the need to consider ways to improve clinical training in this area. Fortunately, some strong pointers are available from the research findings, specifically:

- The interview results showed that the development of the clinical psychologists’ therapeutic skills was experienced as piecemeal, being dependent on placements and supervisors, and lacking cohesiveness and depth. They also felt that they were missing a strong theoretical framework or structure for their therapeutic practice. While clinical placements will always be central in training, this research indicates the need for stronger input in psychotherapy within the core academic programme. ***It is recommended that clinical training programmes provide more cohesive and in-depth input in psychotherapy theory and skills development within their academic programme so that a stronger foundation is established.***
- Both the survey and the interviews show the value of longer experience of personal therapy, of “*learning from the inside*”, offering the clinical psychologists a greater emotional capacity and confidence in their therapeutic work. Given this finding, it is reassuring to see that three-quarters of clinical psychologists have engaged in their own personal therapy. However, with the significance of *longer* attendance for confident practice, it highlights the importance of this process being engaged in at early stage. Clinical psychology training has not normally mandated personal therapy work, although two of our Irish programmes do now mandate a small number of hours. This research endorses this development, personal therapy work offering clinical trainees another key element in their foundation for confident therapeutic practice. ***It is recommended that personal therapy work becomes a required part of clinical training and is financially subsidised as a core part of the training programme.***

- A final key finding in this study is the importance of the clinical psychologists having satisfying supervisory support, of “having somewhere to go” with the personal impact of what is often complex therapeutic work. While this issue is more relevant to post-qualification practice, it also underlines the importance of placement supervisors offering process supervision for clinical trainees, while being mindful of the vulnerabilities this can bring up. Thus, ***it is recommended that clinical training supervisors are advised regarding the importance of process supervision for confident therapeutic work and are offered training for providing such supervision to their clinical trainees.***

**Irish nationwide survey:
Psychologists' supervision practices & needs**

Research report for PSI Supervision Policy Group

January, 2012

Aisling McMahon, Reg.Clin.Psychol.Ps.S.I., M.I.A.H.I.P., M.I.A.C.P.

1. The research context and participants

In March 2011, a “Supervision and Psychotherapy Practice Survey for Psychologists” was distributed in Ireland. The survey was an expanded version of that being planned by Aisling McMahon as part of a doctoral study on psychologists’ psychotherapy practice¹. In consultation with Dr. Katie Baird, then PSI Director of Professional Development, the survey became dual purpose to also inform a planned PSI supervision policy. This research offers ***the first nationwide survey of Irish psychologists’ supervision practices and needs.***

There were 431 participants in the supervision part of the survey. Three-quarters (329) of these worked in health service settings, representing 51% of all Irish health service psychologists (as per HPSI, 2010, figures). The other 102 participants worked in non-health service settings (e.g., private practice, academia). Excluding workforce surveys, ***with over 400 participants, this was the largest response for a survey with Irish psychologists.***

The survey participants were mainly clinical (47%) and counselling psychologists (23%). An additional 16% were qualified in more than one specialism, over two-thirds of these psychologists having a clinical qualification. The other participants were educational (8%) and organisational (3%) psychologists, there being a small number of health, forensic and CBT psychologists taking part (3%).

The psychologists were qualified an average of 11 years (6 months-40 years) and were predominantly female (79%). They mostly worked in the HSE (42%), voluntary sector (27%), private practice (25%) and educational/academic settings (17%). Their career grade profile matched the nationwide profile and they worked across the major client groups, most commonly with adults (43%). On average, the psychologists spent 57% of their work time in direct client contact.

2. Survey results²

The survey results are given under three main headings – receiving supervision, providing supervision, and feedback regarding the planned PSI policy on supervision.

