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The construing of trainee clinical psychologists in relation to personality, theoretical orientation and factors that influence clinical practice

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Overview

This thesis consists of three parts:

1) Part one is a literature review of the factors relevant to the development of professional identity in clinical psychologists and other health professionals. The use of repertory grid as a tool to investigate professional identity is evaluated. The review also focuses on four further aspects of professional identity in clinical psychologists; personality, theoretical orientation, psychological adaptation, and factors that influence their clinical practice. The review concludes with a discussion and summary of the findings.

2) Part two is an empirical investigation into the professional identity of first and third year trainee clinical psychologists. The study used repertory grids to elicit constructs relevant to professional identity and questionnaire methods to investigate their personality, preference for theoretical orientation and the factors that influence their clinical practice.

3) Part three is a critical appraisal of the research. It addresses the origins of the research questions as well as the processes present throughout the period of conducting the study. The appraisal concludes with a commentary on the limitations of the design with particular focus on the repertory grid methodology. Future research is also discussed in light of the findings of the study.

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Part 1: Literature Review

The developing professional identity of trainee clinical psychologists and other health professionals

Abstract

Literature pertaining to the development of professional identity in clinical psychologists and other health professionals is reviewed. Particular attention is given to studies of professional identity using repertory grid methodology. Other factors of personality, preference for theoretical orientation and factors that influence clinical practice that were found to be relevant to a clinical psychologist's professional identity are also examined. Findings are summarised and discussed in terms of external and internal factors influencing professional identity.

Introduction

This literature review seeks to examine the development of professional identity in clinical psychologists whilst training. It will review models of professional development with reference to factors which may influence identity such as personality. It will also review how professional identity influences trainees in their model of clinical practice. The use of repertory grid methodology (based on Personal Construct Psychology; Kelly, 1955) as a potentially valuable tool for investigating professional identity in healthcare professions will be discussed. After each section a review of the associated methodology will be presented. A final summary and conclusion will end the paper.

The literature was sourced from the psychINFO database, academic search engines (Google scholar) and papers referenced by those originally obtained. All abstracts were read for relevance (n=41) and the most relevant (n=33) will be reviewed below. Search terms used were "psychologist / psychology / clinical psychology / therapist / psychotherapist" combined with "identity / professional identity / identity development / identity models". The papers on repertory grids were included where the methodology was used to measure professional identity explicitly. Search terms for these papers were "repertory grid" combined with "identity / professional identity / identity development / identity models". All papers on the psychological adaptation of trainee clinical psychologists were included.

A broadly cognitive definition of professional identity will be used throughout the review. It is considered that the term reflects an extension of self concept within a professional environment and that its acquisition includes the development of specific knowledge and skills along with potentially new or adjusted values, attitudes and self identity (Kaslow et al., 1992). An alternative to this definition is the more recent narrative exploration of 'storying professional identity' (Winslade, 2002) which consists

of a similar view of the process of developing professional identity but that it is conceptualised by not being self-contained or owned within the individual nor "independent of those who consult them" (Winslade, 2003, p. 3). While this definition is a useful alternative, it is not considered further here as it is not congruent with the historical models of professional identity that predate this view and would therefore make meaningful comparisons difficult.

Some of the papers refer to the USA system of training, which differs slightly to the UK system and will not be extensively discussed except where there are clear parallels.

Models of Developing Professional Identity in Trainee Clinical Psychologists

The process of becoming a psychologist is lengthy, arduous, complex and involves a transformation of identity at both a personal and professional level (Bruss & Kopala, 1993). The paucity of research into this area of critical development for a trainee clinical psychologist was noted over 20 years ago (Watts, 1987) with psychology training literature being largely concerned with content and structure of programmes as opposed to the training process (Soloway, 1985). The situation has not improved in recent years (Pilgrim & Treacher, 1992; Kaslow et al., 1992; O'Donovan & Dyck, 2005) with little information about trainee clinical psychologists' developing professional identity and how it influences their trajectory through training. Indeed, the majority of the recent research on training issues related to clinical psychology has focused on service provision and cost effectiveness of training (e.g. Mackenzie & Roth, 1999), factors that influence clinical practice (Lucock et al., 2006) and psychological adaptation (Brooks et al., 2002). This is somewhat surprising given the emphasis on encouraging reflective practice during training (Lucock, et al., 2006). Indeed, the professional identity of those

working psychotherapeutically may be inextricably linked to their personal identity (Bruss & Kopala, 1993). Most studies into professional identity development have been conducted in the USA, which, in important 'pre-qualification' respects, may not be too dissimilar to UK models of clinical psychology training.

The few studies that are available fall into the categories of models that attempt to explain how training impacts on professional identity, and individual differences in developing professional identity. The models in the literature cover psychology experiences that span pre-training, training and newly qualified positions. All provide a framework by which to understand the developing student's professional identity.

One of the first attempts to categorise the trainee's developing professional identity was by Kaslow and Rice (1985). The terms '*professional adolescence*' and '*professional young-adulthood*' were used to describe the interval between the pre-doctoral (in the UK: pre qualification) and post doctoral training (in the UK: first NHS job). In the *adolescent* period, it is hypothesised that the trainee is emerging as a professional and will function more independently and develop more collegial relationships with the training staff. Before this, the struggles of adolescence are encapsulated by the question "Am I just a student or am I a competent professional who can function independently?" Kaslow and Rice (1985) liken this to developmental adolescence; a time where there are many demands and a person can feel torn in many different directions. They suggest several factors that are important in the late parts of the adolescent stage, just prior to 'professional young adulthood'.

- Trainees retain some degree of dependence on programme staff for feedback for developing their personal and professional identity.

- The imminent relocation for some trainees that involves leaving social support systems and a developed and respected role in their previous work.
- Apprehension about clinical activities.

The *young-adulthood* stage is considered to be the forum for working through the psychosocial conflict of identity; cohesion versus role confusion, intimacy versus self-absorption and the deepening of commitment to the profession. A better sense of the newly qualified psychologist's identity will develop within the training context and the trainee becomes far more autonomous. With this brings much professional self doubt and questioning of a basic professional identity as a clinical psychologist. For example, it can trigger a questioning of the trainee's contribution as a psychologist and if anything separates them from non-psychologists in terms of initially more concrete techniques they apply. The authors consider this stage to signify the process of creating a more integrated sense of self, separate from authority figures.

Table 1: *Translation of Friedman and Kaslow's (1986) six stage training model to DClinPsy training.*

Number & Name of Stage	Suggested translation to DClinPsy model
1. Excitement and Anticipatory Anxiety	Year 1
2. Dependency and Identification	
3. Activity and Continued Dependency	Year 2
4. Exuberance and Taking Charge	
5. Identity and Independence	Year 3 and onwards
6. Calm and Collegiality	

Friedman and Kaslow (1986) posit a six stage model of developing professional identity in therapists shown in Table 1. They suggest that developing a professional identity is integral to the process of training and once achieved, will serve as a framework for therapists to make sense of their work and their own lives. The authors also consider the "Healer Identity" an important aspect of the wider professional identity. This implies that the therapist has faith in oneself as a 'healer'. As the authors point out, the therapist's tool differs somewhat to that of the medic as it is an invisible entity. Thus, the therapist in training may have some difficulty believing in its effectiveness at the outset, making it a desirable yet complex goal for training. Implicit in the model is the relationship a trainee has with their supervisor, which ranges from dealing with the trainee's self doubt at Stage Two, through to a less idealised, more equal relationship at Stage Six. Achieving the sixth stage of professional identity was considered to take no less than four years and frequently many more, with professional identity development continuing long into the therapist's career.

A further developmental model of professional identity was proposed by Kaslow et al. (1992). This drew on previous work (Friedman & Kaslow, 1986; Kaslow & Rice, 1985) and relevant work on child and adult development (Winnicott, 1971). The authors suggest that this developmental perspective "enables psychologists to appreciate the professional issues and tasks associated with postdoctoral training" (p.371) and suggest three phases; early, middle and late.

The early phase is characterised by negotiation. The trainee has to negotiate new roles and fitting into a new team, the autonomy and independence that new role affords, and the supervision that may be different from pre-training. Negotiating and becoming comfortable with a new status is also part of the early stage and research responsibilities also increase.

The middle phase of training is more complex but focuses on the consolidation of role and a growing confidence that is reflected in the professional identity of the trainee. The trainee is busy carving a unique role and may no longer adopt their supervisor's views and could potentially work in opposition to them. Clinical decisions are based on a more internalised frame of reference and the need for external support is reduced. The trainee is more able to identify their own strengths and weakness and becomes more open to supervision involving a self-reflective style. The supervisory relationship evolves further with supervisors being seen as 'consultants' as opposed to 'bosses'. As a result of these changes, the professional identity becomes more cohesive and the professional "true self" emerges. This facilitates the trainee's ability to draw on more creative resources. Kaslow et al. (1992) suggest that this is reflected in the developmental idea of play where children express and learn through playing (Winnicott, 1971).

The late phase is primarily concerned with the anticipation of becoming an 'adult' qualified psychologist. For the trainee it is the end of a long 'studenthood' and the prospect of addressing professional goals in order to evolve into the role of a qualified psychologist can evoke fear and anxiety. The authors refer to this late phase also as the termination phase and suggest that finishing training can be difficult, especially for those trainees who have been more dependent on supervision. However, the adaptive resolution of the termination phase can enhance the trainee's professional identity. The process of internalising the role of an independently operating psychologist may facilitate identification with other qualified psychologists, i.e. once the role feels genuine it may enable the newly qualified psychologist to establish collegial relationships in place of the mentoring relationships that were dominant in training.

Pilgrim and Treacher (1992) present a commentary on a model of identity development postulated by Mollon (1989). Mollon (1989) expresses concerns about the professional identity of clinical psychologists in general by drawing the contrast between medical training, which is based on a model of apprenticeship, i.e. learning from experience, and clinical psychology training, which is based on learning from research. Mollon (1989) suggests that the latter encourages a more detached intellectual stance rather than one that facilitates emotional contact with the patient. Pilgrim and Treacher (1992) argue that this represents a lack of insight into medical training, as students typically spend two years studying scientific information before beginning practice and therefore medics face a similar problem to clinical psychology trainees. They also argue that there is an element of apprenticeship in clinical training in the supervisor-student relationship.

Mollon (1989) goes further by asserting that psychodynamic psychotherapists' identity is more clear as there is an identification among peer groups and the role and techniques of practice are well defined. He suggests that clinical psychology has no such clearly defined parameters to which its practitioners can specifically relate. He therefore sees the clinical psychologist's professional identity as "uncertain if not fraudulent" (p.7).

Like Kaslow et al. (1992), Mollon (1989) uses a developmental perspective to describe the development of professional identity, albeit a fraudulent one. This model utilises Freudian developmental concepts. Mollon (1989) suggests that there are two ways of developing a professional identity: an omnipotent assumption of identity based on projective identification or one derived from learning and development. In the former, the psychologist is in the appropriate role, conducting the appropriate tasks but through the 'pretending', becomes convinced of their aptitude, skills and effectiveness. Thus, an

identity is developed not based on fact but on the psychologist's (fraudulent) image of themselves.

Supervision of the trainee is an important factor in the above models. Pilgrim and Treacher (1992) suggest that in line with Mollon (1989), supervision can vary in terms of how it facilitates the trainee to explore personal issues and that it can be sometimes difficult. It is suggested that unless the supervisor has a training in a model that legitimates this exploration, this process cannot occur and the trainee misses out as perhaps their supervisor did in their own training. This could influence professional identity profoundly.

The approach to training in the UK is critiqued by Pilgrim and Treacher (1992) who quote anecdotal evidence from a trainee who suggested that "the training approach assumes the trainee to be an 'empty bottle' that is to be filled by the institution's own wine. It neglects that the trainee's bottle may already be filled with vintage wine that when mixed with the new, creates a lethal concoction" (p. 131). This analogy nicely explains how the 'person' of the trainee and their experience can be lost during training. The concept that a trainee may already have some form of professional identity has been discussed in relation to other professions, e.g. nursing (Howkins & Ewens, 1997), suggesting an early identity shaped naturally by experience. This is supported by Gilbert (1989) who acknowledges that why people end up practising psychotherapy, their choice of approach and the way they put this into practice are important questions to be answered to learn about the 'person' of the therapist. They recommend that it is as important to focus training on the style of the therapist as well as the technique. Pilgrim and Treacher (1992) use the direct quote from the above text: "we need both the singer and the song" (p. 217) and conclude that clinical training had focused more on the song (training) not the singer (trainee).

This last thought by Pilgrim and Treacher (1992) and the notion that finishing training is difficult for trainees that are more dependent on supervision, are some of the only references to individual differences that may influence the trainee psychologist's trajectory through training. Kaslow et al. (1992) refer directly to the absence of any empirical evaluation of personality factors. There are, however, some studies that have attempted to address such individual differences in professional identity development in other domains. These studies are reviewed below.

Individual Differences: Gender

McGowen and Hart (1990) examine gender differences in professional identity formation and postulate that differences in male and female developmental experiences have influence on a professional level. The language used in this section is reflective of that used by the authors themselves, although their views on sex and gender do seem outmoded by modern standards. McGowen and Hart (1990) suggest that gender differences in professional identity development can be understood in terms of innate divergent values. According to the authors, the work of Giligan (1982) suggests that women have an identity based on attachment, whereas men have an identity based on separation. They suggest that women prefer relational thinking and men instrumental thinking. Moreover, these differing styles favour women as therapists with heightened empathy and sensitivity, but tend not to be traits useful in ruthless career progression. Men, on the other hand, have innate traits that facilitate such professional advancement. A further three areas of difference that similarly influence professional identity of women are explored. *Relational Focus* refers to a woman's difficulty in tending to herself, e.g. putting the needs of other before her own. *Distance versus Intimacy*, rooted in early mother-daughter identification suggests a woman may experience problems with

separating or continuing to tolerate distance relationships, even if they are destructive. McGowen and Hart (1990) suggest that the implication of this for a woman's professional identity is that her anger is tolerated at her own expense in order to avoid the separation that might result from displaying it. *Contextual Decision Making* (taken from the work of Gilligan, 1982) suggests that women are more likely than men to consider their decisions based on the effect they might have on others.

McGowen and Hart (1990) also point out how the training system is generally biased to a male standard of achievement i.e. competitive or confrontational styles of teaching. They suggest that this may be inappropriate in fostering intellectual and professional growth in women. The above factors combined suggest that gender may play a significant role in how professional identity is developed.

Individual Differences: Ethnicity

Ethnicity was considered by Watts (1987) to be a contributing factor in the development of professional identity in clinical psychology trainees. He investigated the professional identity of 43 black trainees in PhD programs in the USA using a semi structured interview. Watts found that values, professional career goals and theoretical perspective were highly interrelated as variables associated with professional identity. In terms of values, Watts found that students' professional work and world view tend to reflect their socio-political values. Students who indicated that social change orientation would be part of their future work were also more likely to plan to work with black populations and work with other professionals who engage in cultural issues. This finding was interpreted as "evidence for a professional identity that fuses a socio-political perspective with a relevant area of professional work and a logically consistent

population interest" (p.34). So it seems that one's personal views can influence the area of psychology in which one would wish to specialise.

Individual Differences: Training

Hamilton (1977) studied the differences between counselling and clinical psychologists in their professional identity. She developed a measure designed to capture the psychologists' perceived areas of importance of achievement in their training. The measure used two subscales of content and process in training. Seven content clusters and five process clusters were identified from the responses. In the contents cluster, clinical psychologists rated 'child work' higher than did counselling psychologists. Counselling psychologists rated 'training', 'vocational skills' and 'program process' (leadership skills) higher than did clinical psychologists. Of the process clusters, counselling psychologists rated 'personal maturity', 'being a good therapist' and 'self exploration and awareness' higher than did clinical psychologists. Due to lack of differences in 'research skills', 'assessment skills' or 'consultative skills' as rated by the two psychologist groups, these content clusters were considered core aspects of achievement in their training. This suggests that training and background can influence professional identity although some aspects are common to both clinical and counselling psychology. Furthermore, knowledge regarding lifespan seems to be a central aspect of the clinical psychologist's identity, which may distinguish them from similar professionals.

