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Review Article

Should Personal Psychological Therapy be Mandated to Trainee Clinical Psychologists?

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Introduction

In this article, I will be discussing the appropriateness of making personal-psychological therapy (PPT) mandatory in the British Doctoral in Clinical Psychology programmes (DCLINs). PPT, for this article, is defined as the practice of mental health practitioners undertaking psychological treatment from another qualified clinician (Kumari, 2011). The psychological treatment can be in any psychological modality from cognitive behavioural therapy to psychodynamic psychotherapy (Summers & Barber, 2010).

As someone with multiple marginalised identities, I have always been interested in team working and the attitudes and responses to difference. By difference, I mean when someone has one or more marginalised identities that have been associated with a history of oppression and discrimination (Kanai et al., 2020). For example, people that self-identify as queer (Berila, 2016). It has been unfortunate and disappointing that in my journey and for a profession that prides itself in equality and social justice (Hammack, 2018), difference has been treated with derision and disparagement. This is not only from my personal experience but also from witnessing how people with various psychiatric diagnoses have been spoken about in multi-disciplinary team meetings. Conversely, I have not noticed such attitudes amongst trainee counselling psychologists (TCoPs) and counselling psychologists (CoPs) that I have met. I would like to emphasise that this is from my experience and observations. I have noticed that TCoPs and CoPs tended to be more considerate, accepting and comfortable with difference than TCPs and CPs. This made me wonder if such a general trend may be because of the former being mandated to have PPT in training.

Conversely, being on the DCLIN has been one of the hardest endeavours that I have undertaken. I believe this is because of being in the system of clinical psychology that is indifferent and at times antagonistic, to difference. I do not think that I would have gone as far as I did without PPT. However, even despite undergoing PPT since my second year of training, it does not feel enough to process the trauma of being different in a White, heteronormative and able-bodied-centric profession. Many TCPs with one or more marginalised identities and TCPs with mainstream identities (i.e., White, neurotypical, middle class etc.) have told me they had to seek therapy to cope with the demands and stresses of training. My research projects are consistent with the fact that issues of difference tend to be treated with contempt and dismissal.

Whether PPT should be mandatory in the DCLIN is an important topic. This is because applied psychologists such as CPs and CoPs draw from psychological and psychotherapeutic theories to undertake assessments, make sense of problems and ease psychological distress (British Psychological Society [BPS], 2019; Jones Neilson & Nicholas, 2016). However, this competency involves the applied psychologist reflecting on how they may be affected by others (i.e., patients, colleagues etc.) and their clinical practice (Thompson & Thompson, 2018). It also involves the applied psychologist reflecting on how they may be impacting others, a process that is defined as reflexivity (Thompson & Thompson, 2018). However, just because reflexivity is a key competence in clinical psychology does not mean that TCPs and CPs are infallible in their thinking and decision-making regarding their practice (Baldwin, 2013; BPS, 2019). For example, interpersonal patterns, such as dismissal or coercion, can be enacted on colleagues and patients, which may have stemmed from erroneous assumptions or prejudices (Racker, 2018). This example of inadequate reflexivity and self-awareness can lead to iatrogenic harm and impoverished morale (Parry et al., 2016).

Although TCPs learn multiple psychological models, they are not immune to experiencing mental health difficulties (Curvis, 2019; Grice et al., 2018; Kaeding et al., 2017; Randall, 2019; Simpson et al., 2019). Furthermore, the DCLIN comprises juggling academic demands, research demands, clinical demands and personal commitments or responsibilities (Addai et al., 2019; Kaeding et al., 2017; Simpson et al., 2019). Based on the content of DCLIN curriculums, which also comprises learning psychotherapeutic skills, if the essential training costs are funded, then it makes sense for PPT to be funded too. Conversely, if the BPS, a judging body for clinical psychology, made PPT mandatory for TCoPs (Kumari, 2011), they should have made the same rule for TCPs as well. Job vacancies for CPs, except for neuropsychology vacancies, currently also accept applicants that are CoPs (Jones Neilson & Nicholas, 2016; Spelman, 2021). CPs and CoPs being able to apply for the same roles indicate that both may be similar in their application of psychological theories and frameworks to their practice (Smith, 2019; Spelman, 2021). However, this may not justify that PPT should be made mandatory in the DCLIN. If self-awareness and reflexive practice is the goal in the training of TCPs, then such attributes could be developed through supervision and reflective groups, aspects that are embedded in DCLINs (BPS, 2019). This depends, however, on whether reflective practice and supervision suffice in developing self-awareness and reflexivity skills. In this article, I attempt to answer the following questions:

1. Is PPT so integral to self-awareness and other CP skills (i.e., leadership) that it should be made mandatory in DCLINs?
2. If the answer to the above is ‘no’, then is reflective practice and supervision in DCLINs sufficient in developing self-awareness and other CP skills?
3. If the answer to the above questions is ‘no’, then is there a suitable alternative?