2.1 Receiving supervision

The large majority of the psychologists (91%) reported currently attending supervision, often attending more than one type of supervision. Most (88%) were currently attending

¹ The survey and the psychotherapy study report are available from Aisling at aislismcmahon@gmail.com

² Darina Errity carried out qualitative coding analyses with the survey’s open response items, two days of her time being funded by PSI Council, and Aisling carried out a validity check of the coding; Dr. David Hevey provided a quality check of statistical analyses

clinical supervision³, one-half (51%) attending at least fortnightly and 82% attending at least once-monthly.

The most common type of supervision attended was individual line management supervision at work (by 58%), followed by group or peer clinical supervision at work (by 52%), both typically attended on a once-monthly basis or less. Table 1 below gives more details of types of supervision attended and rates of attendance.

Type of supervision	Attending at least once-fortnightly	Attending once 3-weekly	Attending once-monthly or less	Not currently attending
Individual LM at workplace	13% (N=55)	3% (N=12)	43% (N=184)	42% (N=180)
Group/peer CS at workplace	10% (N=45)	2% (N=9)	40% (N=171)	48% (N=206)
Individual CS externally	13% (N=56)	6% (N=24)	23% (N=99)	58% (N=252)
Individual CS at workplace	15% (N=65)	2% (N=9)	18% (N=76)	65% (N=281)
Group/peer CS externally	4% (N=16)	1% (N=5)	22% (N=96)	73% (N=314)
Group LM at workplace	5% (N=20)	0.5% (N=2)	17% (N=74)	78% (N=335)

Notes: LM=Line management supervision; CS=Clinical supervision; more than one type of supervision could be selected; most common attendance rates are in bold type

Table 1: Type and frequency of supervision attended

For those who were attending fee-paying external supervision and not in private practice (154), nearly one-half (47%) were getting funded by their workplace to do so, and nearly three-quarters (73%) were given time by their workplace to attend.

When asked if they had the choice, for those for whom it was relevant (359; e.g., not in private practice), **two-thirds (68%) of the psychologists indicated that they would prefer to attend separate supervisors for line management and clinical supervision**, 15% stating a preference for just one supervisor and 17% having no preference. Regarding the location of clinical supervision, **under one-half (46%) said they would prefer external clinical supervision**, just over-one quarter (27%) would prefer it internally in their workplace and for another quarter (27%) the location did not matter to them.

As can be seen in Figure 1 below, about one-half (51%) of the psychologists were either quite or very satisfied with their supervisory support. However, a sizeable one-third (32%) were at least somewhat dissatisfied and 9% were very dissatisfied.

³ Clinical supervision is understood to be where the supervisee has a confidential and reflective space to explore and/or receive guidance on any aspects of their work and their own professional development, with the aim of supporting and enhancing clinical practice.

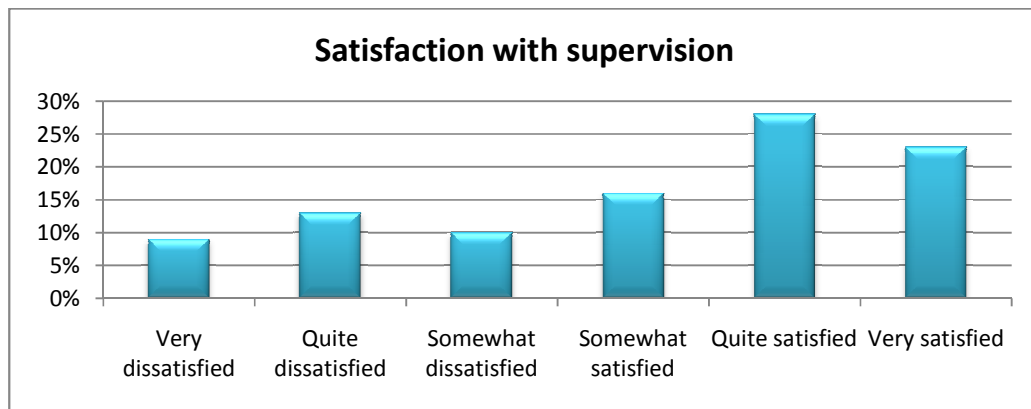


Figure 1: Satisfaction with supervisory support

It was found (all significant at the $p < .001$ level) that those who were more satisfied with their supervisory support:

- attended clinical supervision and did so more frequently
- attended external individual clinical supervision and did so more frequently
- received funding from their workplace to attend external supervision

The counselling psychologists were more satisfied with their supervisory support than the other psychology specialisms ($p < .001$). This seems to be explained by the fact that counselling psychologists attended clinical supervision more frequently (75% attended at least fortnightly while only 48% of clinical psychologists and 36% of educational psychologists did so) and more often attended external clinical supervision.

No other factors were found to be related to satisfaction with supervision, such as attending group/peer supervision, attending individual clinical supervision at work, years practising or career grade. However, it was found that *attendance at individual line management supervision at work was associated with less satisfaction with supervisory support* ($p < .001$).

Based on their current or most recent experience of receiving clinical supervision, the psychologists strongly agreed that:

- *Clinical supervision [is] necessary for experienced psychologists (83%)*
- *I [believe] that attending clinical supervision is a valuable use of my time (79%)*
- *Clinical supervision meetings offer me a valuable reflective space (74%)*
- *Attending clinical supervision improves the quality of care I offer clients (74%)*

Most were very positive about their experience of clinical supervision, there only being some splitting of views on two issues:

- *Giving time to attend clinical supervision increases other work pressures (36% agreed; 52% disagreed)*
- *I can feel under pressure to perform in clinical supervision sessions (30% agreed; 56% disagreed)*

As can be seen, about one-third of the psychologists felt increased work pressure from giving time to supervision, suggesting that their supervision time may not be protected or clearly scheduled. A similar number felt under some pressure to perform in clinical supervision, suggesting a likely line management or reporting element to their supervision.

Those who were more satisfied with their supervisory support agreed more strongly (all significant at $p < .001$ level) that they *learned from their clinical supervisor's or supervision group's experience*, that they experienced *support and containment* from their clinical supervision, and that they *could discuss sensitive or personal process issues* in their clinical supervision.

Finally in this section on receiving supervision, the psychologists were asked to *comment on the reason for their level of satisfaction with their supervisory support*, 311 doing so. Five themes were identified in their responses:

1. Relationship with supervisor (39% of comments)

The relationship dynamic with the psychologists' supervisors was most commonly commented upon, the psychologists expressing concern about issues of power, trust, and exposure to judgement. Both satisfying (e.g., *"there is trust in the relationship and this allows me to really be myself"*) and dissatisfying experiences (*"can be judgmental and at times has made me feel criticized and blamed"*) were described. The need for an experienced and supportive supervisor was often noted and a number commented on the value of the additional insights offered by their supervisors. Many described their difficulty finding the "right" supervisor, one who offered them the personal and professional support they needed, and those who had done so felt very aware of their good fortune.

2. Need for more (22%)

The next strongest theme concerned the need for more frequent supervision, the barriers noted being that of cost, time and the low priority and lack of resources given to supervision in their workplaces. Nearly all the comments under this theme expressed dissatisfaction due to not having enough supervision (e.g., *"I attend...once monthly which I find to be totally inadequate for my needs"*). Accessing supervision seemed to be a particular problem for senior level practitioners, who expressed frustration with the perception that supervision was no longer necessary at their level.

3. Personal fit of format (18%)

Nearly one-fifth of the psychologists commented on the format of clinical supervision they personally valued. Many expressed a strong preference for separation of line management and clinical supervision, feeling vulnerability in opening up with their managers (e.g., *"it does not feel like a safe place, as she is my manager"*). Others expressed their preference for external rather than internal clinical supervision, although cost was often noted as a barrier. The psychologists also noted the benefits they experienced from both individual and peer group supervision, there being no clear preference of format here.