Summary of the developing professional identity of trainee clinical psychologists.

The literature presented in this section covers that available concerning how the professional identity of a trainee clinical psychologist might develop. It comprises small studies, case studies, and conjecture but there is limited empirical evidence

from investigating identity in trainee clinical psychologists. It is, however, acknowledged that the literature base (for both USA and UK training systems) is limited and somewhat dated and is therefore perhaps unreflective of recent changes that have occurred in the training programs both in the UK and USA in recent times.

Methodological concerns might be levelled at some of the studies that propose 'stage models' of professional identity development, in that the stages are based on the experiences of the psychologists writing the article rather than empirical investigation. Although the need for empirical support is mentioned by Kaslow et al. (1992), there has not been any, to the investigator's knowledge. Without such support, it is difficult to accept the validity of the suggested series of models. The developmental perspective is an interesting one and may serve as a useful frame of reference for training organisers who might supply better 'parenting' as a result, but an updated investigation that incorporates current trainees' views would be desirable.

The Freudian developmental perspective supplies us with a useful tool by which to tackle the issue of developing professional identity, but the manner in which it is suggested prohibits its integration into a current understanding. As Pilgrim and Treacher (1992) point out in their review of Mollon's (1989) conception of identity development; as an analyst who was clearly unsupportive of the then current training process, the model does not posit a balanced view. It was also inaccurate in its representation of medical and psychological training.

To evaluate the models of professional identity development further, there is a limited literature base describing how individual differences might influence trainees through the development of their professional identity. It seems likely that there is some variability in when trainees make the transition through the six stage model (Friedman & Kaslow, 1986). Considering the wide range of backgrounds from

which clinical psychology trainees are currently drawn, it seems unlikely that all would experience the same progression through the stages of development. The model would certainly benefit from some comment on the variables that might influence the trainee's trajectory through these stages.

The only study to report the views of trainee clinical psychologists is presented by Pilgrim and Treacher (1992). This consists of eight individual perspectives on the training process in the late 1970s. The authors (1992) do not summarise the perspectives as, they are so idiosyncratic that important details would be missed. As a result, themes are difficult to establish and, with so few participants, impossible to generalise. This dated material also precludes any insight into modern training as courses have changed so much: length, organisation, content and evaluation have all evolved over the thirty years since the accounts were recorded.

Despite the conjectural nature and methodological concerns of the studies reviewed here, they do present some initial (and to a great extent intuitive) frameworks by which to view the developing professional identity of the trainee psychologist. The models appear to have some face validity but would require extensive evaluation.

Gender, ethnicity and training are reported to influence the professional identity of psychologists, but only one paper was available on each. As with the models above, how gender influences professional identity is based on the experience of particular authors (McGowen & Hart, 1990) rather than empirical investigation. Although now perhaps out-moded, they suggest that innate values in men and women influence their trajectory through training and draw attention to the inequalities experienced by female psychologists throughout the training and workplace experience due to the male-friendly system. While providing an

interesting adjunct to the review, the views are of two psychologists who trained over 20 years ago and as such may no longer reflect the experience of the female psychologist.

The work on ethnicity conducted by Watts (1987) shows a more empirical approach. Watts himself comments on the limitations of the study, including low sample size (and hence caution in making any conclusions based on statistical differences), representativeness of the sample and interviewer bias. Furthermore, there was no 'control' comparison group, which would have differentiated black clinical trainees' identity from that of the predominantly white trainees. The study does highlight a link between world view (personal factors) and its influence on professional work. This characteristic of professional identity could be transferable beyond ethnicity, but at least shows some individual differences influencing the way psychologists work in terms of area of specialism.

Hamilton's (1977) study on differences between clinical and counselling psychologists' professional identity similarly suffers from low sample size. The rather sweeping generalisations made in the article are based on data gathered from very few psychologists and as such must be considered with caution. The study suggests 'assessment skills', 'research skills', and 'consultative skills' are 'core' to both clinical and counselling psychologists' professional identities. The conclusions might be disputed, as statistical difference between groups is clear but actual numerical difference is relatively small. The study does however present an intriguing argument for possible differences in professional identities between different branches of applied psychology training.

While this review of articles attempts to describe aspects of the process of developing a professional identity as a trainee clinical psychologist, there is little

empirical investigation in this field. What follows are a number of empirical studies on professional identity in other healthcare professions.

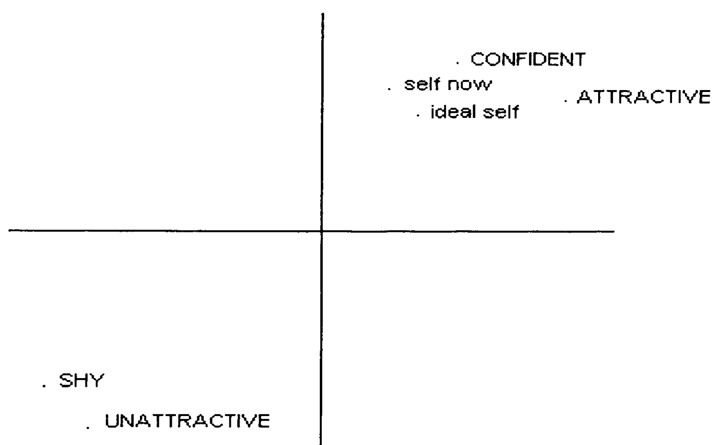
Repertory Grid studies of professional identity

The investigation of professional identity has been undertaken using Kelly's (1955) repertory grid methodology. This involves a semi structured interview procedure where a range of *elements*, which can be people or situations in one's life, are described in terms of constructs and rated. This results in a matrix of numbers which are thought to reflect the psychological relationships between the *elements* and constructs and which could be subjected to further statistical analyses.

The output of a repertory grid analysis yields a myriad of comparisons between *elements*, and constructs split into their relevant poles. This can be conceptualised in quadrants of 'construct space' in which the relationship between elements and constructs can be plotted. For example, a grid that shows high self esteem might be as illustrated as in graph 1.

Graph 1.

High self esteem indicated by element-CONSTRUCT positions in construct space

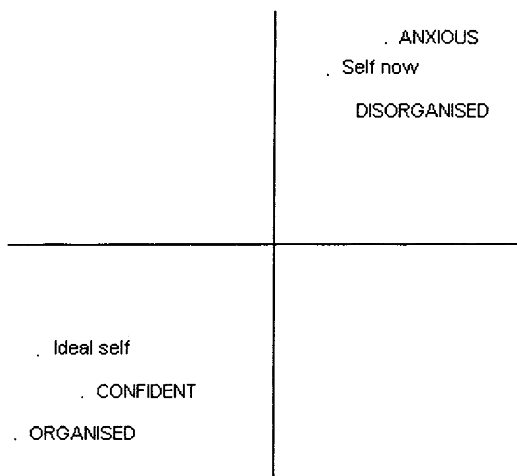


There is a small distance between *self now* and *ideal self* elements, indicating the individual in this example construes themselves as similar to their *ideal self.* This has been demonstrated as a measure of self esteem elsewhere (Winter, 1992). However, in this example, it is further elaborated by the nearby construct poles of 'confident' and 'attractive' indicating what gives this person their high self esteem. Furthermore, the contrast poles of these constructs (shy & unattractive) are construed as dissimilar to both *self now* and *ideal self,* observable by the greater distance from them in opposite quadrants.

By contrast, graph 2 shows a plot of low self esteem.

Graph 2.

Low self esteem indicated by element-CONSTRUCT positions in construct space



Graph 2 shows *ideal self* a greater distance away from the *self now* element, indicating that this individual construes themself as far from ideal. Similarly to graph 1, the constructs give an idea as to why this person construes themself as dissimilar to their *ideal self.* The distances between constructs and elements in graphs 1 and 2 are

represented numerically in a principal component analysis by Euclidean distance i.e. a distance that might be measured by a ruler. For example, the smaller the Euclidean distance between elements, the more similar the individual construes them to be.

The repertory grid lends itself particularly well to studying self perceptions, with 'the self' being a central concept of Personal Construct Psychology (PCP). With the exception of the Winter et al. (2006) paper that uses repertory grids to explore therapists' views on their own and others' theoretical orientation, no literature exists using repertory grid methodology to investigate the professional identity of psychologists. However, there are a handful of studies that investigate professional identity in social workers, nurses and medical students.

Ryle (1975) used repertory grids with social work trainees at the beginning and end of a training course. He used a mixture of supplied and elicited constructs to investigate how far potential problems in the social work role could be identified from grid interpretations and how much change occurred during training. He cites an example of a social work trainee who construed insecure people as making him anxious and people who could not express feelings as making him angry. Furthermore, the clustering of *elements* and the close distance between *self* and *ideal self* showed a defensive identification with 'normals' (i.e. not patients) and a low motivation to change respectively. At the end of training, Ryle (1975) demonstrated that there was a shift in a desirable direction in that training had "penetrated the trainee's defences" (p. 117) resulting in him no longer being made to feel anxious by insecure people or angry by those who cannot express themselves. This use of repertory grids very elegantly described a change in the professional identity of a social work trainee and also provided an area for the trainee to work upon during their training.

Howkins and Ewens (1997) investigated the changing self perceptions of 26 nurses from various fields of practice both at the beginning and at the end of their specialist community nurses' training which ran for nine months. A repertory grid design was used in which the elements were self and health and social care professional roles.

It was hypothesised that students would have an undeveloped professional identity at the beginning of their new course, as they would be leaving behind their previous established role and beginning specialist training. The results showed that, contrary to the authors' hypothesis, students rated their *self* and *professional role* elements as being similar, as indicated by a small distance between these elements. This suggests the nurses had perhaps already developed a professional identity in their initial training which was not further elaborated during the specialist training.

Madill and Latchford (2005) examined change in identity of first year medical students after the first exposure to human dissection. The study aimed to increase understanding of the transition from lay person to doctor in training. The four participants were asked to complete repertory grids at the beginning and end of the first term.

The study yielded results that were perhaps unsurprising. The medical students construed *myself as a medical student* and dissimilar to a *doctor I admire* and at point one but *myself when I qualify* as similar to *a doctor I admire* at time two. Madill and Latchford (2006) suggest the relationships between these three variables over the two time points show that medical students see themselves as becoming more similar to a doctor they admire as they pass though training. Madill and Latchford (2006) infer that medical students see themselves as not possessing the skills/ability they would like to at the outset, but were "optimistic about developing

valued professional characteristics by the end of their college training"(p. 10). The study appears to show a process of enculturation as a medical student and how the 'student' or 'learner' role features highly at the beginning of training.

The results also suggested that the medical students' identity had been integrated into the person as a whole, as the element *me at home* was construed as more similar to *me as a medical student* at time two. The study allows some insight into how medical students perceive their developing professional identity in that it seems perhaps unsurprisingly, that professional identity is not necessarily separate from personal identity.

The repertory grid design has been used to investigate the difference between student and fully qualified nurses' perspectives on the important attributes of a nurse (March & McPherson, 1996). The traditional triadic elicitation method was used in a grid with 48 student nurses and 24 fully qualified nurses. Role titles concerned with the professional self and aspects of nursing were used as elements in the grid. The study found that 'caring' was the most commonly elicited construct among students with nearly all mentioning it. By contrast, less than half the fully qualified nurses mentioned the construct. This suggests that more experienced nurses put less emphasis on 'caring' as an important part of their identity. In contrast, the construct of 'caring/compassionate' was rated in the top three attributes of qualified nurses in other studies (Wilson & Retsas, 1997; Retsas & Wilson, 1997).

March and McPherson (1996) show further differences between students and fully qualified nurses by comparing their own results with a study by Morrison (1991) whose results showed elicited constructs identical to their own study with the exception of 'intelligence' and 'confidence'. These were constructs that were only elicited by the student group, therefore suggesting some stability in construing of fully qualified nurses.

A follow up study presented in the same article consisted of a large scale survey that aimed to validate their findings of difference between students and fully qualified nurses. In this survey, 266 students and 262 fully qualified nurses were asked to rate the top 15 constructs elicited in the first part of the study. While statistically there appeared to be differences, actual differences in the data were very small and the significance arose from the large sample size. In reality, attributes were rated largely the same by both students and fully qualified nurses.

Wilson and Retsas (1997) elicited and ranked in terms of effectiveness the personal constructs of nurses that characterised the important attributes of nurses in general and effective nurses in particular. 'Good knowledge base', 'good interpersonal and communication skills,' 'caring and compassionate' and 'good clinical skills' were ranked respectively as the most important attributes of a nurse. Those constructs together with 'good decision making and problem solving skills' were ranked as the most important attributes of an effective nurse.

These constructs alone do not perhaps facilitate an understanding of the nurses' own professional identity. However, a cluster analysis of the construct ratings showed that there was a significant elemental distance between self perceptions of an *effective nurse* and a nurse's *ideal self.* A similar result was found in a subsequent study where there was a significant elemental distance between *current self* and *ideal self* in terms of effective attributes of a gerontology nurse (Retsas & Wilson, 1997). This might suggest that the professional identity of nurses in this study included the perception that they are not at the professional level to which they aspire. The study does not mention any reasons for why this might be, although one might hypothesise that constraints of the surrounding system (i.e. resources, access to further training, feeling overworked) might be to blame.

Winter et al. (2006) investigated the personal constructs of professionals practising therapy of various orientations. The therapists construed their own orientation as more positive than others (i.e. the elemental distance between *own therapy* and *ideal therapy* was small). Construing was investigated in terms of how therapists viewed their own and others' models in terms of some supplied constructs. These consisted of how 'humanistic' vs. 'cognitive behavioural' the therapies were and how effective they were, their potential to harm, how comfortable they were to use, their concern with the present and future and their conscious awareness. Perhaps unsurprisingly, there was greater commonality of construing within than between orientations. Personal construct therapists were the most homogeneous group in terms of commonality of construing and cognitive-behavioural therapists the least.

Where constructs were elicited rather than supplied, cognitive-behavioural approaches were described by such construct poles as 'symptom focused' and 'technique focused', with analytic approaches described by construct poles such as 'very time consuming' and 'trains via apostolic succession'.

Other outcomes from the grids were that cognitive-behavioural therapists used a large number of constructs concerning technical aspects of therapy with the psychodynamic therapists paying close attention to psychodynamic structure and processes. The personal construct therapists were concerned with personal meaning, and the systemic therapists focused on the social context of therapy. Curiously, therapists were relatively unconcerned with the usefulness of therapy, and did not pay much attention to theoretical issues.

This repertory grid paper shows that the professional identity of practising therapists can be defined by the way in which they choose to practise. This is observable in the way they construe their own and others' chosen models of therapy. This is further

explored in the next section of the review which examines the link between personality and theoretical orientation.

Summary of the Repertory Grid as a tool for investigating Professional Identity

A criticism often made towards studies involving repertory grid methodology is that as the technique can be considered "seductive" (Bell, 1988, p. 114); it can appear as a simple but intrinsically psychological method that is easy to apply but is often used without direct link to the theory that inspired it (Fransella et al., 2004). This can mean any findings can be misinterpreted and as a result, misguided conclusions made. The literature reviewed here often gives little detail of the rationale for using the methodology. In the nursing literature, it is often difficult to see the theoretical basis for using repertory grid technique or for the detailed analyses that have been conducted with the data. This point is made by Rawlinson (1995) who suggests that any research undertaken using this methodology should be supervised by someone experienced in personal construct psychology research.