Advantages of Personal Psychological Therapy (PPT) in Doctorate in Clinical Psychology Programmes (DCLINs)

The aspects of PPT in DCLINs that I will be discussing are the functions or benefits that it could lead to. This is self-awareness, psychological support and professional benefits as reported in the literature.

Self-awareness

In discussing difference, Turner (2020) posited that the contempt for difference may be explained by the defence mechanism projective identification (Freud, 2018). Projective identification operates when a person psychologically places an aspect of themselves, usually ego-dystonic, onto another person (Freud, 2018; Turner, 2020). Projective identification may be reflected because racism and other forms of discrimination and workplace bullying are still rife in the NHS (Madhok, 2022; Prasad, 2021) and clinical psychology (Addai et al., 2019; Newness, 2021; Prajapati et al., 2019). This leads one to consider whether people had sides to themselves or traits that they did not want to face (Duncan, 2012; Hughes & Youngson, 2009; Ivey & Waldeck, 2014). As mentioned earlier, this can be pernicious not only to the practitioner but also to others, including patients (Duncan, 2012; Parry et al., 2016; Racker, 2018).

As outlined in the beginning, PPT has been reported to improve self-awareness and insight into relational patterns amongst TCPs (Duncan, 2012; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Murphy et al., 2018). Some argue self-awareness and working with others are fundamental to all the skills and responsibilities of being a CP. This includes and is not limited to consultancy, leadership, managing and being managed, conducting research, being a supervisor and supervisee, teaching, team working and training (Hughes & Youngson, 2009).

A common thread is that these responsibilities "involve being in a position of power, with levels of responsibility for others" (Hughes & Youngson, 2009, p. 41). Self-awareness comprises an awareness of how our personal histories (i.e., heritage, sexuality and religion) influence our self-conduct, interpersonal patterns and how we do our work (Bager-Charleson, 2000; Hughes & Youngson, 2009). It is consistent in the literature that self-awareness is positively correlated with both personal and professional development (i.e., Bailey et al., 2001; Ramani et al., 2019; Rubens et al., 2018).

There is evidence that PPT is beneficial to TCPs in the application of self-awareness to clinical practice. One benefit is that PPT supports TCPs in integrating both their personal and professional identities effectively and safely (Ivey & Waldeck, 2014). This can be achieved through mastering the "use of the self" (Edwards, 2018, p. 515), which is defined as managing ourselves in a manner that promotes and maintain healthy relationships with ourselves and others (Obholzer, 2020; Ryle & Kerr, 2020).

How we act or what is required of us may depend on whether we are alone or whether we are with others, including the context and culture (Banaji, 1994; Greene, 2018; Ryle & Kerr, 2020). This leads to us having multiple selves, which may include selves that are outside of our consciousness (Abrams & Zweig, 1991; Greene, 2018; Ryle & Kerr, 2020). Understanding ourselves, including our hidden selves, and how we interact or communicate with others enables us to be more effective in our work (Hughes & Youngson, 2009). PPT has been found to increase psychology practitioners' awareness of themselves, including TCPs (Hughes & Youngson, 2009; Ivey & Waldeck, 2014; Moe & Thimm, 2021; Ryle & Kerr, 2020). However, what remains unanswered is whether there was indeed a direct link between self-awareness and effective, ethical practice (Murphy, 2018). It has been reported that PPT can help to mitigate countertransference issues (Ivey & Waldeck, 2014). Countertransference occurs when a therapist behaves, thinks or feels about a patient as they would to persons in their past or personal life (Adams, 2013; Racker, 2018). PPT may lead to better management of countertransference issues through insight from experience as a patient (Ivey & Waldeck, 2014). However such benefits may be limited to psychoanalytic therapy (Abrahams & Rohleder, 2021; Adams, 2013; Summers & Barber, 2010) or psychoanalytic-oriented therapies such as cognitive analytic therapy (CAT; Ryle & Kerr, 2020). Still, a longitudinal study on the link between PPT and clinical effectiveness is yet to be done (Ivey & Waldeck, 2014; Murphy et a., 2018).