4. *Quality of sessions* (13%)

A number of the psychologists described some key qualities that they valued in their clinical supervision sessions, specifically having time to reflect, to work with process issues and to be challenged to develop their skills or understanding. The psychologists either commented on their appreciation of these qualities in their supervision sessions (e.g., “supervision provides valuable space for reflection”) or their dissatisfaction with their absence (e.g., “supervisor focuses on content issues and prefers not to look at process issues as much”).

5. *Supervision as a necessity* (12%)

Finally, some of the psychologists took the opportunity to assert their belief in supervision as a necessary and essential element of their work, enhancing their skills and the service they offered their clients, for instance: “a critical component of my clinical work”.

2.2 Providing supervision

The majority (70%) of the psychologists were currently providing supervision to others, or had done so in the past. However, **44% had attended no training in supervision, 25% of those supervising doing so without any training in this area.** The most common supervisor training was attendance at an individual training day or days (see Figure 2).

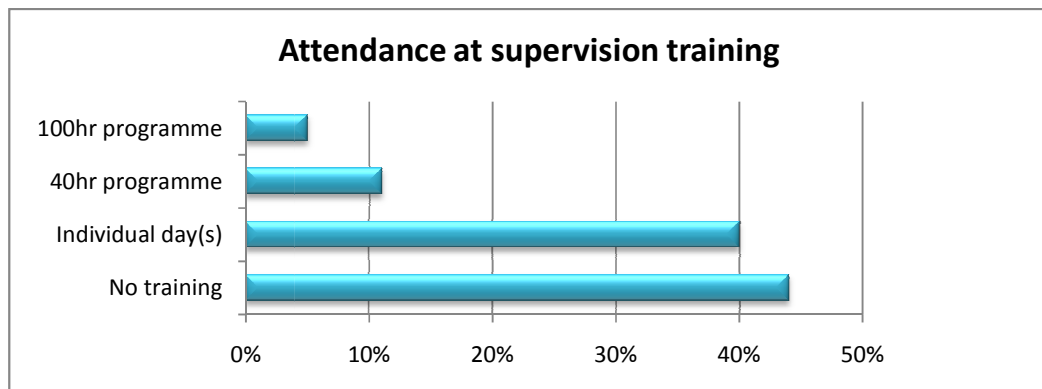


Figure 2: Attendance at supervision training

Most of the psychologists rated themselves as either somewhat (30%) or quite (31%) confident in providing supervision, with nearly one-third (30%) rating themselves as at least somewhat low in confidence (see Figure 3).

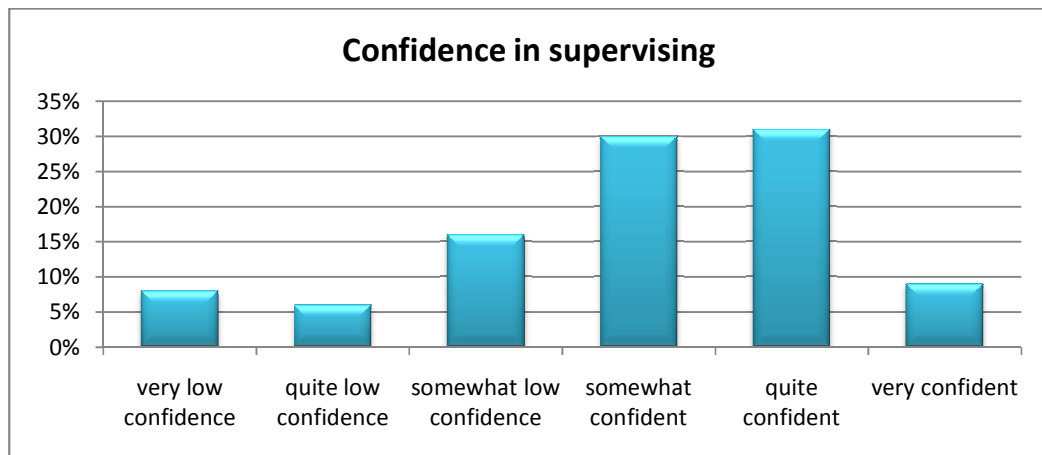


Figure 3: Confidence in providing supervision

It was found that those who were more confident in their supervisory ability:

- were longer qualified ($p < .001$)
- had more training in supervision ($p < .001$)
- had experience of providing supervision ($p < .001$)
- were more satisfied with their own supervisory support ($p < .05$)
- were of a higher career grade ($p < .001$)
- had engaged in formal psychotherapy training ($p < .001$)
- had spent longer attending their own personal therapy ($p < .001$)

A logistic regression analysis showed that (in order of predictive strength) having spent longer attending personal therapy, being longer qualified as a psychologist, and having had more training in supervision were independent predictors of confidence as a supervisor. **These three factors – substantial personal therapy, more supervision training and longer work experience - accurately predicted 89% of the more confident supervisors.** The other 4 factors above were not independent predictors of confidence.

Finally in this section on providing supervision, the psychologists were asked to give a *reason for their level of confidence*, 327 doing so. Five major themes were identified:

1. **Learning through experience** (79%)

The majority of the psychologists commented on how their experience, or lack of it, affected their level of confidence. This included their experience as a practitioner, as a supervisor, of their supervisees' areas of work, and of being supervised, for example: *"I have experienced both good and bad supervision: I would hope to be able to know what not to do"*.

2. **Having training** (35%)

About one-third of the psychologists commented on the value of their training in supervision (e.g., *“I have a solid foundation having attended supervision training”*) or their desire to have such training (e.g., *“I would feel more confident if I had access to supervision training”*). Nearly all comments were in relation to formal training, but a minority described their efforts to develop their skills or knowledge informally, such as through reading.

3. **Feeling able** (15%)

A number expressed how they had received good feedback from their supervisees and had observed their supervisees' progress (e.g., *“People I have supervised have reported getting a lot out of the sessions”*). They also felt they had the right skills for the work, commenting on their ability to reflect, be supportive and build good relationships with their supervisees.

4. **Enjoying the work** (5%)

A small number of the psychologists expressed their enjoyment in supervisory work, describing the work as meaningful and worthwhile (e.g., *“Am very passionate about it”*). However, a few commented on how they found supervisory work difficult or uncomfortable, for instance: *“I don't enjoy providing individual supervision – it's not my forte”*.

5. **Needing external support** (3%)

Finally, some of the psychologists expressed either the need for, or the value of, supervision policies in their workplaces, this affecting their confidence in providing supervision and the time they had available for this work, for example: *“I work in an organisation with good supervisory structures”*.

2.3 PSI Supervision Policy

The majority (80%) of the psychologists agreed that a PSI policy on supervision would be helpful for their work, only 6% saying no, and the rest (14%) being unsure. Eight sample recommendations (mostly drawn from BPS clinical and counselling supervision policy documents) were given to the psychologists and they were asked to indicate their views on their possible inclusion in the PSI policy. The proposed policy recommendations with the most endorsements were:

- a recommendation that psychologists attend career-long supervision (88% agreed)
- training and accreditation standards for psychologist supervisors (78%)
- standards regarding supervisors' note-keeping and reporting responsibilities (77%)
- a recommended minimum attendance at supervision (74%)
- a recommended limit to the maximum number of supervisees for peer/group supervision sessions (70%)

The other three proposals had a greater division of opinion:

- a recommended ratio of clinical supervision hours to client contact hours (46% yes; 26% no; 28% unsure)
- a recommendation that line management and clinical supervision are provided by separate supervisors/supervision groups (60% yes; 17% no; 23% unsure)
- supervisors from other professional groups accepted (63% yes; 14% no; 23% unsure)

The psychologists were also *invited to give open comments on the proposed PSI policy*, 156 doing so. Their contributions are summarised under six headings:

1. Opinions on the overall policy (58 comments)

Over one-third of the comments made were opinions about the overall policy - 14 strongly supported it, and a further 24 supported the policy but had concerns about its implementation or the costs of increased supervision attendance, for example:

“I feel that this policy is badly needed in the Irish system”

“there is an issue of cost, time and availability of suitable supervisors. Making recommendations in the absence of sufficient resources is unhelpful”

Nineteen psychologists expressed negative opinions about the policy, most viewing it as too prescriptive, for instance:

“too much regulation can destroy creativity and the ‘rules’ to be followed become more important than the actual supervision”

2. Criticisms of minimum hours and ratios (41 comments)

Over one-quarter of the comments expressed concerns that prescribing minimum hours and client ratios for frequency of supervision attendance would set a low benchmark that would be taken as standard by management, for example:

“no to a month minimum as line managers may take that as adequate”

“the content of supervision...is of far greater importance than the quantity”

“one size does not fit all”

3. Opinions on separation of line management and clinical supervision (32 comments)

One-fifth of the comments made were on the issue of proposing separation of line management and clinical supervision, there being an equal splitting of opinion - 12 didn't want separation, 11 advocated separation and the remainder saw the benefits of separate supervisors but were aware of logistical difficulties such as the cost and time implications:

“the direction where possible should be to separate them out”

“my line manager works in my profession so I don't see the need and would not welcome a requirement to have a 'separate' supervisor”

4. Opinions on supervisors from other professional groups (18 comments)

A number made comments on the proposed acceptance of supervisors from other professional groups, again opinions being divided - 7 agreed, seeing the benefits, and 7 disagreed, wanting supervision from within their own discipline, while 4 commented on the pros and cons of both positions. A couple of representative comments were:

“would think it very important that supervisors from other professional groups be accepted”

“strongly disagree with other professionals providing supervision, regardless of context, I feel it is wholly inappropriate”

5. Opinions on training and accreditation standards (9 comments)

A small number of comments were made on the proposal to have training and accreditation standards for supervisors, 5 expressing opinions against this, prioritising the value of experience, and 4 being in favour as a means of safeguarding standards, both sides being seen here:

“important so that supervisor and supervisee will have clear expectations about the supervision process...and to ensure quality”

“some fears around the need...to have accredited training. What is more important in my view is the knowledge base the clinical supervisor has”

6. Other suggestions (16 comments)

A handful of other comments were made by the psychologists regarding the policy, including suggestions that PSI provides help in finding supervisors, that supervisors should in turn have supervision of their supervisory work, that web/phone supervision would be recognised, and that PSI have reciprocal recognition with other professional bodies such as IACP. Finally, a few psychologists suggested using more egalitarian terminology rather than “supervision”, for instance:

“the term supervision may be off-putting for some...recognize the value of peer mentoring and support and would prefer a model of that type”

3. Review of survey results

There was a good response rate to this nationwide survey – 431 psychologists participated in this research, representing 51% of the total population of Irish health service psychologists as well as 102 psychologists working in non-health service settings. The majority were clinical and counselling psychologists. The main results were as follows:

There is a high rate of attendance at supervision (92% attending supervision of any type and 88% attending clinical supervision) but the frequency of attendance is low, typically once-monthly, and many expressed the need for more frequent supervision.

Two-thirds of the psychologists want separation of line management and clinical supervision.

Three-quarters have preferences regarding external or work-based clinical supervision – just under one-half preferring external and one-quarter preferring work-based supervision.

One-half of the psychologists are either very or quite satisfied with their supervisory support, and a sizeable one-third are dissatisfied.

The more satisfied psychologists attend clinical supervision more frequently and attend external individual clinical supervision. Less satisfied psychologists have line management supervision at work.

Significant issues related to satisfaction for these psychologists include the importance of a trusted, supportive relationship with their supervisor, having supervision frequently enough, having a good personal fit of format, and having time for process issues, reflection and challenge in the supervision sessions.