A problematic theme for the literature in this area is not so much the low sample size but the generalisations that are made from the results. Howkins and Ewens (1997) assess 26 nurses but from the findings suggest structural changes to the nurses' training. Madill and Latchford (2005) have four participants but make no reference to the drawbacks in making conclusions based on such small numbers. Ryle (1975) also only cites one trainee as an example, although in this case it was more appropriate as the function of the study was to identify individual problems in professional role and no generalisations are made. Fransella et al. (2004) recommend Mair's (1964) definition of reliability: 'assessing predictable stability and predictable change' as opposed to creating measures that are stable as "stability exists in that which is measured" (Fransella et al.,

2004 p. 133). The studies that make such generalisations based on such small numbers appear to violate this definition.

The study by March and McPherson (1996) initially elicited constructs by the traditional technique but then supplied them to a wider sample to rate. These results were used to conclude that there may not be the differences in construing between student and fully qualified nurses that the initial elicitation had suggested. Ryle (1975) also used a mixture of supplied and elicited constructs. However, supplying constructs for rating is an arguably unreliable method as the validity of what is presented is assumed (Beail, 1984). This along with other views are presented by Thorne and Mullarkey (1996) in a review of the debate of supplying or eliciting constructs. They conclude that if there is evidence that the constructs are representative then it may be acceptable (Easterby-Smith, 1980). It is therefore perhaps questionable whether constructs elicited from 48 nurses and 24 qualified nurses by March and McPherson (1996) can be deemed to be sufficiently representative.

While the repertory grid studies have given some insight into the developing professional identity, with the exception of Winter et al. (2006), the studies do not include any other variables that might be predictive of how the participants construe, such as personality or theoretical orientation. Winter et al. (2006) demonstrate how repertory grid technique can be used to investigate construing with a link to standardised measures such as the Therapist Attitude Questionnaire-Short Form (Neimeyer and Morton, 1997) and the Direction of Interest Questionnaire (Caine et al., 1982). It can accommodate both qualitative and quantitative perspectives with the elicitation of constructs and the subsequent ratings that can be subjected to statistical analyses. It can also provide information about how change occurs, in terms of the content of construing

process, in addition to merely numerical indicators of change that might be gained from purely quantitative designs.

A paper by Mazhindu (1992) critically evaluates the methodology as a research tool in nurse education and practice. The merits of the methodology are described as its idiographic nature that allows participants to use their own words when describing their personal world and also promotes detailed exploration of personal meaning. Mazindu (1992) suggests the grid gives a structure to subjective information that allows comparisons to be made between individuals. It also permits analysis of the relationship within and between individuals' constructs and elements over time.

The limitations of the methodology suggested by these studies focus on the type of output yielded from a grid. Mazindu was concerned that grids tend to evoke adjectives connoting stable personality attributes when a person can actually be both poles under different circumstances or contexts. She also quotes Jahoda (1988) who suggests that categorising people according to their more frequent pole is not reflective of their full repertoire of 'stances and emotions'.

As demonstrated above, individual differences appear to play a role in the development of a professional identity in trainee psychologists. One of the most researched and stable individual differences is personality. There is evidence to suggest that the personality of the trainee clinical psychologist influences such aspects of their work as theoretical orientation (Arthur, 2000, 2001) and adaptation (Brooks et al., 2002). This review will take each in turn and present the most relevant evidence to support these hypotheses.

Additional factors of professional identity

Personality and Theoretical Orientation

The body of work concerning how personality influences the theoretical orientation of a psychologist spans many years with the initial concerted effort in 1978 with a special edition of the 'Psychotherapy, Theory, Research and Practice' journal. However, much of this work was based on the conjecture of the authors with no empirical research involved. Such research that did exist contained methodological problems that precluded any reliable generalisations. The outcome of this work is still important to consider as it provides the building blocks for the more rigorous research to follow.

Herron (1978) described several factors that he considered as determinants of developing a theoretical orientation. He places more emphasis on external factors, such as exposure to a certain model and a desire to work in a context that requires a particular orientation. He mentions personality but suggests this is less of an influence as different theories offer similar possibilities and as such would be applied in a comparable way regardless of personality of psychologists. Cummings and Lucchese (1978) offer a similar viewpoint and support external factors as primary determinants of theoretical orientation. They describe 'accidental factors' as a primary role, which may even determine an orientation at odds with one's personality, for example, the first model to which a trainee is exposed and through teaching and supervision during the training period. This is echoed by Ellis (1978) who suggests that individuals do choose a theoretical orientation that is congruent with their personality, preferences and tastes but not exclusively. He asserts that one can become convinced of the efficacy of a theoretical 'system' through personal experience rather than evidence and choose to begin practising it for that reason alone. He asserts that therapists generally tend to choose a system they like to follow, and that their likes and dislikes are part of their

personality structure. An interesting addition to the debate is Ellis' suggestion that it is the manner in which psychologists apply their system that is profoundly influenced by their personality.

Walton (1978) carried out a survey of 134 male therapists using a semantic differential task based on personality characteristics. The research distinguished orientations by therapists' self concepts, but could not make the causal link as to whether this was influenced by training or personality. Steiner (1978) concurs with the notion that external factors are the primary determinant of theoretical orientation after her survey of 30 therapists. She found that one's own therapist was considered the top factor contributing to the therapist's current orientation, followed by reading done in training, the influence of one's 'instructor' in terms of orientation during training, and the orientation of one's senior colleagues in a clinical setting. The first choice (orientation of one's own therapist) is unsurprising given that the majority of respondents were psychoanalytic psychotherapists. The training experience is a primary factor in Steiner's (1978) research and is congruent with Cummings and Lucchese's (1978) conclusions.

The overall message from this early body of work is that external factors such as influences during training and current clinical setting are responsible for the developing theoretical orientation of the clinical psychologist. While research since the 1978 edition of 'Psychotherapy, Theory, Research and Practice' has been sporadic, a spate of more empirically based research in the area began in the 1990s. Arthur (2001) presents a critical review of all studies in this vein to date. He concludes that most of the early work is methodologically flawed mainly by the selection process and the measures used to collect the data. Although some studies that have yielded valid results (Schandell et al., 1997; Arthur, 2000) do suggest a link between personality and theoretical orientation. Arthur (2001) analysed the trait-orientation link in 13 published studies by collapsing the

data into descriptive form and drawing out commonalities. The traits of both behaviourists and psychoanalysts from the literature demonstrate the link in detail:

The cognitive behaviourist/behaviourist

They can be down to earth, conventional, inartistic, traditional, predictable, orderly, stable and realistic; they rate themselves as active, having initiative, and with being practical, assertive, dominant and extrovert (p.54)

The psychodynamic psychotherapist

They have a feeling reactivity (sic), acceptance of aggression and capacity for contact; a fluid, changing, creative, non-conforming, imaginative, individualistic and active personality style is seen (p.56)

For trainee clinical psychologists, Arthur (2000) makes the point that it can be difficult for them to establish what theoretical orientation appeals as the associated image may be stereotyped. He places the responsibility with the training institution to discuss with the potential trainee how their personality may affect their best suited orientation. Arthur (2000) asserts that orientations should not be prescribed or a new perspective may be lost but that care should be taken to inform of the possible dissonance that may occur if trainees with certain personality types work with incongruent therapy models.

Personality, it seems, is implicated in the process of developing a theoretical identity as a trainee. However, the relevant research is only concerned with the identification of the factor of personality and not the process that occurs, i.e. how one comes to identify with a model. This is addressed by Bitar et al. (2007) who conducted a qualitative study to determine the factors and the process involved in developing a theoretical orientation. They found that the factors involved personal (internal) and professional (external) factors. Personality was present in the personal factors and the process was described as a goodness of fit between chosen theory and personality. Personal values were also identified as an influencing factor in developing an orientation.

Bitar et al. (2007) noted that a trainee could not work within a framework that was inconsistent with his belief in God. Another began working within a feminist framework as it resonated with her when she came across it in her training. This links with the research by Watts (1987) who found that personal values influenced the area in which trainees initially wanted to specialise. This perhaps adds further support to a professional identity and resultant clinical practice being influenced by one's personal views, at least inasmuch as cultural issues for Watts (1987) and theological or personal identification with theory for Bitar et al. (2007).

Psychological Adaptation

Several studies using the same sample (Brooks et al., 2002, Kuyken et al., 1998, Kuyken et al., 2000, Kuyken et al., 2003) have demonstrated that personality has also been shown to influence the psychological adaptation of trainee clinical psychologists in their professional life. Psychological adaptation is argued to have three dimensions: morale, social functioning and somatic health concerns (Brooks et al., 2002). Significant difficulties are involved with these dimensions in the transition from year one to year two of the training course (Kuyken, et al. 2000).

Brooks et al. (2002) investigated the link between personality (as measured by the Millon Index of Personality Styles), expectation and adaptation as experienced by trainee clinical psychologists. It was argued that those trainees with a less well-adjusted personality would adapt less well to unmet expectations and other stressors on the course. The study considered poor psychological adaptation to be marked by higher levels of anxiety, depression and poor work adjustment.

Kuyken et al. (1998) found that, of the sample of 364 clinical trainees over all three years of 15 randomly selected training courses, eight per cent were experiencing

poor psychological adaptation. The results showed those trainees with poor personality adjustment were more likely to be 'preserving' rather than 'enhancing' and 'accommodating' rather than 'modifying'. There were 'introversing' rather than 'extraversing' and 'retiring' rather than 'outgoing'. The well-adjusted sample was found to be the reverse. The poorly adjusted sample also reported significantly more negative experience of training in the following areas of expectation: supervision, clinical work, personal and professional identity, impact on life and research teaching. A longitudinal study of trainees' adaptation showed that problems with psychological adaptation are more likely to occur in the transition between first and second years of training. It was suggested that this may be due to a 'negative affect' in trainees who react to the demands of training as threatening and find it more difficult to assimilate and apply increasingly complex information (Kuyken et al., 2000). So, personality/internal factors are again supported as an influence on the trainee but it is when problematic internal factors are coupled with problematic external factors (poor supervision, tutorage) that professional development of the trainee is worst affected.

Social support from both a trainee's home life and the course were shown significantly to predict good adaptation (Kuyken at al., 1998). Coping style predicted a significant degree of variance in adaptation and trainees who used less avoidant coping adapted better over time (Kuyken et al, 2003).

Brooks et al. (2002) conclude that a relationship between personality and adaptation had been illuminated although no comment can be made as to the causality of the relationship due to the correlation design.

It seems that the process of psychological adaptation during training is implicated in the professional identity of trainee clinical psychologists. It is related to

personality and could possibly be used to predict how the training course might be experienced and managed over time.

The next section considers what trainee clinical psychologists perceive to influence their clinical practice; an intrinsic component of a professional identity.

Factors that influence clinical practice

It has been shown so far that professional identity has an influence on how and in which context the trainee chooses to practise after training (Watts, 1987; Arthurs, 2000). It follows that what influences trainees' practice will be integral to their professional development including, perhaps, their identity. A well designed study by Lucock at al. (2006) investigated which factors most influenced the clinical practice of fully qualified and trainee clinical psychologists using a measure developed by the authors (Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies: QuIF-CliPP). They found that for the trainees, the highest rated factors were current supervision, past supervision, client characteristics, client feedback, psychological formulation/assessment developed with the client and professional training. Interestingly, these were all external factors and neither trainee nor fully qualified psychologists rated any internal factors, such as personality, highly.

This study also considered the factors influencing psychologists as defined by their particular theoretical orientation. Cognitive behavioural therapists found evidence based practice more influential than did the other approaches (psychoanalytic, person centred, integrative and eclectic) and non-cognitive behavioural therapists found their life experiences more influential. Cognitive behavioural therapists were less likely to have personal therapy and those who did, did not rate it as a highly influential factor. By contrast, perhaps unsurprisingly, psychoanalytic therapists rated this factor very highly.

While internal factors were not rated in the top influential factors, they were still rated as more important than evidence-based guidelines for both trainees and fully qualified psychologists. Lucock et al. (2006) were surprised that trainees did not rate the evidence based literature, given the research-practice base of most training courses. Supervision and training were rated highly and it was suggested that these would contain frequent reference to evidence-based practice (Lucock et al., 2006). Trainees rated these factors higher than did their fully qualified counterparts, perhaps illuminating their reliance on training during their professional development.

Summary

The early work on how personality influences theoretical orientation was adequately criticised by Arthur, (2000; 2001) who pointed out that the methodological flaws and conjecture were not sufficient evidence to support the general consensus of external influences being the primary determinant of theoretical orientation. While these papers might not have the answers, they did provide a good baseline against which other studies could be measured and indeed inspired Arthur (2001) to suggest methodological criteria for further research. The more recent work has provided ample evidence to support the hypothesis that personality is implicated in the development of a theoretical orientation However, it does not tell us how this process occurs – only that it does.

This issue was picked up by Bitar et al. (2007), but due to the restrictive sample size (n=5) and limited variation in participants' background (systemic therapies only), there was little detail more than was hypothesised in Arthur's papers (2000; 2001) or in fact the early work (Ellis, 1978), namely that therapists choose theories that they like and that they think fits with their 'way of being'.

There is little attention paid to the formative training years in the literature as it focuses mainly on fully qualified psychologists who are settled in their chosen field. This is perhaps understandable, given that psychologists may take time to find their milieu. However, the time at which the embrionic psychologist is open to the most influential expereince is during training, and as such, detailing the beginning of the process would be invaluable.

The work on personality and adaptation is sparse but consistent in rigorous methodology. The process of personality influencing how a trainee adapts to their professional world is detailed and the predictive factors tested but it does not take account of how this process might change over the training period. We know that the transition from first to second year is, according to the data, the most stressful period but we are not told how the negative affect that causes the problematic adaptation develops over the course of training and if it is influenced by other factors.

The only study on the factors that influence the clinical practice of trainee clinical psychologists (Lucock et al., 2006) is one of sound methodology and valuable conclusions. The QuIF-CliPP has been validated with adequate psychometric properties and has yielded information regarding important factors in clinical practice. What this study lacks is also information on the process, i.e. why do trainees find previous supervision more of an influence on their practice than do fully qualified psychologists? The paper makes appropriate hypotheses about this but does not supply any evidence.

Discussion

This review has sought to bring together a disjointed literature base to highlight the important factors in the professional identity of trainee clinical psychologists. There is no one current theory as to how it develops, is maintained or influenced. Early work

focused on explaining the acquisition of professional identity from a developmental perspective has not been followed up or adequately tested, to the investigator's knowledge. Later, more work focused on individual factors that might influence its development but again, this was conducted over 15 years ago and will not reflect current, modern training programmes. Other professions have been investigated more thoroughly; nursing research has used repertory grid methodology to great effect to measure how nurses construe their professional identity. This enabled an investigation of the deeper process of the developing identity without losing the power of the experimentally designed study. Unfortunately, the repertory grid technique is often used without due attention to the original theory, which may reduce the potential conclusions that can be drawn from the resulting data. Also mainly due to a small 'n' in many repertory grid studies, there are potential problems in power and generalisability.

More modern research is focused on forging a link between personality of psychologists and their choice of theoretical orientation. The process of coming to 'own' a certain approach and becoming skilled in its application as a psychologist is surely a key factor in developing professional identity. The empirical data suggest that internal factors certainly do influence orientation choice and, as such, are intrinsic to identity. Little detail is paid to the training experience and the processes by which this decision comes to be made. It focuses more on obtaining the personality characteristics of fully qualified psychologists working in a specific area. Most of the research makes use of personality measures based on theory generated factors rather than the more generally accepted Big Five theory of personality which was derived from factor analysis, which may leave the reliability of results open to question. While methodologically more rigorous, the research still leaves an unanswered question around the process of *how* one selects a theoretical orientation.