History and Context

The significance of the impact of self-awareness can be observed in patterns amongst TCPs in the literature. One of them is the reason people may want to be on the DCLIN. There is a trend of people choosing clinical psychology as a career because of their personal histories (Duncan, 2012; Grice et al., 2018; Huynh & Rhodes, 2011). Clinical psychology and other healthcare professions may be chosen because of experiences of adverse circumstances or mental health difficulties (Grice et al., 2018; Randall, 2019; Kaeding et al., 2017). Such people or psychology practitioners may then have high odds of experiencing vicarious trauma and stress from other demands (Huynh & Rhodes, 2011; Kaeding et al., 2017; Simpson et al., 2019). Adding to this, mental health difficulties are high amongst TCPs (Grice et al., 2018; Kaeding et al., 2017; Simpson et al., 2019). Mental health difficulties may also be inadvertently perpetuated by response behaviours such as perfectionism and TCPs placing self-care at the bottom of their priorities (Kaeding et al., 2017; Simpson et al., 2019). Perfectionism or unrelenting standards is high amongst TCPs, thus making them vulnerable to burnout (Kaeding et al., 2017) and emotional exhaustion (Simpson et al., 2019). PPT can help address vulnerabilities and factors that are associated with burnout, psychological distress and emotional exhaustion (Edwards, 2018; Murphy et al., 2018; Randall, 2019; Simpson et al., 2019; Wilson et al., 2015).

PPT can be helpful to TCPs with lived experiences (Curvis, 2019; Randall, 2019). A practitioner is said to have lived experience if they have endured mental health difficulties in the past (Curvis, 2019; Miller & Moyer, 2021). They are described as having dual identities (Curvis, 2019; Randall, 2019), which can impact training experience and clinical practice, positively or negatively (Curvis, 2019). Having a dual identity, on the whole, can be complex, which can make knowing where to learn and develop in this area to be difficult (Curvis, 2019). For example, on one hand, TCPs with dual identities can have and demonstrate high levels of empathy towards their patients (Howard, 2017); whilst on the other, overidentification with patients can be more likely (Curvis, 2019). Thus, PPT can be an invaluable aid in this respect.

Support Resource

Even if DCLINs may provide pastoral support and a supportive cohort, PPT may still be needed (Hughes & Youngson, 2009; Murphy et al., 2018; Wilson et al., 2015). This is because TCPs may fear being evaluated unfavourably (Wilson et al., 2015). Conversely, TCPs may have a stigma towards themselves as healthcare professionals experiencing mental health difficulties (Edwards, 2018; Randall, 2019).

This may stem from unfavourable discourses concerning being a practitioner with lived experiences (Curvis, 2019; Randall, 2019). An example is that TCPs may internalise an "us vs. them" discourse (Randall, 2019, p. 71), which is a belief that psychology practitioners or therapists should not, under any circumstances experience mental health difficulties (Adams, 2013; Curvis, 2019; Howard, 2017). The implication is that TCPs may keep their mental health struggles to themselves (Prajapati et al., 2019, Randall, 2019). PPT may then be a more appropriate and safer option, than disclosing to staff, in addressing personal issues and stresses (Grice et al., 2018). PPT can help to address mental health stigma through the experience of being a therapy patient (Edwards, 2018; Hughes & Youngson, 2009; Randall, 2019) and the development of self-compassion (Duncan, 2012; Randall, 2019; Wilson et al., 2015).

Another point that reflective groups and pastoral support on DCLINs may be insufficient is because those spaces may be psychologically unsafe for TCPs (Duncan, 2012). This is likely to be pertinent, especially where people are concerned with difference (Addai et al., 2019; Coop, 2018; Curvis, 2019; Wood & Patel, 2017). Safety may be absent because some spaces are a poor fit for the exploration of personal adversities (Curvis, 2019; Addai et al., 2019). Conversely, TCPs, especially if they have dual identities, may have been taught topics about their lived experience, which can be psychologically distressing (Curvis, 2019). Because of the power difference often present between TCPs and DCLIN staff (Bottrill et al., 2010; Newness, 2021), trainees may feel apprehensive about sharing how they were affected by the teaching (Curvis, 2019). The exploration of personal adversities and other problems is what PPT is designed for (Hawkins & Ryde, 2019).

It can be argued that if PPT was so important, then TCPs should be able to self-fund PPT. Such an argument is flawed because some TCPs may have personal commitments and dependents that may make self-funding PPT impossible (Curvis, 2019; Randall, 2019). Funding PPT can be a powerful message from DCLINs about the importance of self-care and personal and professional development (PPD; Hughes & Youngson, 2009). Even if TCPs may afford PPT, there may be more likely to seek it if it is funded. Funding PPT may also be another way of minimising systemic inequalities, especially where social class or economic privilege is concerned (Curvis, 2019).