Having engaged in substantial personal therapy, attended more supervisory training and having longer work experience were all strongly related to greater confidence as a supervisor. However, 44% of the psychologists have had no supervisor training, a notable one-quarter of those supervising having no training.

The large majority (80%) endorsed the planned PSI supervision policy but some concerns were expressed about the details of recommendations and implementation.

4. Conclusions and recommendations

A PSI policy recommending career-long supervision is endorsed by the large majority of Irish psychologists and needs to be put in place as soon as possible. This research shows that while one-half of Irish psychologists are at least quite satisfied with their supervisory support, a sizeable one-third are dissatisfied. It is anticipated that a professional policy on supervision will be important in supporting better and more satisfying access to supervision for psychologists.

While the majority of psychologists are attending supervision, the regularity of attendance is generally low, typically once-monthly, and more is wanted. This research showed that attending clinical supervision⁴ is related to more satisfaction, whereas attending line

⁴ As a general supervision policy for all applied groups is being planned, the term “clinical” supervision, while in common use amongst psychologists and in the literature, may need to be reconsidered in relation to non-clinical and non-counselling psychologists; some of the organisational and educational psychologists in the survey research commented that the term did not apply to their practice with non-clinical clients.

management supervision is related to less satisfaction. The majority of the psychologists strongly believed that attending clinical supervision was a valuable use of their time and improved the quality of care they offered clients. It was also found that those who are more satisfied with their supervision are attending clinical supervision more frequently, typically on a fortnightly basis. Based on these research findings, including a one session a month minimum standard for clinical supervision, as the BPS Clinical Division have done, will not meet psychologists' expressed needs for more frequent supervision. ***It is recommended that a higher minimum standard than one session per month is set for clinical supervision in the PSI policy, ideally a once-fortnightly standard being set, while noting some considerations in relation to client load.***

While some expressed concern about having two supervisors, the majority (two-thirds) want separation of clinical and line management supervision, many expressing difficulties being open in clinical supervision with their line managers. One-third of the psychologists reported feeling under pressure to perform in their clinical supervision sessions, implying a reporting/managerial dynamic in the supervisory relationship. While 15-17% of psychologists do not want separation of line management and clinical supervision, the large majority do, and a significant proportion have expressed difficulties in the absence of such separation, indicating that some protection is needed. ***It is recommended that a requirement for separation of line management and clinical supervision is included in the policy.***

This research indicates the need to facilitate choice regarding internal or external clinical supervision as three-quarters of psychologists have preferences. Those who had external individual clinical supervision were more satisfied with their supervisory support but only one-half stated a preference for external supervision and one-quarter had a preference for work-based supervision. Thus, it is not recommended that a policy line is set on this issue, but ***it is suggested that the policy recommend that psychology managers offer their staff choices for internal and external supervision so that an appropriate personal fit in terms of supervisory relationship, format and content can be accessed.*** The psychologists in this research made a large number of comments on these issues, indicating the supportive value of a good fit in terms of supervision as well as the negative impact of a bad fit.

More training in providing supervision is urgently needed as 40% of the psychologists in this research have had no training, not even a one-day workshop, this including one-quarter of supervisors. Three-quarters of psychologists endorsed the inclusion of supervisor training and accreditation standards in the PSI policy. ***It is recommended that training and accreditation standards are established for psychologist supervisors and that resources are put into training and supporting those offering supervision as a matter of urgency*** if policy requirements for career-long supervision are being put in place.

While a minority (14%) did not want supervisors from other professional groups to be accepted within the PSI policy, the majority (63%) of the psychologists endorsed this as a policy recommendation. When implementing requirements for professional practice, it is believed important to increase the range of choices to meet such requirements, where appropriate. Thus, ***it is recommended that supervisors accredited with related professional organisations are accepted within the PSI policy.***