Personality was also seen to influence how trainee clinical psychologists adapt during their training. The results of these studies made a firm link between good and poor psychological adaptation and its consequences. More details exist regarding the process of how a certain personality type may deal with aspects of the course and the consequences of dealing with it in that way. This perhaps gives an idea about how one's identity might be shaped by this process i.e. if one is poorly adjusted, copes in an avoidant manner and suffers from the pressures of the course, one's identity is likely to be quite different to one who adjusts well, copes adequately and manages pressure effectively.

There is only one piece of literature that empirically investigates the influences on clinical practice of trainee clinical psychologists. This tells us that personal factors are not high on the list and more physical training aspects are important. This is perhaps unsurprising but it is important to note that these factors will also be relevant to the professional identity, particularly at this formative time.

As the literature is so disjointed, it is important to have a means of summarising the information presented in this review. The main contributing factors to a professional identity can be summarized as *internal factors*, *external factors* and *process issues*.

External factors

The external factors are Supervisor; both pre (Kaslow & Rice, 1985) and during training (Friedman & Kaslow, 1986) and their theoretical orientation and personal style (Steiner, 1978). Early clinical experience (Cummings & Luccchese, 1978), models exposed to during training (Steiner, 1978) and type of training (Hamilton, 1977) also feature.

Internal factors

Personality (Arthur, 2001, Schandell, 1997) and consequent adaptation (Brooks et al., 2002) and coping styles (Kuyken et al., 2003), ethnicity (Watts, 1987) and gender (McGowen & Hart, 1990) are all integral factors in developing a professional identity.

Process issues

While it is possible to highlight the individual factors from the literature, the process that occurs within the trainee is not so clear, i.e. how those factors operate. The first question pertinent to the professional identity of a trainee clinical psychologist is perhaps do they bring an existing identity to training or does training alone supply it? According to Howkins and Ewens (1997), nurses began their specialist training with a good sense of a professional identity. It is therefore logical that trainee psychologists, a majority of which have worked in assistant psychology posts, would have some established sense of their role and identity. This might at least be true from the beginning of training where a trainee has certain expectations of how to fit in. Training, however, may not be as expected; Brooks et al. (2002) documented the process of unmet expectations, and suggested that personality mediates the consequences for a trainee. Thus, it may be possible that professional identity may need more to be adjusted than created by a course.

The concept of maturing through the stages of training, most eloquently presented by Kaslow et al. (1992) in the most recent formation of their model, presents another process abundant in trainee clinical psychologists. From the initial dependence through to the separation from the authority (Kaslow & Rice, 1985) and becoming a separate entity with a personal style and dealing with the termination of their studenthood (Kaslow et al., 1992), the trainee undergoes a definite maturational process. The aspect of becoming an independent psychologist at the end of the training or

maturational process is reflected in the work by Madill and Latchford (2005) who showed that the medical students in their study identified their current selves in training as being distant from their ideal professional selves. They identified firmly as students admiring of others at the beginning of their first year but less so as they move through the year.

The notion of not being where one would wish as a professional does not just appear during training. Wilson and Retsas (1997) highlighted how qualified nurses were able to suggest effective attributes of a nurse but many did not class themselves as having all the qualities. This perhaps is an aspect of professional identity that requires further investigation as it is unclear if psychologists feel the same or if one ever reaches the point of being comfortable with the level of one's competencies. However, according to the models of training, this is very likely.

The more disturbing view of developing a professional identity came from Mollon (1989) who asserted that clinical psychologists' identity can come from 'an omnipotent assumption of identity through projective identification' (p.114). This suggests that a trainee can go through a process that makes them 'unconsciously incompetent' but operate as if they are fully competent. This model was steeped in criticism for its in accurate descriptions of medical and psychological training.

Methodology

The main criticisms for the literature reviewed here are in the area of design, sampling and identity measurement. Many of the papers on developing professional identity were conjecture lacking any empirical testing. The repertory grid studies often lacked a clear rationale for using the methodology, no clear link to the theory and often small sample groups. The papers linking personality to theoretical orientation were more rigorous but

the measures used were primarily those based on Jungian theory and not the generally accepted factor analysed trait model (Big Five). The design of these studies did not allow for any observation of the process behind how personality influences theoretical orientation. The measures for theoretical orientation were variable and, as such, difficult to compare.

The repertory grid methodology has many positive aspects for this area of research. As the self is a central feature, a grid yields a measurable and comparable distance between self and various specified elements (roles), as seen here with the nurses and medical students. This is particularly useful to measure change over time. Any further research would benefit from this approach if conducted in line with the Fransella et al. (2004) recommendations presented above.

Conclusion

This literature review has brought together a disjointed body of work on the professional identity of trainee clinical psychologists. It has attempted to detail the aspects of professional identity presented across the literature and present them in a coherent structure. It has identified three factors that are common throughout the papers reviewed: external factors, internal factors and the process by which they operate. There seem to be some links between the factors, although much of the literature is methodologically flawed. The lack of research in this area should be addressed and any further research may benefit from using the repertory grid methodology which seems particularly suited to this area of study.

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Part2: Empirical Paper

The construing of trainee clinical psychologists in relation to personality, theoretical orientation and factors that influence clinical practice

Abstract

The study aimed to examine the developing professional identity of trainee clinical psychologists. The construing of trainees was investigated along with personality, preference for theoretical orientation and the factors that influence their clinical practice. Differences were found between first and third year trainee groups in terms of external and internal factors of professional identity. Across both groups, personality was found to be related to self esteem and theoretical orientation and theoretical orientation to structure of construing. Findings are discussed within a personal construct psychology framework.

Introduction

In the UK, doctoral training in clinical psychology is a three year process that consists of academic teaching, clinical placements and a research thesis. Over the last five years, the training programmes nationwide have produced over 500 clinical psychologists each year. Acquiring a place on a course is notoriously difficult with 2442 applicants for 554 places last year (27% success rate). Due to this high demand and limited supply, the training has been described as a Holy Grail whose attainment is accompanied by both relief and bitter resentment (Cushway & Jay, 2000).

Psychological experience of the training program

During training, trainee clinical psychologists have a dual status as postgraduate students and healthcare employees. The trainee clinical psychologists are exposed to a wide variety of experiences in terms of clinical placements and supervisors and are evaluated both academically and clinically throughout. There is a limited body of literature that has attempted to investigate the experiences of the UK trainees. The literature reports that trainees can experience high levels of distress due to the emotive nature of the work, professional self-doubt, low levels of self-esteem, depression and anxiety. They can have difficulties making the psychological adaptations (including effective learning strategies) necessary successfully to engage in the training program (Hannigan et al., 2004; Cushway & Tyler, 1996; Kuyken et al., 1998; Kuyken et al., 2003). Furthermore, the psychologist in training is continually being evaluated which can lead to a `crisis of confidence' and a sense of always working on the edge of one's competence (Cherniss, 1980).

Training courses seek to recruit people from a varied background in terms of experience, ethnicity, gender and age. A typical cohort may contain a range of personalities that will experience the training in an equally varied way. Some literature has commented on which individual differences might impact on a trainee's trajectory through training. Several models have been postulated regarding the developing professional identity of the trainee clinical psychologist in the USA (Kaslow & Rice, 1985; Friedman & Kaslow, 1986; Kaslow et al., 1992). Also explored are factors implicated in the professional identity such as personality and theoretical orientation (Arthur, 2001) and the factors that influence clinical practice (Lucock et al., 2006). Ethnicity (Watts, 1987), gender (McGowen & Hart, 1990) and psychological adaptation (Brooks et al., 2002) also appear to contribute to the developing professional identity.

Models of professional identity

An early model of the development of professional identity among trainee clinical psychologists in the USA was postulated by Kaslow and Rice (1985). This consisted of two phases of '*professional adolescence*' and '*professional young-adulthood*' which were used to describe the interval between the pre-doctoral and post doctoral training. The UK equivalent of this would be pre-qualification and a first NHS job respectively. The main tenets of this model were that trainees initially face a process where they emerge as professionals from a previously 'student' identity and go on to become more autonomously functioning psychologists, independent from their supervisors. Kaslow and Rice (1985) suggest that trainees face dilemmas as they pass through these phases, which are similar to the developmental stage of adolescence, when many demands are made and individuals

may feel torn in many directions but eventually emerge with a more integrated sense of self.

Later work postulated a six stage model (Friedman & Kaslow, 1986) followed by a reduced three stage model (Kaslow et al., 1992), each based on developmental comparisons. Both serve as a comprehensive description of the process and impact of training but are based purely on the experience of the authors (fully qualified clinical psychologists with long-standing experience). While this may be a valuable autobiographical, narrative perspective, it lacks empirical support.

Personality and its influence of professional identity

Addis and Jacob (2000) draw an analogy between clinical training and personal therapy; both being affected by individual differences before and during the process. Both can be approached from a variety of different theoretical perspectives or models that link process to outcome and both can be aimed at achieving a variety of different outcomes. This analogy highlights the importance of investigating the potentially stable individual differences (Costa & McCrae, 1988) that influence how trainee clinical psychologists might experience their training. The literature suggests that personality can affect how individuals experience stress, develop coping strategies, utilize social support and adapt psychologically (Brooks et al., 2002). Moreover, personality has been documented as a factor in the causes, correlates and consequences of poor psychological adaptation in health professionals more generally (Firth-Cozens & Payne, 1999) and in trainee clinical psychologists specifically (Kuyken et al., 2000).

One of the main contributing factors that influence a therapist's choice in theoretical orientation is the therapist's personality (Arthur 2000; Pozanski & McLennan, 2003). It is therefore possible that theoretical orientation may be based on emotional rather than intellectual preferences or biases (Adams, 1984). This is particularly salient for trainee clinical psychologists who will be developing knowledge of the theoretical approaches and making judgments about where they identify and align themselves. Theoretical orientation has been measured effectively by Pozanski and McLennan (1999) who developed the Counsellor Theoretical Position Scale which comprises of two dimensions; Rational-Intuitive and Objective-Subjective. The measure was developed with these implicit dimensions as they considered 'school' based approaches to measuring theoretical orientation limiting. Their findings showed that CBT therapists tended to score higher on the Rational-Intuitive dimension, psychodynamic therapists higher on the Objective Subjective dimension and systemic therapists had intermediate scores.

Arthur (2001) conducted a review of the literature and chose 13 papers making trait-orientation links that could be compared on common measures of each. Common traits were established for cognitive-behavioural therapists and psychodynamic psychotherapists. Traits included in the description of cognitive-behavioural therapists were practical, assertive, dominant and extrovert characteristics. Psychodynamic psychotherapists were described as creative, non-conforming, imaginative and individualistic. While asserting common traits related to practitioners of certain therapeutic models, Arthur (2000) also comments on how difficult it can be for a trainee clinical psychologist to choose an orientation as the models can be stereotyped and presumably therefore avoided because of misconception. The research in this area has tended to use the Myers-Briggs Type

Indicator (Briggs et al., 1985), which is based on Jungian principles and may have limited generalisability. One exception to this methodology was a study by Schandell et al. (1997), which used the NEO-PI. The findings showed that 'agreeableness' was associated with CBT practitioners but no other traits with any other models. Ellis (1978), in contrast to Adams (1984), commented that decisions regarding theoretical orientations are not mostly influenced by personality but by intellectual interest or circumstance (e.g. supervision) and it is the way in which the model is *applied* that is influenced by internal factors such as personality.

Personality has also been implicated in another area integral to professional identity: self-esteem. Robbins et al. (2001) found that personality as measured by the NEO–PI accounted for 34% of the variance in self-esteem.

Factors that influence the clinical practice of trainee clinical psychologists

Lucock et al. (2006) investigated the factors that influence the clinical practice of fully qualified and trainee clinical psychologists and psychotherapists. A survey indicated that for trainees, current supervision, past supervision, client characteristics, client feedback, psychological formulation and professional training were important factors. Although external factors appear most valued by trainees in the Lucock et al. (2006) study, internal factors have been found to have some influence on a trainee's professional identity elsewhere. Bitar et al. (2007) found through a qualitative approach that internal factors can also be implicated in how a trainee decides to practise. It was found that theological and personal identities impacted on the particular frameworks a trainee adopts in their clinical work. This is echoed in terms of ethnicity (Watts, 1987) and gender (McGowen & Hart, 1990).

There is evidence to suggest that trainee clinical psychologists are subject to intense and varied experiences in their professional lives that are mediated by internal factors such as personality. In turn, these internal processes can also impact upon external factors such as their practice and preference of theoretical orientation.

The UK research on training issues related to clinical psychology has tended to focus on service provision and cost effectiveness of training (e.g. Mackenzie & Roth, 1999), factors that influence clinical practice (Lucock et al., 2006) and psychological adaptation (Brooks et al., 2002). There are no studies demonstrating how trainee clinical psychologists experience this process from a personal perspective.

Repertory grids as a tool to investigate professional identity

The repertory grid is a technique that has been used to investigate the professional identity of individuals from a uniquely personal perspective, particularly in the health professions. The technique was designed by Kelly (1955) as a means of exploring constructs that he believed underpinned how people understand and anticipate events in their world. It is a phenomenological approach which combines qualitative and quantitative methodology to yield data specifically relevant to the individual. It is perhaps well suited to this area of research because it places 'the self' as a central theme to the methodology and is based on constructivist learning principles (Neimeyer, 1993) where individuals can either *Assimilate* information into existing knowledge frameworks or change those frameworks by *Accommodating* the information that does not fit.

Grids yield a measurable and comparable distance between self and various specified *elements* (roles). Statistical correlations show whether elements and

constructs are related and Euclidean distances (statistical conception of 'real' distance) calculate how 'near' or 'far' elements are to each other, e.g. how similar or different does one consider one's *self* to be to one's *highly respected supervisor* (see p. 23 of literature review).

Certain implicit conclusions have been drawn from grid outputs. Neuroticism has been shown to be related to individuals who construe 'tightly' (Winter, 1985), that is, in a unidimensional manner. According to Kelly (1955), a tight construer's construing system is designed to minimise anxiety by increasing predictability. At the other end of the spectrum, loose construing has been associated with thought disorder (Bannister & Fransella, 1967). Distance between the elements of current *self* and *ideal self* has been used as an index of self esteem in a normal and depressed clinical population (Winter, 1992).

Repertory grids were used by Howkins and Ewens (1997) to investigate the developing professional identity of qualified nurses moving into specialist training. The grids enabled them to show that nurses considered their professional identity to be largely established *before* specialist training with *self now* and *professional role* elements being relatively close to each other before and after the specialist training course. Using repertory grids, Madill and Latchford (2005) were able to observe how the personal and professional identities of first year medical students became 'integrated' over the first two years along with a process of 'enculturation' as medical students, with their identity stabilising over the same period. March and McPherson (1996) compared the elicited constructs of 'effective nurses' from both qualified and student nurses. It was found that the construct of 'caring' was rated higher by students than by qualified nurses. In the same paper the results were compared with a similar study by Morrison (1991) who found, in addition to a few

other constructs in the student group, identical constructs to March and McPherson (1996) in both groups suggesting some reliability in the construing of nurses in the domain of professional identity.

Winter et al. (2006) used grids to investigate the views of therapists practising various forms of therapy. Therapists viewed their own model as more positive than others but were relatively unconcerned with the usefulness of therapy or theoretical issues. There was considerable consistency in construing within, rather than between models. This perhaps suggests that therapists' chosen theoretical model is particularly salient in their professional and possibly personal identities. This coupled with the evidence of a relationship between personality and theoretical orientation suggests a rich source of data.