Professional Benefits

Out of the reasons PPT should be funded and perhaps, even made mandatory on DCLINs, are its associated professional benefits, particularly regarding PPD (Curvis, 2019; Edwards, 2018; Hughes & Youngson, 2009, Ivey & Waldeck, 2014; Murphy et al., 2018, Randall, 2019; Wilson et al., 2015). PPD or clinical governance is the act of continually engaging in personal growth and learning (Barger-Charleson, 2020; Hughes & Youngson, 2009; Rupert & Dorociak, 2019). It is one of the key requirements stated by the regulatory bodies for TCPs and CPs, the BPS and the Health and Care Professions Council (HCPC; Golding & Grey, 2008; Tribe & Morrissey, 2020).

There is evidence that PPT is an efficacious tool for TCPs in mastering the competencies of a CP, including and not limited to assessment, formulation, intervention, communication and leadership (Edwards, 2018; Hughes & Youngson, 2009; Wilson et al., 2015). One of the ways PPT may enable TCPs to master their competencies is by enhancing their abilities in approaching their practice from multiple perspectives that can contradict each other (Randall, 2019). This ability may then co-occur with developing a better tolerance for ambiguity in their practice (Grimmer & Tribe, 2001). Being able to work with ambiguity is one competency of being a CP (BPS, 2019). Dealing with ambiguity is necessary when working amidst complex systems and working with patients that may have entrenched mental health difficulties (Curvis, 2019; Rupert & Dorociak, 2019).

The other consistent benefit of PPT is that it enhances insight and competence in learning psychotherapeutic skills (Hughes & Youngson, 2009; Randall, 2019, Ivey & Waldeck, 2014). In having a better understanding of our psychological distress with a good therapist, we build more agency in managing our difficulties or solving them (Randall, 2019). Such benefits from therapy may then lead to us having more empathy with patients (Curvis, 2019; Edwards, 2018; Randall, 2019). The benefits of PPT in psychotherapeutic skills do not stop there. It can also strengthen beliefs in the modality of the PPT and associated psychological change (Murphy et al., 2018). PPT can also be preventative regarding TCPs causing iatrogenic harm (Edwards, 2018).

Disadvantages of PPT in DCLINs

The most obvious reason it may not be a good idea to make PPT mandatory on DCLINs is to do with ethical issues (Ivey & Waldeck, 2014). Making PPT mandatory can make it coercive (Camilla, 2022). It can be argued that people should have the liberty to decide whether to undertake PPT (Harpur, 2022; Haye, 2022). There is also an argument that if PPT was mandatory, then the benefits that would have been gained if chosen voluntarily, may be lost (Mansell, 2022). There is some evidence that mandated PPT can be counterproductive. First, it can make people feel resentful especially if they have to use personal funds (McMahon, 2018). Second, TCPs might feel like they are assessed (Murphy et al., 2018) and anxious about what PPT might reveal about them (Wilson et al., 2015). They might not be ready or be too occupied emotionally, especially in the context of DCLIN demands, to undergo PPT (Hughes & Youngson, 2009). Another drawback of PPT is that it can exacerbate self-esteem issues and unhelpful comparisons with peers (Wilson et al., 2015). There have also been reports that having PPT coincided with disputes with family members and partners (Hughes & Youngson, 2009; Murphy et al., 2018). Lastly, sharing difficulties, history and feelings can be very uncomfortable and unethical, especially where the TCP is a private person and is mandated to undergo PPT (Wilson et al., 2015). The drawbacks outlined may be magnified if there are personal and professional links between the psychological therapists and DCLIN staff, leading to conflicts of interest. For example, if TCPs are mandated to see a DCLIN staff for PPT (Murphy et al., 2018).