Repertory grid methodology has proven to be useful in the above studies and this is perhaps because, as Bannister and Fransella wrote in 1967, "The technique focuses attention on the patient's (sic) view of his world in his own terms rather than on the practice of categorizing him in terms of a standard professional conceptual framework" (p. 981). This is echoed by Mazhindu (1992) who suggests that objectivity is maximized and that the idiographic nature of the technique encourages the individual to use their own words when discussing information that is personally relevant and it provides information "as to an individual's perceptual field, consequently promoting detailed exploration of personal meaning with public record more easily" (p. 605). Mazhindu (1992) goes on to say that the technique gives structure to subjective information, making comparisons between individuals possible. It also permits analysis of change not only within but between individuals.

The present study seeks to use the grid methodology to investigate how professional identity of cohorts of trainee clinical psychologists may develop over

time. Professional identity will be defined in broadly cognitive terms as an extension of self concept within a professional context that develops with specific knowledge and skills along with potentially new or adjusted values, attitudes and self identity (Kaslow et al., 1992). The study will make use of repertory grids to gain quantifiable personal perspectives from the trainees regarding their professional lives. In addition, measures of personality, theoretical orientation and the factors that influence clinical practice that have been shown to be implicated in the professional identity of trainee clinical psychologists will be used. The relationship between scores from these measures and trainees' construing systems will be investigated. The NEO five factor Personality Inventory will be used for its reported reliability (Costa & McRae, 1992) and to supply an alternative personality model to the existing literature that focuses on the Jungian model (Myers-Briggs Type Indicator). As the Big Five model is not based on any particular psychological theory, but rather on language, generalisations made from the five factor model will be more useful outside of psychodynamic therapy. The Theoretical Orientation and Experiences Survey (TOES: Buckman, 2006) and the Counsellor Theoretical Position Scale (CTPS: Pozanski & McLennan, 1999) will be used to collect data on theoretical orientation in trainee clinical psychologists in line with Pozanski and McLennan's (1999) recommendation that a 'school' based approach (e.g. TOES) to measuring theoretical orientation should be cross referenced with a more objective measure (CTPS). The QuIF-CliPP (Lucock et al., 2006) will also be used as it is the only existing instrument standardised to measure factors influencing the clinical practice of trainee clinical psychologists in the UK.

It is hoped that the combination of phenomenological and quantitative approaches will yield the empirical support missing from the early models of professional identity.

Hypotheses are divided into two sets. Section one details predictions about differences between third and first year trainee groups. As personality is considered to be a stable characteristic (Costa & McCrae, 1988), it would not be expected that there would be differences between first and third year trainee groups within this variable. As such, section two makes predictions about the professional identity of trainee clinical psychologists in general.

Identity in first and third year trainees: between group comparisons

1) Based on previous repertory grid research into professional identity, the present study predicts that the professional identity of trainee clinical psychologists will expand and develop over the course of training. In particular, it is predicted that third year trainee clinical psychologists will have a more developed sense of self and professional identity than first years. This will be observable from the *self at current point in training* element being construed as more similar to other key elements such as *ideal self, self after training, how I'd like to be as a supervisor and highly regarded supervisor.* This will be reflected in smaller distances between these elements after principal component analysis of the grid. A more developed sense of self will differentiate the third year trainee from their year group and a such, third year trainees will construe themselves as being less similar to a *typical trainee clinical psychologist* as measured by a significantly larger distance between these elements for third and first year trainees.

2) In order to manage the new environment and experiences with a view to processing a plethora of new information to which they will be exposed, first year trainees will construe in a looser manner than the third year trainees who are accustomed to the training experience as measured by a smaller percentage of variance on the first component after principal component analysis of the grid.

3) In developing their professional identity (in line with constructivist theory), third year trainees will be less reliant on external sources of information as '*Assimilation*' will be their chief strategy. Third years will have developed a wider information base to draw from and will therefore draw more on internal resources. This will be observable from the sections of the QuIF-CliPP; Literature, Training, Practice and Personal Factors.

4) Through experience and developing skills, third year trainees are predicted to be interested in exploratory elements of therapy. They will therefore rate the Objective-Subjective dimension of the CTPS higher than do first year trainees indicating a preference for the Objective pole as this involves items characteristic of this quality. The Rational-Intuitive dimension contains items relating to more logical, rigid and directive approaches that might appeal to less experienced first year trainees as more containing. This will be measured by higher scores on this dimension indicating a preference for the Rational pole.

5) In line with Kaslow and Rice (1985), trainees in the third year will have developed more collegial relationships with staff and identify with them more as consultants than "bosses". They will therefore construe the *self at current point in training* as more similar to the *highly respected supervisor* and *member of the course team* elements.

Influence of personality on self esteem and theoretical orientation

6) Personality will be related to self esteem in a similar manner as Robins et al. (2001) found in the general population: trainees with higher self-esteem (as measured by the distance between *self at current point in training* and *ideal self*) will rate themselves higher in extroversion, conscientiousness, agreeableness and openness to experience.

7) The relationship between personality, as measured by the NEO-PI, and theoretical orientation, as measured by the TOES, will be similar to that found in previous research in that CBT orientated trainees will be more likely to be higher in extroversion (Arthur, 2001) and agreeableness (Schandell et al., 1997) and non CBT orientated trainees will be higher in Openness to Experience (Arthur, 2001).

8) As CBT therapists have been shown to exhibit more extroverted, open and agreeable personality traits, looser construing trainees are more likely to identify with CBT than with the psychodynamic and systemic therapies.

9) Based on findings by Pozanski and McLennan (1999), on the CTPS, CBT orientated trainees will score towards the Objective and Rational poles indicated by higher scores on each dimension. Psychodynamic orientated trainees will score towards the subjective and intuitive poles indicated by lower scores on each dimension. Systemic orientated trainees will score in the middle of the range for each dimension.

Method

Participants

All participants were trainee clinical psychologists in the process of completing the Doctorate of Clinical Psychology course at University College London. Of the 50 participants, five were male and 45 female with ages ranging from 24 to 32. There were 25 trainees in each year group. In both groups, the sample represented over 60% of the trainees in that particular year.

To obtain the sample, a website was prepared containing available time slots for participants to come for the interview. Participants were informed about the study by email (directed at years one and three separately) asking them to opt in. Three rounds of emails were required to recruit the majority with the remainder approached through a contact in the first year trainees and personally by the investigator for the third year trainees. Participants were then sent a more detailed information sheet (see appendix E) regarding the specific details of the study and asked to follow a link to the website and to pick a suitable slot to come for interview. Their slot was confirmed with them and any questions prior to the interview were addressed.

Materials

Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (QuIF-CliPP)

The Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (see appendix A) was developed from structured interviews with six psychological therapists from a range of professional backgrounds and therapeutic orientations, which generated 39 items on four categories: training, literature, practice and personal factors. There are additional demographic items, professional background

and a qualitative section to describe the most powerful influence on the psychologists' practice. The measure is suitable for use with both qualified and trainee clinical psychologists and has measured the factors influencing the practice of both groups (Lucock et al., 2006).

Test-retest reliability was calculated for 32 therapists and the overall Pearson correlations were 0.85 (n = 14) for the total scores, 0.55 for the literature scale (n = 29), 0.75 for the training scale (n = 21), 0.67 for the practice scale (n = 27) and 0.76 for the life experiences and personal factors scale (n = 23). All were significant at the 0.01 level (two tailed, Lucock et al., 2006).

Therapeutic Orientation and Experiences Survey (TOES)

This measure was developed by Buckman (2006) in order to assess participants' preference for therapeutic orientations. It also assessed their teaching and supervisory experiences during training in terms of exposure to different orientations.

The TOES (see appendix B) is a 28 item measure that incorporates a variant of Hill and O'Grady's (1985) multidimensional measure of therapeutic orientation that focuses on the three dominant models in the UK: CBT, systemic and psychodynamic psychotherapy. Only the first 9 items that explicitly relate to preferred theoretical orientation will be used for analysis in the present study. Participants rate each item on a one to five Likert scale ranging from "not at all"(1) to "very much"(5).

Counsellor Theoretical Position Scale (CTPS)

The CTPS (see appendix C) was used as a check of validity of the TOES since measuring orientation on the basis of 'school' alone might be a limited approach as it may give an inaccurate or incomplete representation of their beliefs about therapy

(Pozanski & McLennan, 1999). The CTPS has 40 items that contribute to two bipolar dimensions: *Rational-Intuitive* and *Objective-Subjective*. The *Rational-Intuitive* (RI) dimension is a preferred style of learning either through rational judgement based on logic and analytic reasoning or intuitive process (Pozanski & McLennan, 1999). The *Objective-Subjective* (OS) dimension is a preferred style of learning through observable, objective measurements or subjective, introspective and experientially acquired knowledge (Pozanski & McLennan, 1999). The two dimensions were found to be reliable with internal consistency of 0.87 and 0.81 for RI and OS dimensions respectively and factor analysis found the two dimensions to be distinct constructs (Pozanski & McLennan, 1999).

NEO Personality Inventory (NEO-PI)

The NEO Personality Inventory (NEO PI-R, Costa & McRae, 1992) is based on the Five-Factor model, yielding a score on each of the five personality traits: Neuroticism, Extroversion, Openness to Experience, Agreeableness and Conscientiousness. It consists of 60 items where participants respond to a statement by indicating the extent to which it describes them. The self-report form was used for administration. Costa and McCrae (1992) report internal coefficients ranging from 0.68 to 0.86. Scores were standardised with supplied norms (Costa & McCrae, 1992) for analysis.

Repertory Grids

The repertory grid used in the present study contained 12 elements and 12 elicited constructs. Elements used in the grid were *self at current point in training, ideal self, self after training, how I'd like to be as a supervisor, highly respected supervisor, low respected supervisor, a patient I haven't enjoyed working with, a patient I have enjoyed working with, a member of the course team, a typical trainee*

clinical psychologist and a typical fully qualified clinical psychologist and a trainee clinical psychologist from another course. These particular elements were used as they were deemed to reflect the most relevant/influencing roles on a trainee clinical psychologists' professional identity. They also contain a balance between self elements and roles, which would be important for facilitating the elicitation. 12 elements and 12 constructs were used as anymore would have increased the time of administering a grid to a potentially impractical length for administration.

Procedure

At the start of the session, participants were asked to sign a consent form (see appendix F). Then a brief explanation was given about what to expect and they were presented with the measures described in the materials section. Participants were advised that they could complete the questionnaires in their own time and return them as soon as possible.

When completing the grid, participants were first asked to give the name of a person they knew to represent each of the elements: they were advised that although their responses were confidential this need not be the real name so as to protect the person's anonymity. These elements were then presented in triads always containing the '*self at current point in training*' element to ensure self-relevant constructs. Participants were asked to think of a way in which two of the elements were similar but different to the third (emergent pole). Once this construct pole emerged, the participant was then asked for what they would consider to be the opposite of this, thereby eliciting the implicit pole. Elements were presented in random combinations until ten constructs were elicited. Two 'problem' constructs were elicited by asking the participant to think of an area of the course which they found more difficult, e.g. organisation. They were then asked for the opposite of

this to form the 'problem construct'. With all 12 constructs elicited, participants were then presented with their listed construct poles on either side of a seven to one Likert scale, e.g.

Chaotic 7 6 5 4 3 2 1 Organised

Participants were then asked to rate each element on each construct according to this scale. The resulting matrix of numbers was analysed using the Idiogrid programme (version 2.4, Grice, 2007). Grid and questionnaire scores were then entered into SPSS (version 14) for analysis.

Statistical analysis

All variables are normally distributed. Independent t-tests were used to investigate difference between the first and third year groups. These tests were conducted without correction for multiple comparisons due to the specific nature of the hypotheses. Correlations and Multiple regressions were used to examine the group as a whole. The alpha level was set at .05 for all results.

Ethical considerations

The study was given full ethical approval by the UCL Committee (1211/001) with minimal risk to the participants (see appendix D). Trainee clinical psychologists were informed that participation in the study was entirely voluntary and to decline would not in any way impact upon their training experience. All necessary procedures were undertaken to ensure the anonymity of the participants' responses. This was particularly salient given the fact that many of the participants were personally known to the investigator.

Results

Results are presented with each hypothesis in turn; the between group analysis is presented first followed by the correlational group analysis.

Between group findings

To test the hypothesis that third year trainees would construe themselves as closer to key roles in their professional lives than first year trainees, the Euclidean distances between these roles and the *self at current point in training* element for the two groups were compared (see table 1).

Table 1. *Means and Standard deviation for Euclidean distances*

Self at current point in training element compared with other relevant elements	First Years Mean SD(N)	Third Years Mean SD(N)	*t* & *p* values	Degrees of freedom
Ideal Self	.89(.24)	.81(.33)	t=1.11 p=>.05	48
How I'd like to be as a supervisor	.92(.22)	.79(.33)	t=1.75 p=>.05	41.16
A highly respected supervisor	.96(.21)	.89(.39)	t = .832 p = .409	48
Self after training	.58(.20)	.44(.25)	t=2.303 p=.026*	48
A typical trainee clinical psychologist	.50(.17)	.62(.19)	t=-2.24 p=0.29*	48

All tests are two tailed; *p<.05

To investigate whether first year trainees' construing will be looser than that of third year trainees in order to *accommodate* new experiences, the structure of construing in the two groups was examined. It was found that first year trainee clinical psychologists' structure of construing, as measured by the percentage of variance on the first component after principal component analysis of the grid

(M=58%, SD=10.29), was significantly looser than that of third year trainees (M=66.18%, SD=2.72, $t(49)=-2.29$, $p=.026$).

To investigate whether first year trainees will be more reliant on external sources of information and third year trainees on internal sources, first the most influential factors were elicited using the same methodology as Lucock et al., (2006), by using items that had a mean rating of over 4.5 for either first or third year groups. These factors were then compared between year groups. Table 2 shows the means for the most influential items for the first and third year trainees and independent t tests comparing the two groups.

Table 2. *Means and standard deviations of most influential factors for the first and third year trainee clinical psychologists and independent t-tests comparing first and third year trainees*

Most influential factors	First Year Mean *SD (N)*	Third Year Mean *SD (N)*	*t* & *p* values	Degrees of freedom
Text books	4.65(.79)	3.71(1.37)	$t = 3.017$ $p = .005$*	36.41
Professional training	5.73(.53)	5.58(.83)	$t = .753$ $p = .463$	38.72
Current supervision	5.64 (.57)	5.43(.79)	$t = 1.041$ $p = .303$	48
Past supervision	3.96(2.01)	5.43(.59)	$t = -3.508$ $p = .002$*	28.43
Peer/collegial discussion	4.28(1.31)	4.65(.88)	$t = -1.145$ $p = -.372$	48
Client characteristics	4.80(.70)	5.35(.78)	$t = -2.561$ $p = .014$*	48
Client feedback	4.36(1.19)	4.78(1.39)	$t = -1.140$ $p = .260$	48
Psychological formulation	5.08(1.04)	5.35(1.03)	$t = -.898$ $p = .374$	48
Intuition/judgment	3.88(.67)	4.52(1.08)	$t = -2.166$ $p = .036$*	48
Things I picked up along the way	4.09(1.08)	4.61(1.12)	$t = -1.607$ $p = .115$	48
Personal philosophy	3.72(1.14)	4.68(1.26)	$t = -2.884$ $p = .006$*	48

All tests are two tailed
*p<.05

Due to their wider experience and skill set, trainees in the third year would be predicted to be more interested in exploratory elements of therapy. However, the difference between scores on the RI and OS dimensions of the CTPS for first and third year trainee clinical psychologists was not significant. This is presented in Table 3.

Table 3. *Means and standard deviations of RI and OS dimensions of the CTPS for the first and third year trainee clinical psychologists and independent t-tests comparing first and third year trainees*

Dimension	First year Mean *SD(N)*	Third Year Mean *SD(N)*	*t* & *p* values
Rational – Intuitive	3.26(.59)	3.52(.62)	$t = -1.54$ $p = .130$
Objective – Subjective	3.49(.54)	3.55(.67)	$t = -.348$ $p = .729$

All tests are two tailed; degrees of freedom = 48

To explore the predicted transition of relationships between trainees and staff / supervisors from more formal to more collegial, Euclidean distance between *self at current point in training* and relevant elements were compared between year groups. Table 4 shows there is no significant group differences for first and third year trainees in terms of how similarly they construe themselves to a *highly respected supervisor* or *a member of the course team.*

Table 4. *Means, standard deviation and independent t-tests for first and third year trainee clinical psychologists Euclidean distances between self at current point in training and a highly respected supervisor and a member of the course team.*

Elements	First year Mean SD(N)	Third year Mean SD(N)	*t* & *p* values
Self at current point in training and *highly respected supervisor*	.96(.21)	.89(.39)	$t = .832$ $p = .409$
Self at current point in training and *member of the course team*	.90(.24)	.25	$t = .987$ $p = .329$

All tests are two tailed; degrees of freedom = 48

Correlational findings from the sample as a whole

The Euclidean distance between *self at current point in training* and *ideal self* is considered to represent self esteem. Correlations between this measure of self esteem and adaptive personality attributes would be expected to be in a negative direction (see literature review, p. 22 - 24).

As predicted, a negative correlation was found between self esteem and conscientiousness (r=-599, p<.0001) and agreeableness (r=-.285, p=.043). A positive correlation was found between self esteem and neuroticism (r=.385, p=.005). There was no relationship between self esteem and extroversion or openness to experience.

In exploring these relationships further, results showed that neuroticism independently predicts self esteem. However, when conscientiousness is added to the regression model, neuroticism no longer does so. This is presented in table 5.

Table 5. *Regression to show relationship between self esteem, neuroticism and conscientiousness*

	B	*SE B*	ß
Step 1			
Constant	.209	.224	
Neuroticism	.013	.005	.385*
Step 2			
Constant	1.134	.285	
Neuroticism	.007	.004	.193
Conscientiousness	-.013	.003	-.529**

Note R^2=.149 for step 1; ΔR^2 = .391 for step 2 (ps<.05).
**p<.001, *p<.05

In order to determine whether conscientiousness mediated between neuroticism and self esteem, a statistical test of mediation (Sobel test) was

conducted. It was found that conscientiousness was indeed a mediating variable between neuroticism and self esteem (t=2.31, p=.021).

The predictions that extroversion would be positively correlated with how likely a trainee would be to use CBT after qualification was not upheld. Preference for CBT as determined by item three of the TOES was indeed significantly negatively correlated with extroversion (r=-.373, p=.007). Also contrary to predictions, there was no relationship between agreeableness and any of the CBT items on the TOES. However, openness to experience was significantly positively correlated with how much trainees identified with the tenets of systemic therapy (t=.393, p=.004), which was predicted. There were no other relationships found between a preference for systemic and psychodynamic therapies and openness to experience.

The prediction that looser construing trainees would show a preference for CBT was not supported as there was a significant negative correlation between tightness of construing and the personal appeal of psychodynamic therapy (r=-.304, p=.033).

Finally, as predicted, the extent to which trainee clinical psychologists identify with the main tenets of CBT (on the TOES) was positively correlated with the Objective pole of the OS dimension of the CTPS. Furthermore, the extent to which trainees find psychodynamic approaches personally appealing (item five of the TOES) is negatively correlated with the Intuitive pole of the RI dimension of the CPTS (r=-.399, p=.004). While it was expected that the extent to which a trainee personally identifies with systemic therapy to have an intermediate relationship between the OS and RI dimensions of the CTPS, it was actually negatively related to the RI dimension (r=-2.97, p=.035).

Discussion

The first section of hypotheses were based on the idea that third year trainees will have developed a more stable sense of self and be working towards achieving their own unique professional identity. The second set of hypotheses related to the sample of trainees as a whole (N=50) and the relationship between personality, structure of construing and preferred theoretical model. In view of concerns expressed by Fransella et al. (2004) that the repertory grid methodology is too frequently used without reference to the personal construct theory from whence it came, I have attempted in this discussion to link the substantial findings with the theory.

Identity of first and third year trainees: between group comparisons

Construing the self

The significant finding from these hypotheses was a significant difference between first years trainees and third year trainees on distances between *typical trainee clinical psychologist* and *self at current point in training*. This demonstrates that first year trainees construe themselves as more similar to a stereotype of a typical trainee than do third year trainees. This is important as it shows the third year trainees distancing themselves from the 'typical' group and perhaps identifying more as individuals. It is possible that this is due to trainees evolving and developing, and becoming confident in their own unique style. This could be a product of having studied a wide range of theories, experienced different models and *assimilating* them into a working knowledge, disregarding ideas that do not fit personally, and being able to draw from this knowledge base as an 'individual' psychologist. This finding is similar to the proposed transition from *professional-*

adolescence to *professional-adulthood* described by Kaslow and Rice (1985), the Identity and Independence stage of Friedman and Kaslow's (1986) six stage model of professional identity development and the Late stage of the Kaslow et al. (1992) model. Within a PCP theory framework, it is perhaps evidence of a less active commonality corollary within the third year group as compared to the first year group: Kelly defined the commonality corollary as "*the extent that one person employs a construction of experience which is similar to that employed by another, his processes are psychologically similar to those of the other person*" (Kelly, 1955, p.90).

There may also be group factors that contribute to this larger distance between third year trainees and their construing of a typical trainee. Relationships within the cohort are likely to change over the three years of study; trainees get to know their peers better and form different impressions of them than they may have had initially. Their knowledge of their colleagues will have grown beyond their immediate social group and they will have acquired a more detailed understanding of a greater proportion of the cohort. Trainees are perhaps becoming aware that the way in which they construe their personal/professional roles is different to others within the cohort. This suggests that the 'individuality corollary' is becoming more salient for trainees in the third year group. Kelly defined the individuality corollary as "*Persons differ from each other in their constructions of events*" (Kelly, 1955, p. 137). With this deeper understanding, the trainees are more able to place themselves within that group.

The same principles may apply to one's own knowledge of clinical psychology; as one's knowledge deepens it becomes easier to decide where one stands in relation to psychological schools or models and those that champion them.

Linked to this is the idea that arguably, trainees begin to realise that whatever 'psychological output' comes from them is channelled though them and that even manualised treatments will be influenced to some extent by the person applying them. This is perhaps similar to what Ellis (1978) said in that it is not the therapists' personality that leads them to a certain model, but the way in which they apply that model.

To contribute to construing of dissimilarity between third year trainees and *a typical trainee* is the third year trainees' awareness of imminent change of role. The inevitable reality is that in less than six months, third year trainees will no longer be students and will be thrust into new roles as independent qualified psychologists. It is perhaps unsurprising to find that third year trainees construe themselves at their current point in training as more similar than do first year trainees to the *self after training* element. This perhaps supports the assertion that third year trainees consider themselves to be moving away from their student role and towards the role of an independent psychologist. As an important aspect of professional identity it resonates not only with the above discussion but also with Kaslow and Rice's (1985) concept of moving from *professional adolescence* to *professional adulthood.* This factor of 'role change' or in Kellian terms 'role dislodgement' is also key to the following Personal Construct theory interpretation of the findings in the present study.

Structure of Construing

There was a significant difference between the first and third year trainee clinical psychologists in terms of the size of component one after principal components

analysis of the grid, suggesting the third year group construe significantly more tightly than the first year group.

In Kellian terms, '*Threat*' is said to result from becoming aware of imminent dislodgement from one's core role, in this case, as a trainee clinical psychologist. Also involved may be Kellian '*Anxiety*' which comes from an awareness that events lie outside of one's understanding and control, or not being able to construe a situation e.g. the new role of a qualified clinical psychologist. So if *Anxiety* and *Threat* are being experienced by the third year trainees, the expected result might be an attempt to make life more predictable in order to protect oneself against these unpleasant emotional transitions. This is demonstrated by third year trainees construing more tightly than do first year trainees. The effect of construing tightly is to make one's environment unvarying and thus, more predictable and as Kelly wrote, the tight construer is busy building a system that is "*designed to be anxiety tight*" (Kelly, 1955, p. 849).

The move into training undoubtedly involves a significant change into a different and much sought after role. First year trainees effectively relinquish their current, perhaps established, role in favour of one that is unknown and as a consequence a great deal of heightened emotion would be expected. However, after several months of being a trainee, the role will be increasingly familiar and there will be considerably less *Threat* and *Anxiety* as, to some extent, they will have resolved the concerns about the new role as trainee and loss of old role. This is further exacerbated by the intense relief that accompanies getting a place on training; the Holy Grail (Cushway, 2000). These trainees may be experiencing Kellian '*Happiness*', which can be defined as "*awareness of validation of a portion of one's core structure*" (McCoy, 1981, p. 39), e.g. the portion that so desperately

wanted to become a trainee clinical psychologist. It is possible that there is a realisation that others recognise and share the same view point with the '*commonality corollary*' being elaborated and the bond between members of the cohort may be stronger as a result. This may also be observed in the first year trainees rating of themselves as more similar to the *typical trainee clinical psychologist* element.

In relinquishing their previous role in favour of that of trainee clinical psychologist, the new trainees will be exposed to novel ideas, models and ways of thinking that may be compatible or incompatible with their previous role. With the old and new worlds colliding, the trainees' construing will be affected; what was once held as certain (tightly construed), may now be challenged. This is evident in the significantly looser construing of the first year trainees. It is possible that in Kellian terms the new trainees are at the beginning of the creativity cycle "*The Creativity Cycle is one which starts with loosened construction and terminates with tightened and validated construction.*" (Kelly, 1955, p. 7). The new trainees will be asked to loosen their construing in order to take on and *accommodate* new ideas that may be incompatible with their existing position. They are also faced with an initially unpredictable professional life (e.g. clinical group activities, placements) fraught with anxiety-provoking experiences and unknown expectations (e.g. doctoral course work, academic/clinical performance). Kelly explained this as "*Loosened construction ..sets the stage for creative thinking...The loosening releases facts, long taken as self-evident, from their conceptual moorings. Once so freed, they may be seen in new aspects hitherto unsuspected, and the creative cycle may get underway.*" (Kelly, 1955, p. 1031). By loosening their construing, the trainees are more able to tackle these challenges in an adaptive manner that does not

threaten any core constructs and cause further intense anxiety. Indeed, exposure to new ideas does not have to be problematic: Kelly's *Fragmentation Corollary* says a person can maintain current ideas whilst entertaining new ones.

For the third year trainees, once they have had more experience of training and processed and identified with new ideas (or indeed confirmed existing beliefs), it is possible that they will move further on in the *Creativity Cycle*. The move from loose to tighter construing could also be evidence of a more developed professional identity, trainees have processed a range of ideas and are coming to identify with a selection of them that personally resonate.

Factors that influence clinical practice

Further evidence of third year trainees having a more developed professional identity is observable in the significant difference between first and third year trainees in how much text books influence their clinical practice. Third year trainees rely on text books significantly less than do first year trainees and this can be explained in terms of how first year trainees are perhaps involved more in *Accommodating* new information. It is possible that exposure to intensive blocks of teaching about therapy for inexperienced trainees will require more *Accommodation* of this information than *Assimilation* as the content will be relatively new for most. The backbone to the teaching at UCL is one of developmental psychopathology and this too will have to be processed and adopted by some trainees.

The present study also found that the third year trainees' clinical practice was significantly more influenced by their own personal philosophy, their intuition and client characteristics than was that of the first year trainees. This suggests they are drawing from existing knowledge rather than sourcing knowledge like the first

year trainees. The increase in internal factors suggests that professional identity of the third year trainees is developing and perhaps incorporating a personal identity alongside it.

This was evident in other research on developing professional identity (Madill & Latchford, 2006). Over the 30 months of training it is likely the third year trainees will have developed a certain amount of working knowledge that can be drawn upon in any instance. This working knowledge (as opposed to knowledge that is sought) perhaps allows trainees to begin incorporating their own ideas about how to apply their chosen theory and can draw from what has worked and what has not in their experience; an early sense of 'practice-based evidence'. This is again congruent with the processes of *Accommodation* and *Assimilation.*

Further evidence for trainees consulting their working knowledge comes from a significant difference between first and third year trainees on how much past supervision influences their practice. Possibilities here are that the third year trainees make more use of what they have learnt thought the process of training, or the result is skewed because first year trainees may not have had as much clinical supervision on which to draw. Either way, the results suggest that third year trainees are reflecting on their experience when they work clinically; not just at the current supervision. This perhaps suggests more about the developing professional identity of the trainee; during training each trainee is likely to have encountered a range of supervisors with whom they identify with to a greater or lesser extent in terms of personal and professional style. This may also be true in the reverse for disidentification, that is they have experienced a way in which they do not want to be. Once the trainee has experienced a way of working which resonates with their own style, it is conceivably more likely that this has been internalised and the

trainee will consult this for answers. This suggests some form of professional identity development: the trainee now has their own guiding principles. This is supported by the fact that third year trainees' clinical practice is more influenced by their own personal philosophy and intuition.

Theoretical orientation

There were no significant group differences on the CTPS or TOES. Perhaps because the CTPS measures theoretical orientation in a non-school based approach, the results are a more valid account of the trainees' underlying principles in their identification with a theoretical orientation. This perhaps suggests that theoretical orientation is not based on amount of experience and potentially more on an emotional basis as Adams (1984) suggested.

Relationships with staff / supervisors

There were no significant findings to support the prediction that third year trainees will have more collegial relationships with staff than do first year trainees. The fact that first years do not construe themselves as similar to *a highly respected supervisor* or *a member of the course team* can be perhaps explained intuitively by their inexperience. That third year trainees do not construe themselves as similar to these elements is perhaps that their experience of training has shown them that the doctoral training is not the 'fait accompli' they may have first thought. In other words, training does not supply everything required to become like a psychologist they respect. This is a different finding to that of Madill and Latchford (2006) who reported that medical students make a significant move towards the *a doctor I admire* element during their training and perhaps suggests a difference either

between medical and clinical psychology training schemes or between the people who study on them.

From the between group findings, it is evident that there are some significant differences on factors that fall into the categories of internal and external factors. Personal philosophy, intuition, the internalised construction of: *a highly respected supervisor, typical trainee* and *self after training* might be considered internal factors where client characteristics, supervision and text books might be considered factors that occur between the trainee and an 'other' and therefore external factors.

Professional identity of trainee clinical psychologists across both groups

Personality and self esteem

There were a number of significant relationships between personality and construing in the group as a whole. There was a significant positive relationship between Neuroticism and self esteem (as measured by the distance between *self at current point in training* and *ideal self*). It is important to note that the more individuals see themselves as similar to their *ideal self* then the higher is their self esteem. In this case, high Neuroticism corresponds to low self esteem and vice-versa. In contrast, high levels of Agreeableness and Conscientiousness are significantly positively associated with high self esteem. This perhaps suggests that both Agreeableness and Conscientiousness are protective factors for self esteem while neuroticism posses a risk.

With the competing demands and the high pressure to perform that persists during training, it is perhaps unsurprising that neuroticism is a key factor in trainee's self esteem. With the definition of Neuroticism (Costa & McCrae, 1992)

including being more prone to negative affective states and more responsive to negative feedback, the process of reflection that is encouraged and built upon throughout training may be implicated in this relationship. To examine one's own actions and thoughts and scrutinise them could, for more neurotic trainees, be a painful process and be interpreted negatively. The more conscientious or agreeable trainees may see this as an important opportunity to learn about themselves that will lead to being a more competent practitioner and therefore understand the process in a more positive light.

Regression analysis shows that when conscientiousness is added to the model of high neuroticism independently predicting low self esteem, neuroticism looses its predictive power. One way of explaining these results is that conscientiousness is a protective factor for self esteem in more neurotic trainees. As the trait of Conscientiousness traditionally includes carefulness, thoroughness, and organisation, trainees who more methodically manage the demands placed on them are more likely to have higher self esteem. It is perhaps also the sense of agency and/or taking an active role in managing one's difficulties that is key in maintaining self esteem.