There is growing evidence that PPT may not be needed for TCPs to grow in their self- awareness and professional effectiveness. Chigwedere et al. (2021) conducted a quasi- experimental study comparing TCoPs who had PPT with trainee cognitive behavioural therapy (CBT) therapists who engaged in self-practice of CBT techniques. TCoPs and trainee CBT therapists were compared in the study on outcomes relating to PPD: empathy, self-awareness, therapeutic confidence and perception of therapeutic effectiveness. It was noteworthy that trainee CBT therapists statistically had higher outcomes than TCoPs. However, this finding should be interpreted with caution because it was a quasi-experimental study. This means that the participants were not recruited from the same setting for a true comparison to be tested as in what researchers would do when implementing a case-control study or prospective cohort study (Fletcher, 2019). The consequences of such significant differences in the setting of the groups may indicate selection bias (Crombie, 2022). Further, while age was identified as not being a significant confounding variable in the study sample (Chigwedere et al. 2021), there may be other significant factors which could have impacted

the results i.e., socio-economic status or region. However, despite the limitations of the study, the illustrated efficacy of self-practice tasks regarding PD outcomes is noteworthy. Similar studies with groups of participants recruited from the same setting (i.e., the same cohort) would help enhance the implications of the findings of Chigwedere et al. (2021)'s study. Overall, it appears that more addition of self-practice tasks on the DCLIN may be a more pragmatic alternative to PPT in the training of TCPs.

Critical Reflections

In writing this article, I cannot help but feel conflicted. Part of me feels disillusioned from personal experience and hearing and reading from people like myself with marginalised identities experiencing one microaggression to another in this profession. The silence and neutrality in this profession, particularly from DCLIN staff is deafening. Should people such as myself continue to suffer and be hypervigilant to acts of being othered? I am not sure. But then another part of me values freedom and TCPs to do whatever ethnically to ease and enhance their DCLIN training experience. I find myself mindful of being perceived as being radical and being a catalyst for changes that may be seen as unnecessary and stressful.

I also cannot help but reflect my bias in the favour of making PPT mandatory. I would like to argue that there is evidence that trainee applied psychologists or trainee psychological therapists that were against mandated PPT in the beginning, reflected that they later valued it in terms of their PPD (Edwards, 2018; Murphy et al., 2018). A personal point is that PPT is mandated in CoP courses on top of TCoPs paying for matriculation and at times their supervision, costs that are covered by Health Education England on DCLIN courses (Spelman, 2021). TCoPs being mandated to pay for their PPT seems to be universally accepted. My argument is that one can choose whether to enrol in a course, and the DCLIN is not any different. The argument about mandated PPT in DCLINs being coercive is flawed because people still have the liberty to decide whether to apply. This is especially because the DCLIN training places are oversubscribed (Golding & Moss, 2019; Mayers & Mwale, 2018). McMahon (2018) conducted a study on the views of making PPT mandatory amongst CPs and CoPs. It was interesting that CoPs were in favour of this, and CPs were not. The latter's rationale was that they wanted to protect TCP's choice and psychological safety, arguing that readiness was important. However, the argument that if PPT was mandatory on the DCLIN, then people still had the choice of whether to apply, still stands.

There is another argument that whether mandatory PPT would help improve the training experiences of TCPs and CPs with one or more marginalised identities in the profession. Whilst I cannot answer whether this would be the case, I am curious whether mandatory PPT, especially if it was funded would help with this problem, especially given its associated benefits. Perhaps, I wonder, not making PPT mandatory but making it a funded option, might be a healthy compromise. This option has been proposed as long as there was no conflict of interest between DCLINs and psychological therapists, and the stance and expectations of undergoing PPT were delineated (Wilson et al., 2015). As highlighted earlier, from my own experience and the literature (Curvis, 2019; Edwards, 2018; Ivey & Waldeck, 2014, Murphy et al., 2018; Wilson et al., 2015), it seems that funded PPT would be beneficial to TCPs.

Conclusions

In this article, it was illustrated that PPT can be of relevance to DCLINs. This article also argued why it may be prudent, unnecessary, or unethical to make PPT mandatory on DCLINs. PPT being mandated to TCoPs was used to provide context. If CPs and CoPs are eligible for nearly all applied psychologist roles, with overlaps in their training, then it may be logical to also make PPT mandatory on DCLINs. Despite the reports on the personal and professional benefits of PPTs, there remains a gap in empirical direct evidence of such links (Murphy et al., 2018). Conversely, this article has highlighted that the benefits of PPT may be futile if it was indeed made mandatory. CoP doctoral courses were revisited with the argument that people still had the agency to decide whether to apply for a DCLIN training space if PPT was mandatory. The promise of self-practice tasks as an alternative to PPT was discussed as well as a compromise of making the latter funded but still an option to TCPs. In considering both sides of the argument, the associated benefits of PPT and the potential coerciveness in making it mandatory, my stance is that it should be a voluntary endeavour. However, given the reported benefits of PPT that have been discussed in this article, I believe it should be encouraged to TCPs in DCLINs and funded to minimise systemic inequalities.

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