Personality and theoretical orientation

The findings of the present study do not support the claim that CBT orientated trainees will be more likely to be higher in extroversion (Arthur, 2001) and agreeableness (Schandell et al., 1997) and non CBT orientated trainees will be higher in Openness to Experience (Arthur, 2001). There was a significant negative relationship between extroversion and the likelihood of using CBT when qualified and a significant positive relationship between Extroversion and the likelihood of

using Systemic therapy when qualified. Openness was also positively related to how much trainees identified with systemic therapy and how much it appealed personally. The difference between this study's findings and that which has come before perhaps suggests there is a difference between fully qualified psychologists and trainees. At the beginning of training to be a therapist it is conceivable that trainees will seek more containing models such as CBT rather than other less structured approaches. In this respect, when considering Costa and McCrae's (1992) definition of these traits, it is perhaps understandable that Openness and Extroversion corresponds to personal appeal and identification of theories that use more unusual ideas. Perhaps these theories are not 'unusual' per se, but after the predominant CBT teaching that adorns the early part of the course, they may seem more so. When they do appear on the curriculum, those more extroverted and open to experience may identify with these theories and begin to disassociate from the principles of CBT.

Theoretical orientation and structure of construing

A significant finding in this area is that although no relationship existed between structure of construing and personal appeal of systemic therapy, there was a significant negative relationship between the structure of construing and personal appeal of psychodynamic psychotherapy. Indeed, tightness of construing predicts how much psychodynamic therapy personally appeals to trainees in this sample with the looser construers finding it more appealing. This finding does not fit with previous research on the relationship between personality and theoretical orientation in that more extroverted traits have been associated with CBT. However, Winter (1983) found that tighter construing before treatment predicted a good outcome for

patients who received CBT and poor outcome for those in a psychoanalytic group intervention. This perhaps suggests that there is not just a quality of CBT that suits both the tightly construed therapist and patient alike, but one that contraindicates the analytic model. This is certainly reflected in the results of the present study.

Although not consistent with the hypothesis, it again suggests that trainees, as opposed to fully qualified psychologists in the Arthur, (2001) and Schandell et al. (1997) studies, might seek a more containing approach to therapy that is evident in CBT. As mentioned above, Neuroticism has been linked with tighter construing (Winter, 1985) which has the effect of making one's environment more predictable in an effort to reduce anxiety. Therefore it is fitting that tighter construing trainees find less structured approaches less to their taste. The main tenants of CBT would certainly be congruent with this style of construing with its directive nature and more rigid structure.

Agreement on theoretical orientation between the CTPS and the TOES

There appears to be a good deal of internal validity to the measures of theoretical orientation in that, as outlined by Pozanski and McLennan (1999), the RI dimension of the CTPS is significantly positively correlated with all three of the CBT items of the TOES and significantly negatively correlated with psychodynamic items of the TOES. Pozanski and McLennan (1999) also stated that systemic therapy should correspond to the mid point between RI and OS dimensions. In the present study the systemic therapy items on the TOES were significantly negatively correlated with the RI dimension, which although not consistent with the hypothesis, might be due to the fact that first year trainees would have had no systemic teaching and therefore results may be skewed.

Summary & Implications

The main findings of the present study indicate that there are significant differences between first and third year groups in terms of factors that influence their clinical practice, theoretical orientation and style of construing. The implications of these findings are potentially useful in managing trainees at the beginning and end of their training. The results can be categorised into *Primary Needs* and *Roles*.

The results suggest that *Accommodation* of new information is the primary need of first year trainees, while *Assimilation* is that of the third year trainees. These concepts refer to the learning principles postulated by Piaget (1958) where one can either *Assimilate* information into existing knowledge frameworks or change those frameworks by *Accommodating* the information that does not fit.

To facilitate *Accommodation* the first years might benefit from clear signposts to factual information that will help them build their knowledge base. This might come in the form of a list of basic texts or articles given at the outset of the course that characterise the stance of the institution that will form the foundation of their approach and make what is to follow more predictable. For third year trainees it was indicated that they drew more from past experience and perhaps *Assimilated* new information into the existing framework. A specific awareness of this might give rise to a greater focus on stimulating the existing working knowledge such as an emphasis on seminars or group discussion on academic or practice issues rather than didactic teaching methods. These factors might also facilitate the growth of the personal philosophy that third year trainees see as more of a significant influence on their practice than do first year trainees. It may also help to facilitate appropriate professional autonomy.

In terms of role, first year trainees are busy identifying and establishing their new role while third year trainees are in the process of relinquishing theirs. Being facilitative of establishing a new role might involve encouraging interaction between year groups; this would give the first year trainees a chance to experience those in a role to which they will be aspiring. Information traded in such sessions may make the coming months more predictable and therefore less anxiety provoking. Kelly's (1955) discussion of the *commonality corollary* suggests that discussing constructs can help build shared constructs. This may lead to more identification with the role of trainee and could be achieved by using common constructs elicited in a fashion similar to that of the present study. Similarly, third year trainees may benefit from interactions with newly qualified psychologists in either a one to one buddy scheme (similar to that offered at the outset of training) or in a group. The existing transitional workshops where newly qualified psychologists come back to talk about their experiences are a good example of this. Making the future more predictable in both cases should alleviate the Kellian *Anxiety* and *Threat* that can occur when changing roles.

Limitations

The main limitation of the study was in using independent groups of first and third year trainees. Although a longitudinal design was not viable for the DClinPsy thesis, it would have yielded more valid and reliable results. The implications of using independent samples are that the findings are products of individual groups and differences may not be due to year group but to other factors. This would affect the validity of results under the section one hypotheses but not those of section two, which referred to the whole sample.

The sample came from UCL and as such no comparisons or generalisations are possible to other courses. While limiting in this respect, it does give a detailed picture of trainees at this particular institution and the sample is not contaminated with differing approaches and teaching methods. Implications can also be tailored to the institution in this case.

It is possible that more valid results could have been achieved if the first years had been interviewed nearer to the outset of their training. It was considered appropriate by the investigator to wait as it was expected that recruitment would have been more difficult as the process of settling in may have taken priority over volunteering for the study. To reconcile this, data was collected over a period of two months in order to gain a 'snapshot' of trainees at their current point in training, albeit around two thirds of the way through the first year.

Using trainee clinical psychologists as a sample group for a DClinPsy thesis may have had some confounding effects on the data. As some trainees were personally known to the investigator, it is possible that demand characteristics may have been in operation for those trainees. While this is offset by the repertory grid methodology in which measures are implicit in responses, the more obvious scale such as the NEO may have skewed the results.

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Part 3: Critical appraisal

Introduction

This appraisal seeks to discuss the experience of conducting the research project. It is split into three main sections: *before*, *during* and *after* the study and will consider the salient processes at each of these points. *Before the study* considers the process of selecting a project, the origins of the research questions and the selection of measures. *During the study* discusses the recruitment process and contains a sub-section on conducting research with fellow trainee clinical psychologists. *After the data collection* contains sub-sections on how the investigator's perception of professional identity changed during the course of the study, limitations of the methodology and considerations for future research conducted in this domain.

Before the Study

The literature review was perhaps the most important component of the study. Whilst reading, research questions began to develop as the quality of previous research using repertory grids could not supply reliable answers. The existing literature on professional identity of psychologists began to resonate with my own questions about training. I could certainly identify with many of the anecdotal reports from the USA (Kaslow & Rice, 1985; Friedman & Kaslow, 1986; Kaslow, 1992) but at the same time was surprised that there was little empirical support for their clearly informed accounts. The relationships between trainees and their supervisors seemed to stand out as important and the repertory grids seemed to offer an extremely useful way of investigating them. The concept of analysing 'distance' between people or roles at different time points seemed to have the potential to contribute empirical evidence and with trainee clinical psychologists; a groups that have been rather under-investigated.

There was little investigation of the process of change in professional identity. The nursing literature showed some evidence of a dynamic and developing professional identity but there were no ideas as to why this might occur. I was therefore keen to add some standardised measures of personality and theoretical orientation, as they were clearly an influential part of identity, to shed some light as to what might be mediating this change. The Lucock et al. (2006) study was probably the most important measure as it would give an idea of processes of change that is bespoke to trainee clinical psychologists in terms of their practice, as the QuIF-CliPP had been used with them as a sample.

The decision to use two measures of theoretical orientation was largely influenced by the literature (Pozanski & McLennan, 1999). I had predicted that trainees may be particularly susceptible to identifying with a particular model of therapy as they strive to develop their professional identity and may choose 'ideals' with which they would like to fit, but with which perhaps they do not yet have the experience fully to identify. The use of the CTPS, which contains items that do not explicitly relate to a 'school' of therapy, enables the researcher to triangulate the results to check for this. There was considerable agreement between the two measures suggesting that perhaps preference for theoretical orientation could be measured quite reliably.

The literature that I had accumulated did not support my own experience in terms of what were my perceptions of personality types and how I expected them to operate professionally. Thus, I was keen to investigate the relationship between these variables for myself.

During the Study

At first only half of the required number of participants volunteered, which led to further pleading emails to each year group which generated only a few more. It seemed that the motivation for volunteering was being compromised by diffused responsibility. I made use of a friend in the first year who offered personally to spread the word and make clear my desperation hoping that it might inspire some guilt and consequent volunteering. This did work and supplied enough participants to begin collecting data effectively, i.e. a trip to college would yield several participants and not just one. I was less concerned about the third year trainees as I have a personal relationship with many. However, due to their own workload, it was occasionally difficult to get them to commit to the study.

Conducting research with fellow trainee clinical psychologists

This element of the study brought with it several issues worthy of discussion. Having a personal relationship with participants was point of consideration; as the study required information on personality and for the participants to 'perform' a task, I anticipated certain issues to arise. It seemed possible that some trainees might feel uncomfortable in sharing information relating to their personality. Also, performance anxiety might be implicated in the process of 'completing a task' as it was described in the information sheet. It is possible that these two issues are among those responsible for the non-participation of those trainees who I expected to volunteer and who did not, not withstanding their own high workload.

In terms of the actual collection of data, it is possible that establishing a rapport with the participants was enhanced by sharing their role as a trainee clinical psychologist. The repertory grid can be a difficult task for some but on reflection,

managing performance anxiety was easier with colleagues. I would hope that this contributed to a more valid data set as well as making the experience more pleasant for the participants.

An additional factor of working with colleagues that is worthy of comment is the potential for social desirability demand characteristics. Particularly considering the content of the study, it may have been a limiting factor in the validity of the results. Although anonymity was assured, the fact that I as the investigator might have an informed opinion on their responses, may have influenced them.

After the data collection

The changing phenomena under study

During the course of the study, my understanding about the professional identity of trainee clinical psychologists changed a great deal. I had developed my own ideas about the identity of trainees, both personally and professionally and expected more variety than I found. There were some overlaps in constructs and perspectives that I had expected, although many were different to my own. This had the effect of making me feel more individual as a psychologist and possibly had a positive effect on my own professional identity.

From the qualitative aspects of the grids that were not reported in the study, I noted that many people were less confident than I had expected. This was especially true for the first year trainees who were overwhelmingly anxious as a group. I thought that this was inconsistent with how I felt as a first year trainee and was surprised that many lacked confidence. Many third year trainees were also

lacking in confidence, which again surprised me, having expected my colleagues to feel more confident at this late stage of their training.

I also expected for trainees to have a more established sense of self identity at the outset of training and was surprised by how inferior the first year trainees felt in relation to other clinical psychologists. I imagined that after an undergraduate degree and (in most cases) a good deal of experience, trainees would feel more established as psychologists.

I was struck by how little personal and professional identities overlapped for the first year trainees compared to the third year trainees. This has always been an important issue for me as a psychologist and probably why I noticed it. I have always been keen to let my personal identity inform my professional identity as a way to be genuine. It seemed that for many first year trainees, their personal identity was a separate issue and that it might take more experience and confidence to allow this to emerge. It was very clear when a trainee approached their professional training with overlapping personal and professional identities, as their constructs were qualitatively congruent with this outlook. An example of this was a participant whose emergent construct poles (all elicited from the elements of professional role titles) included 'sense of humour', 'easy going' and 'sporty' together with 'organised', 'professional' and 'knowledgeable'.

Limitations

A detailed discussion of the limitations of this study can be found in the discussion section of the empirical paper. There are however some additional weaknesses in the study that are more appropriate in this section due to their more reflective nature.

Although the study yielded some very interesting results, the repertory grids require some evaluation as a methodology. As stated above, the process of administering repertory grids is a laborious one as is the subsequent lengthy data entry. Furthermore, learning to use the Idiogrid statistical package, and interpreting the meaning of the vast output of results was very challenging. Thus, the methodology should not be used without some consideration of the perceived benefits of the grids, in terms of acquiring meaningful data, which is at least equal to the cost of collecting it. For this to be appropriately evaluated, some thought must be given to the psychometric properties of the methodology as with no standard grid and thus no normative data for comparisons, even leading proponents of the theory have expressed concern about the neglect of psychometric considerations (Winter, 1997). The assumption that the meaning in grid data is a function of mathematical relationships has also been questioned (Fromme, 1998). Indeed, even the evaluation of the validity of the grid data should be conceived within the PCP framework (Fransella, 2004). Criticisms have also been levelled at the methodology in terms of practicalities: variable perceptions of elements when they are of low personal relevance, varying contexts in which the elements are perceived during the administration of the grid, a 'halo' effect (particularly relevant with trainees being interviewed by a fellow trainee) intruding into ratings as the participant sees the matrix build and accidental reversal of rating scales when responding (Yorke, 1978). As stated on page 30 of the literature review, repertory grid research has also been criticised for not discussing the results in the context of the wider PCP theory (Fransella et al., 2004) As such, an appropriate knowledge of PCP is advisable on the part of the investigator, with, as stated in the Literature

review, supervision from someone experienced in use of the theory (Rawlinson, 1995).

In conclusion, the methodology requires an extended period of time, a concerted effort, a sound understanding of the theory and appropriate supervision in order to ensure the outcome is valid and findings are generalisable.

Using standardised measures with trainee clinical psychologists may have affected the validity of the data. For a psychologist, perhaps more so than for a layman, the NEO-Personality Inventory items are perhaps quite obvious in what they seek to address and as such may have left this particular measure open to the social desirability demand characteristics. This is particularly salient for the present study as the main investigator was often personally known to the participants.

As the study required participants to complete a selection of questionnaires, they were given these at the time of the interview with the instruction to return them when they could. This resulted in some being returned immediately and some not returning without several prompts. Although all questionnaires were eventually returned, perhaps the main problem was bringing them back to college as third year trainees especially have very little contact time during the period of collection. A viable alternative would have been to make electronic copies of the questionnaires so they could be completed online and returned via email. This may have ensured a swifter and more reliable return rate.

The recruitment for the study was difficult. I sent an email to both groups detailing the study and asking for volunteers but as mentioned above, this did not yield as many replies as I anticipated. On reflection, I wondered if giving a brief presentation to the year groups and passing round a form to opt in would have generated more motivation from the groups. The slow recruitment did hinder the

progress of the study and it ran into the Easter break making it difficult to contact participants. With a more complete sample group early on, this would have been avoided.

The fact that all trainees were from UCL limits the generalisability of the study somewhat. I considered using trainees from other courses when designing the study but came to the conclusion that it would be impractical and too time consuming to get sufficient numbers. I think the trade off was worth it as the results show some powerful effects. However, with more time I would certainly consider using trainees from different courses in order to see if results were specific to institution.

Future research

It would be particularly interesting to repeat the study on the trainees from the first year group once they reach the third year. It would also be interesting to conduct a similar study with elements relevant to being qualified with the third year trainees when they have been in the fully qualified role after two years and are eligible to become supervisors themselves. This would show how identity develops through and beyond the training course.

It would also be useful to focus on other areas within the study with the repertory grid design. For example, examining the distances between self and other therapists (e.g. *Self at current point in training* and *a CBT therapist*). This is similar to Winter et al. (2006) who investigated therapists from different theoretical backgrounds in the UKCP. Used with trainee clinical psychologists, it could provide insight into the differences trainee show in how they place themselves in relation to a therapeutic orientation through training. It may also be interesting to

use elements that reflect the trainee's home life to investigate how their views on themselves outside of the work context change through training in a similar way to Madill and Latchford (2006).

The study showed that trainees in the third year construe themselves as further from *a typical trainee clinical psychologist* than do first year trainees. It would be useful to be able to follow this up with some qualitative analyses to see how explicitly trainees conceptualise this shift. This could be achieved with a content analysis of the constructs elicited in the present study or with an alternative methodology with semi-structured interviews in order to establish if the same themes emerge. A more in-depth understanding of how third year trainees understand their trajectory through training in relation to their professional identity would be invaluable.

The study also showed that neuroticism mediates between conscientiousness and self esteem. This finding might be further strengthened by research using an alternative, more conventional and well-known measure of self esteem, e.g. the Rosenberg Self Esteem Scale (Rosenberg, 1965), than the distance between *self at current point in training* and *ideal self* elements.

More research in this otherwise barren area would be useful to training courses and potential and current trainees alike. Once more is known about how professional identity develops, the more can be done to facilitate the process, helping trainee clinical psychologists to make the most of their individual attributes.

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Appendix A: Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (QuIF-CliPP)

Please indicate the extent to which your *current* clinical practice is influenced by the following factors by circling the appropriate scale point. Example:

My current clinical practice is influenced by:	not at all						a great deal
A1 ➡ *text books*	0	1	2	3	4	5	6

If you feel that a particular factor is not applicable to you, please leave the item blank.

A Literature

My current clinical practice is influenced by:

	not at all						a great deal
A1 ➡ *text books*	0	1	2	3	4	5	6
A2 ➡ *professional guidelines*	0	1	2	3	4	5	6
A3 ➡ *research based journal articles*	0	1	2	3	4	5	6
A4 ➡ *theory based journal articles*	0	1	2	3	4	5	6
A5 ➡ *other kinds of journal articles, e.g. discussion of professional issues*	0	1	2	3	4	5	6
A6 ➡ *electronic journals and databases, e.g. Ovid*	0	1	2	3	4	5	6
A7 ➡ *other information gathered from the internet*	0	1	2	3	4	5	6
A8 ➡ *treatment manuals*	0	1	2	3	4	5	6
A9 ➡ *government documents, e.g. white papers*	0	1	2	3	4	5	6
A10 ➡ *evidence-based practice guidelines*	0	1	2	3	4	5	6
A11 ➡ *non-professional literature, e.g. novels; biographies; poetry; philosophy; spirituality.*	0	1	2	3	4	5	6

Thank you for taking the time to fill in this questionnaire.
Please return in the envelope provided.

A12 ➡ *Please indicate how much time you spend reading **professionally** related literature per week*

less than 1 hour ☐ 5 -10 hours ☐

1 - 5 hours ☐ more than 10 hours ☐

B Training

My current clinical practice is influenced by:

		not at all						a great deal
B1 ➡	*my professional training (please specify type of training)*	0	1	2	3	4	5	6
B2 ➡	*post-qualification training (i) (please specify type of training, leave blank if not applicable)*	0	1	2	3	4	5	6
B3 ➡	*post-qualification training (ii) (please specify type of training, leave blank if not applicable)*	0	1	2	3	4	5	6
B4 ➡	*seminars/workshops*	0	1	2	3	4	5	6
B5 ➡	*conferences*	0	1	2	3	4	5	6
B6 ➡	*providing training for other professionals*	0	1	2	3	4	5	6
B7 ➡	*providing teaching/lecturing for trainees/students*	0	1	2	3	4	5	6

Thank you for taking the time to fill in this questionnaire.
Please return in the envelope provided.

C Practice

My current clinical practice is influenced by:

		not at all						a great deal
C1	➡ *supervision I currently receive*	0	1	2	3	4	5	6
C2	➡ *supervision I have received in the past*	0	1	2	3	4	5	6
C3	➡ *supervision that I provide*	0	1	2	3	4	5	6
C4	➡ *peer/collegial discussion*	0	1	2	3	4	5	6
C5	➡ *organisational / departmental practices and restraints*	0	1	2	3	4	5	6
C6	➡ *environmental characteristics / limitations*	0	1	2	3	4	5	6
C7	➡ *NHS and/or service philosophy*	0	1	2	3	4	5	6
C8	➡ *client characteristics, e.g. situation; thinking style; capacity for relationships; life events.*	0	1	2	3	4	5	6
C9	➡ *client feedback / learning from the client*	0	1	2	3	4	5	6
C10	➡ *psychological formulation / assessment developed with the client*	0	1	2	3	4	5	6
C11	➡ *my intuition and/or judgement*	0	1	2	3	4	5	6
C12	➡ *things I have picked up along the way*	0	1	2	3	4	5	6

Thank you for taking the time to fill in this questionnaire.
Please return in the envelope provided.

D Life Experience and Personal Factors

My current clinical practice is influenced by:

		not at all						a great deal
D1	➡ *my personal philosophy*	0	1	2	3	4	5	6
D2	➡ *my spirituality and/or religion*	0	1	2	3	4	5	6
D3	➡ *friends and/or family who have experienced mental health problems*	0	1	2	3	4	5	6
D4	➡ *friends and/or family who have experienced psychology and/or psychiatry services*	0	1	2	3	4	5	6
D5	➡ *my own therapy (leave blank if not applicable)*	0	1	2	3	4	5	6
D6	➡ *major life events, e.g. deaths; having children, personal pressures.*	0	1	2	3	4	5	6
D7	➡ *family and/or friends generally*	0	1	2	3	4	5	6
D8	➡ *activities and interests aside from work related*	0	1	2	3	4	5	6
D9	➡ *experiences of alternative therapies, e.g. acupunture; homeopathy.*	0	1	2	3	4	5	6
D10	➡ *television programmes and films*	0	1	2	3	4	5	6
D11	➡ *If any significant factors have been missed out please specify:*							
	(i)..							
		0	1	2	3	4	5	6
	(ii)..							
		0	1	2	3	4	5	6
	(iii)..							
		0	1	2	3	4	5	6

Thank you for taking the time to fill in this questionnaire.
Please return in the envelope provided.

Appendix B: Therapeutic Orientation and Experiences Survey (TOES)

Theoretical Orientation and Experiences Survey

Please rate the questions below on the scales provided by circling one number where:
1 = not at all 2 = a little 3 = neutral 4 = somewhat 5 = greatly

---

1) To what extent do you identify with the tenets of cognitive-behavioural therapy?

1 2 3 4 5

2) To what extent does cognitive-behavioural theory appeal to you personally?

1 2 3 4 5

3) How much do you envisage using cognitive-behavioural therapy when qualified?

1 2 3 4 5

---

4) To what extent do you identify with the tenets of psychodynamic therapy?

1 2 3 4 5

5) To what extent does psychodynamic theory appeal to you personally?

1 2 3 4 5

6) How much do you envisage using psychodynamic therapy when qualified?

1 2 3 4 5

---

7) To what extent do you identify with the tenets of systemic therapy?

1 2 3 4 5

8) To what extent does systemic theory appeal to you personally?

1 2 3 4 5

9) How much do you envisage using systemic therapy when qualified?

1 2 3 4 5

Appendix C: Counsellor Theoretical Position Scale (CTPS)

The Counsellor Theoretical Orientation Scale

Please read the following statements and indicate the extent of your agreement or disagreement with each by circling one of CD (completely disagree), MD (moderately disagree), SD (somewhat disagree), E (equally agree and disagree), SA (somewhat agree), MA (moderately agree), CA (completely agree).

An understanding of the reasons for one's behaviour is crucial to behaviour change

CD CA MD SD E SA MA CA

Knowledge is valid only if it is based on logic and/or reason.

CD CA MD SD E SA MA CA

Irrationality is the fundamental cause of psychological dysfunction.

CD CA MD SD E SA MA CA

Clients need to be guided and given information in order to achieve their therapeutic goals

CD CA MD SD E SA MA CA

Improving the client's level of social adjustment ought to be the main therapeutic aim.

CD CA MD SD E SA MA CA

As a psychologist I maintain a detached and objective approach during counselling or psychotherapy interviews.

CD CA MD SD E SA MA CA

It is unwise for a psychologist to respond to a client in a spontaneous, not thought-through manner.

CD CA MD SD E SA MA CA

Any claimed mental process can be translated into a statement describing observable behaviour.

CD CA MD SD E SA MA CA

Valid information comes only from empirical research.

CD CA MD SD E SA MA CA

Nothing is true if it is illogical.

CD CA MD SD E SA MA CA

The brain is the prime mover in human social development.

CD CA MD SD E SA MA CA

Logical analysis and synthesis of information is crucial to one's survival.

CD CA MD SD E SA MA CA

Emotional involvement by a therapist defeats the purpose of therapy.

CD CA MD SD E SA MA CA

Intense negative emotions are manifestations of unrealistic and non-logical cognitions.

CD CA MD SD E SA MA CA

It is preferable that a psychologist remains personally uninvolved in the therapeutic relationship.

CD CA MD SD E SA MA CA

Specific training in counselling or psychotherapy techniques is vital to therapeutic outcome.

CD CA MD SD E SA MA CA

Perceptions define human experience.

CD CA MD SD E SA MA CA

Higher intellectual processes over-ride more primitive functions of feeling and behaviour.

CD CA MD SD E SA MA CA

Unconscious motives and intuitive processes should be considered as essential aspects of psychological theory.

CD CA MD SD E SA MA CA

Unconscious motivation is a very important aspect of human behaviour.

CD CA MD SD E SA MA CA

The emotional process in counselling or psychotherapy is a vital agent of change.

CD CA MD SD E SA MA CA

Interpretation of symbolic meaning enables illumination of depth of human experience.

CD CA MD SD E SA MA CA

The concept of unconscious process is of limited therapeutic value.

CD CA MD SD E SA MA CA

I generally prefer to practice a goal-directed approach to counselling or psychotherapy.

CD CA MD SD E SA MA CA

Understanding of a client's childhood is crucial to therapeutic change.

CD CA MD SD E SA MA CA

Counselling or psychotherapy should focus on 'here-and-now' experiences: There is no need to focus on client's past.

CD CA MD SD E SA MA CA

Human beings need to know meanings rather than simply factual information.

CD CA MD SD E SA MA CA

It is essential to focus on feeling and meaning as communicated by the client.

CD CA MD SD E SA MA CA

People can learn effective coping skills without necessarily having to go into the depths of their private experience.

CD CA MD SD E SA MA CA

Introspective and intuitive methods in counselling or psychotherapy are more useful than explanations, which do not go beyond observable behaviour.

CD CA MD SD E SA MA CA

Self-knowledge deepens our understanding of life.

CD CA MD SD E SA MA CA

An effective psychologist demonstrates sensitivity and personal involvement towards the client.

CD CA MD SD E SA MA CA

Careful re-examination by a client of his/her personal history can alter the client's present emotional life.

CD CA MD SD E SA MA CA

It is important for a psychologist to feel strong personal and emotional involvement with a client.

CD CA MD SD E SA MA CA

Search for meaning and wholeness in life is the essence of human experience.

CD CA MD SD E SA MA CA

Establishing a client's awareness of his/her own emotions and desires is a beneficial therapeutic outcome in itself. -

CD CA MD SD E SA MA CA

I believe counselling or psychotherapy is much more an art form than a science.

CD CA MD SD E SA MA CA

As a psychologist I usually take on an active role in structuring the interview.

CD CA MD SD E SA MA CA

Emotional stability is a product of one's logical and consistent thinking behaviour.

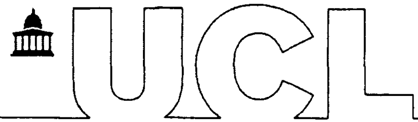
CD CA MD SD E SA MA CA

Cognition is the most powerful factor in determining experience.

CD CA MD SD E SA MA CA

Appendix D: Ethics approval letter

UCL GRADUATE SCHOOL
UCL RESEARCH ETHICS COMMITTEE



Dr Sunjeev Kamboj
Sub-Department of Clinical Health Psychology, UCL

25 September 2007

Dear Dr Kamboj

Notification of Ethical Approval: Project ID/Title: 1211/001:
The construing of trainee clinical psychologists in relation to personality, factors that influence clinical practice and theoretical orientation

I am pleased to confirm that in my capacity as Chair of the UCL Research Ethics Committee I have approved your research proposal for the duration of the study.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Responsibilities Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events.
For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely

Sir John Birch
Chair of the UCL Research Ethics Committee

Cc: Daniel Simmonds, Sub-Department of Clinical Health Psychology, UCL

Appendix E: Information sheet for participants

Information Sheet for Participants in Research Studies

You will be given a copy of this information sheet.

Title of Project:	The Construing of Trainee Clinical Psychologists in relation to personality, factors that influence clinical practice and theoretical orientation.

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: 1211/001

Name, Address and Contact Details of Investigators:

Dr. Sue Watson (principle investigator) & Mr. Daniel Simmonds (trainee clinical psychologist)
Sub-Department of Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or you would like more information.

We are conducting a study to investigate trainee clinical psychologists' experience of the DClinPsy program at UCL. Many Clinical Trainees report that they find the process of training as a difficult time with many personal and professional challenges, and we are interested in your views. We hope the study will provide valuable insights which may be highly relevant to clinical training.

Participating in the study will involve you meeting with me here at UCL for approximately one hour. At the meeting you will be asked to complete a NEO personality inventory, the Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies (QuIF-CliPP), and a measure to investigate your preferred theoretic orientation. We shall also be asking you to complete a repertory grid, which is a structured interview procedure to explore your thoughts about yourself undergoing the clinical training at UCL. There will also be a short demographic questionnaire for you to complete. The meeting will provide you with the opportunity to tell us about your experiences on the clinical training course at UCL. We anticipate that you will find the research procedures interesting and enjoyable. We shall be happy to provide you with feedback after you have completed the research procedures.

Data will be collected and stored in accordance with the Data Protection Act 1998. All data which we collect from you will be coded and anonymised. You will not be identifiable by name on any transcripts. Data will be stored in a locked filing cabinet and password protected electronic database. Data will be retained for five years and then destroyed.

Participation in the study is entirely voluntary. Whether or not you choose to participate will not change the level of help and support you receive as a trainee clinical psychologist at UCL. If you choose to participate, you are free to withdraw at any time without giving a reason.

Thank you for taking the time to read this information sheet. If you would like further information please do not hesitate to contact me.

Appendix F: Informed consent form for participants

Informed Consent Form for Participants in Research Studies
(This form is to be completed independently by the participant after reading the Information Sheet and/or having listened to an explanation about the research.)

Title of Project:	The Construing of Trainee Clinical Psychologists in relation to personality, factors that influence clinical practice and theoretical orientation

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: **1211/001**

Participant's Statement

I ....
agree that I have

- read the information sheet and/or the project has been explained to me orally;
- had the opportunity to ask questions and discuss the study;
- received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a research-related injury.
- I understand that the information I have submitted will be published as a report and I will be sent a copy. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications.

I understand that I am free to withdraw from the study without penalty if I so wish and I consent to the processing of my personal information for the purposes of this study only and that it will not be used for any other purpose. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Signed: Date:

Investigator's Statement

I ....
confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date: