MALENA DIGIUNI Lic MSc

THERAPISTS' PERSONAL THERAPY

Section A: Personal Therapy for Therapists:
A Literature Review
Word Count: 4,997

Section B: Clinical Psychology Students' Perceived Social Stigma and Attitudes Towards Seeking Therapy:
A Cross-national Study
Word Count: 7,979

Section C: Critical Appraisal
Word Count: 1,900

Overall Word Count: 14,892

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

Department of Applied Psychology
CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION FOR MAJOR RESEARCH PROJECT

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed …….. (candidate)

Date ……..

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed …….. (candidate)

Date ……..

Signed …….. (supervisor)

Date ……..

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and abstract to be made available to outside organisations.

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ACKNOWLEDGEMENTS

I would like to express my gratitude to my supervisors, Prof Paul Camic and Dr Fergal Jones, for their assistance and guidance on this major research project. A big thank you goes to the participants, who made this study possible. I am also grateful to my personal therapists, Dr Patricia F. Vazquez and Marie Couper, who held my hand throughout my development as a clinical psychologist. My experiences with them were the source of inspiration for this study.

I am deeply indebted to Prof. Orlinsky, for his comments on an early draft of the proposal for this research project. I must also acknowledge Dr Patricio Dalton, whose passion and motivation inspired me to apply for the doctorate in clinical psychology. His support and encouragement during the first stages of the training were invaluable. A special thanks goes out to those who provided me with statistical advice at times of critical need, Dr Isabella Sullis and Dr Gianluca Grimalda.

I am deeply grateful to my friend from life, Chivi Guidobono; without her understanding and continued support I would not have been able to complete this study. Finally, I want to express my deeply-felt thanks to my mother, for teaching me the value of education; to my father, for proving me that we can achieve anything we want in life; and to my grandmother, for her unconditional support and unwavering faith in me.

DEDICATION

This major research project is especially dedicated to the memory of S. L., the person from whom I learnt the most significant lessons.

SUMMARY OF THE MRP PORTFOLIO

Section A presents a literature review on the topic of personal therapy for therapists.

Section B presents a cross-national empirical study on the topic of social stigma associated with receiving therapy and student therapists' attitudes towards seeking personal therapy.

Section C presents a critical appraisal of the process of conducting the present major research project, including learning outcomes, limitations, implications, and areas for future research.

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Section A

Personal Therapy for Therapists: A Literature Review

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ABSTRACT

Personal therapy has historically been regarded as a core element of a therapist's life. However, there are contested views around the utility and value that personal therapy has for therapists. The present literature review aims to shed some light into this debate by presenting the existent research evidence into four main sections: 1) What we know about the impact of therapists' personal therapy on therapeutic processes and outcomes; 2) What therapists say about their experiences in personal therapy and its value; 2) The type of therapists who engage (and who do not engage) in personal therapy; and 3) therapists' reasons to seek or not to seek therapy. The findings of the review are then discussed and interpreted in terms of the social identity theory and the theory of planned behaviour. Gaps in the literature are identified and possible avenues for future research are suggested.

INTRODUCTION

Authority figures have made unequivocal remarks regarding the need for therapists to undergo personal therapy. Freud claimed "But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is in an analysis of himself." (Freud, 1964, p.246). Similarly, Fromm-Reichmann (1950) stated that "…because of the interpersonal character of the psychotherapeutic process itself, any attempt at intensive psychotherapy is fraught with danger, hence unacceptable, where not preceded by the future psychiatrist's personal analysis." (p.42).

The rationales for personal therapy have historically been based on psychoanalytic theoretical grounds. From this perspective, it is considered that personal therapy serves the main purposes of: a) enhancing the therapist's ability to deliver therapy in an unbiased manner by lessening his "blind spots", b) fostering a sense of conviction in the validity of the therapeutic method employed by having the therapist experiencing its effects, c) fostering mastery of the application of techniques by the therapist's learning from a role model, and d) improving the therapist's life and neurotic issues, so that the stress attached to the clinical work could be better tolerated (Nierenberg, 1972). Therapists with other theoretical orientations have also supported the argument for personal therapy, claiming that therapists of any theoretical orientation would benefit from having the opportunity to understand the client's position and to reduce the likelihood of blind spots and unethical behaviour (Farrel, 1996).

However, arguments against personal therapy also exist. Derner (1960) claimed "To judge a priori, who will be a good therapist by the use of personal therapy experience as a major prediction continues to be questionable. If humanness can be put at the disposal of the patient, he will be a successful patient." (p.14). Similarly, Atkins (2006) pointed out to the

risks of obliging someone who is "well" to undergo therapy, and claimed that "it would be neither intellectually nor ethically coherent" (p.408).

As to shed some light into the above debate, the value of personal therapy for the therapists needs to be further explored. The present review intends to fulfil that need, by responding to the following questions: What do we know about the impact of therapists' personal therapy on therapeutic processes and outcomes? What do therapists say about their experiences in personal therapy and its value? What type of therapists engage (or do not engage) in personal therapy? And what are their reasons to do so? The literature search strategy is presented in Appendix 1. Finally, an argument on how the findings of the present review could be understood in terms of theory will be presented in the discussion section.

In line with most research on therapists' personal therapy (Norcross & Guy, 2007), here, "personal therapy" is used as a generic term to describe the psychological treatment of therapists by means of any theoretical orientation, format, or duration. The term "therapist" is used as a generic term to refer to any professional therapist who delivers psychological therapy. Because the topic of personal therapy is relevant to all therapists, regardless of their professional background; and because the majority of research done on this topic involves mixed samples of therapists (e.g. clinical psychologists, psychotherapists, counsellors), the present review does not discriminate between therapists with different professional titles. However, differences among therapists with diverse theoretical orientations will be acknowledged and explored.

Empirical studies: The impact of therapists' personal therapy on therapeutic outcomes and processes

Five empirical reviews exploring the impact of therapists' personal therapy on therapeutic outcomes and processes revealed inconclusive results. Out of the total of 11 studies reviewed, three indicated that personal therapy had a positive impact on client outcome and processes; seven found no significant effects or mixed results; and one showed that personal therapy was associated with poorer client outcomes (Clark, 1986; Garfield & Kurtz, 1976; Greenberg & Staller, 1981; Macaskill, 1988; and Macran & Shapiro, 1998). Eight further studies looking at how therapists' personal therapy impacted on therapeutic processes (i.e. counter-transference, therapists' attitudes towards their clients, and therapeutic alliance) revealed similarly mixed results. Overall, these findings offer little clear endorsement of how personal therapy enhances clinical practice. The authors, outcomes measured, and main findings of the studies discussed in this section are presented in Appendix 2.

A comprehensive methodological critical review of these studies is out of the scope of the present review. However, when considering this research evidence is important to bear in mind the methodological problems underlying some of their results. Results on clients' outcome are normally affected by the instrument used to measure change, by the person who evaluates that change (i.e. therapist vs. client), and the uncertainty of how much of the change was due to the therapy (Wheeler, 1991). Furthermore, most of the above studies are affected by small sample sizes, failure to control for relevant variables that account for therapists' effectiveness in their practice (e.g. years of experience), and the use of inappropriate statistical tests. These issues make the validity of their findings rather questionable. Conceptual limitations also affect many of the above studies. Some studies measuring

therapeutic process (e.g. counter-transference) are derived in large part from an analytic/psychodynamic orientation. Thus, their results may reflect the therapist's degree of adherence to analytic procedures rather than the therapist' effectiveness in clinical practice (Peeble, 1980).

Survey or interview studies: Therapists' subjective accounts of their personal therapy and its value.

The vast majority (86-90%) of therapists who have done therapy report that their therapy has been very helpful (e.g. Darongkamas, Burton, & Cushway, 1994; Norcross, Dryden, & DeMichelle, 1992; Williams, Coyle, & Lyons, 1999). Studies involving qualified and trainee therapists from different countries and diverse professional backgrounds yield similar findings. Quantitative studies normally employ survey designs with large representative samples (e.g. Bellows, 2007; Bike, Norcross & Schaltz, 2009; Buckley, Karasu, & Charles, 1981; Holzman, Searight, & Hughes, 1996; Macaskill, & Macaskill, 1992; Norcross, Strausser, & Faltus, 1988b; Norcross, Strausser-Kirtland, & Missar, 1988a; Norcross et al. 1992; Pope & Tabachnick, 1994). These studies have been criticised for diminishing therapists' experiences in therapy by quantifying them on Likert scales (Wiseman & Shefler, 2001). Yet, qualitative studies involving in-depth interviews with a small number of participants show results that are consistent with those obtained through quantitative research (e.g. Mackey & Mackey, 1993, 1994; Macran, Stiles, & Smith, 1999; Murphy, 2005; Moller, Timms, & Alilovic, 2009; Oteiza, 2010; Rake & Paley, 2009; Wiseman & Shefler, 2001). Similarly, the qualitative studies have the limitation of involving only a small number of self-selected participants. However, the consistency between their findings and those obtained through quantitative research supports the generalisability of their results to the wider population of therapists. Finally, one study using mix methods (Rizq & Target, 2008a, 2008b) revealed similar findings.

The above studies reveal that therapists who have undergone therapy described their most valued lessons learnt as: a) fostering their personal and professional development by increasing self-awareness, improving self-knowledge, self-esteem, improving personal relationships, reducing symptoms, dealing with issues arising from training, acknowledging the need for therapists to undergo therapy and breaking the divide between the client-therapist roles, and developing a secure sense of professional self-identity; and b) enhancing their competence to work as therapists through learning from the therapist as a role model, gaining experiential learning from being in the client's role, learning about the therapy process, appreciating the importance of transference/counter-transference issues, enhancing their reflective practice, gaining confidence, and improving their skills as therapists.

A minority of therapists (2-38%), however, reported that their experiences in therapy were ineffective or unhelpful. Qualified clinicians described harmful effects of personal therapy as: unresolved transference issues, therapist's sexual or emotional abuse, therapist's incompetence or failure to understand the client, non-sexual dual relationships, increased psychological distress, substantial family stress, and being obliged to undergo therapy (e.g. Buckley et al., 1981; Darongkamas et al., 1994; Norcross et al., 1992; Rake & Paley, 2009). Therapists-in-training reported negative experiences in therapy as: dual relationships, confidentiality issues, feeling coerced to undergo therapy, having a poor therapist, financial burden, obstructing training by leaving trainees feeling too emotional or raw, and provoking fears of being found out to be a fraud: "too unstable to be a clinical psychologist" (Moller et al., 2009, p.379; McEwan & Duncan, 1991).

Although the above research evidence provides consistent results and interesting information about the therapists' experiences in PT, most of them are mainly descriptive in their nature. Quantitative studies, in particular, have been criticised for gathering simplistic "press release" reports from therapists (Marcran et al., 1999). Yet, some qualitative studies

also failed to provide a theoretical framework that could aid the understanding of their findings and guide future research in the area. The only exceptions are Rizq and Target's (2008a, 2008b) study, which draws on Target and Fonagy (1996)'s developmental framework. These authors explored how therapists' attachment status and levels of reflective functioning influence how they experience, recall, and describe using personal therapy in their clinical practice. They found that securely-attached therapists with high levels of reflective function used their therapy to manage feelings evoked by difficult clients. However, insecurely-attached therapists with lower levels of reflective function benefited from therapy in terms of behavioural modelling, but not in terms of managing complex process issues.

In summary, both quantitative and qualitative research findings show that across countries and across professions, most therapists who have done therapy stress its value and report positive learning outcomes. However, a minority of them report negative effects of therapy. Only one qualitative study used theory to guide its research and to interpret its findings.

WHO ENGAGES IN PERSONAL THERAPY AND WHY?

Prevalence of personal therapy as a function of professional activity

Reviewing five studies focused on American seasoned therapists, Norcross and Guy (2005) found that American clinicians delivering psychotherapy are typically more inclined to undergo therapy than those involved in non-treatment roles. Similarly, Voigt (1998) found that psychotherapy practitioners are more likely to have been engaged in therapy than their colleagues working in academic roles. These findings were further confirmed by Bike, Norcross, and Schaltz (2009).

Prevalence of personal therapy as a function of theoretical orientation

A review of five relevant studies regarding American therapists revealed that psychoanalytic/psychodynamic therapists were the most likely to have undergone therapy (82-97%), and that cognitive-behavioural therapists were the least likely to have done so (44-66%). Rates of personal therapy among therapists with humanistic, systemic, and eclectic orientations fell somewhere in between those two extremes (Norcross & Guy, 2005). This variation on the proportions of therapy use among therapists with different theoretical orientations was also found across countries (e.g. in 14 countries from Europe and elsewhere, Orlinsky et al., 2005; in Britain: Norcross et al., 1992; Lucock, Hall, & Noble, 2006), and across time (Bike et al., 2009).

Prevalence of personal therapy as a function of gender

Examining eight studies focused on American therapists, Norcross and Guy (2005) observed that two studies found no significant differences across genders, whilst six showed that more female than male therapists sought therapy. More recently, Bike et al. (2009) observed that, in 1987, more female (84%) than male (71%) therapists had undergone therapy; however, in 2007, differences across genders (female=85%, male=81%) were not statistically significant. Likewise, Orlinsky and colleagues (2005) claimed that gender is not, in itself, a significant parameter of personal therapy across countries. Data from 14 countries showed no significant differences between female (82%) and male (77%) therapists' use of therapy.

Prevalence of personal therapy across countries

The vast majority of the research addressing therapists' therapy focuses on American therapists (Norcross & Guy, 2005). Thus, much of what we know about this topic applies to American therapists only, and may not be generalisable to therapists from elsewhere.

However, a few studies conducted in other countries and one large international study provide some information on the experiences of therapists' personal therapy across the world.

Therapists from 14 countries

In the only international study on therapists' therapy published to date, Orlinsky and colleagues (2005) found that the mean of therapists' use of therapy across 14 countries (N=5,224) was 79%, with a range from 99% to 36% (France: 99%; Switzerland: 96%, Sweden: 94%, Israel: 93%, Denmark: 90%, US: 88%, New Zealand: 84%, Belgium: 83%, Germany: 82%, Norway: 80%, Spain: 79%, Russia: 72%, Portugal: 66%, South Korea 36%).

As observed by the authors, the low number of Portuguese therapists in therapy may be due to them having the greatest proportion of cognitive-behavioural therapists in the wider sample. However, in South Korea, Orlinsky and colleagues claimed that "special circumstances prevail" (p. 183), as there seemed to be a "relative lack of social acceptance regarding counselling and therapy until recently." (Orlinsky et al., 2005, p.191).

Although Orlinsky and colleagues' (2005) sample of Israeli therapists reported a high proportion of therapy use (93%), in Wiseman and Egozi's (2006) sample of Israeli school counsellors (N=103), only 34% had undergone therapy. This lower proportion of therapy use among Israeli therapists may be explained by the different professional activities of school counsellors vs. other therapists, to whom delivering therapy to clients may be a more salient aspect of their work. However, an interesting finding was a significant difference between Jewish and Arab counsellors who had sought therapy (58% of the Jewish sample vs. 22% of the Arab sample). As the authors put it, this result may be explained by the fact that "Jewish (Western) culture grants grater legitimacy to turning to therapy than the more traditional cultures" (p. 342).

British therapists

Britain was not included in Orlinsky et al.'s (2005) study. However, other studies revealed that British therapists are less prone to undertake therapy than their colleagues from other countries. Norcross et al. (1992) found that, out of 993 therapists surveyed, only 39% had received therapy. Such finding revealed an astonishing disparity of therapy use between American and British therapists. Darongkamas and colleagues (1994) confirmed this result. Among 496 therapists (65% response rate), only 41% had sought therapy at least once in their lives. The relatively low proportion of therapy use among British therapists remains true at present. In Daw and Joseph's (2007) sample of 220 therapists, out of the 48 who responded (22% response rate) only 66.7% had undergone therapy.

Canadian therapists

Canada was not part of Orlinsky and colleagues' international study. However, a study suggests that Canadian therapists may be less prone to undergo therapy than their colleagues from elsewhere. In McEwan and Duncan's (1991) sample of 185 Canadian therapists, only 41% had undertaken therapy during training. Unfortunately, participants were not asked whether they had sought therapy prior or post training. Thus, this figure is not representative of the prevalence of therapy use by Canadian therapists in general. However, this figure is surprisingly small compared with the 70% of American therapists who had pursued therapy whilst in training (Guy, Stark, & Poelstra, 1988).

Unfortunately, data regarding prevalence rates among therapists from other cultures, such as African or Latin American countries, is lacking.

Prevalence of personal therapy across time

Bike et al. (2009) replicated a study they had conducted 20 years earlier (Norcross et al, 1988a; Norcross et al., 1988b) and found that psychologists' and social workers' therapy

use had significantly changed from 75% and 72%, respectively, in 1987 to 85% and 83% in 2007. An explanation for the increase in therapy use among American therapists is a wider acceptance of therapy as a self-care strategy. It is thought that the stigma attached to therapy may have reduced (Norcross, Bike, Evans, & Schatz, 2008). Similarly, Wiseman and Egozi found a significant difference between new counsellors (43%) and senior counsellors (20%) use of therapy. Such a result was interpreted by the authors as indicating a change in society, for which nowadays "seeking therapy is deemed more acceptable" (p.341).

In summary, therapists are more likely to have undergone therapy than their colleagues working on academic/non-treatment roles. Therapists who are most likely to have undergone therapy are those those who adhere to a psychoanalytic/psychodynamic orientation, while cognitive-behavioural therapists are the least likely. The majority of therapists from America, Europe, and elsewhere have undergone therapy. However, lower proportions of therapists from Britain, Canada, and South Korea have done so. Some findings seem to suggest that the way in which therapy is viewed by the wider society influences whether therapists engage in therapy or not.

WHY DO THERAPISTS SEEK THERAPY?

Therapists' reasons to seek therapy

Norcross and Connor (2005)'s literature review found that the majority of American therapists and therapists-in-training (50-60%) entered therapy for personal reasons, whilst a minority (10-35%) sought therapy for training or professional purposes. Therapists' three most frequent presenting problems were depression, couple conflicts, and anxiety. Less salient presenting problems included family-of-origin conflicts, and career concerns. Similarly, Liaboe, Guy, Wong, and Deahnert (1989) found that depression accounted for 46% of qualified psychologists' therapy consultations, and Holzman et al. (1996) found that 38%

of graduate students sought therapy for depression. Recently, Bike et al. (2009) observed that American therapists' reasons to seek therapy have not changed much between 1987 and 2007. Data from other countries confirm that the majority of therapists seek therapy for personal reasons rather than for training/professional purposes (e.g. among British therapists, Daw & Joseph, 2007; Macaskill & Macaskill, 1992; among therapists from 14 countries, Orlinsky et al., 2005).

All of the above studies used survey designs. As such, they may have failed to capture the complexity behind the therapists' reasons to undergo therapy. However, the results of some qualitative studies illustrate how therapists' willingness to engage in therapy are not only determined by their conscious reasons to do so, but also by other, more subtle factors. Interviewing five Israeli therapists, Wiseman and Shefler (2001) found that only one participant had sought therapy before training (due to personal issues), whilst the other four participants had sought therapy during training (due to personal reasons, and because it was a training requirement). The authors noted that the only participant who had entered therapy before training was not Israeli born, but had been born in a culture where "therapy [was] quite acceptable" (p.133). Conversely, the cultural views about therapy held by the Israeli society appeared to be very different. One of the participants who sought therapy during training explained that he was initially reluctant to engage in therapy because he held the view that "psychotherapy is a treatment for the mentally ill" (p.133). Similarly, a qualitative study exploring therapists-in-training' experiences in therapy suggests that, regardless of the reasons therapists give to enter therapy, they take into account a wide range of different factors when deciding to enter therapy or not. For example, some therapists have concerns about what seeking therapy may reveal about them (e.g. they worry that in undergoing therapy, they may be found to be a fraud, Moller et al., 2009).

Therapists' reasons not to seek therapy

Reviewing five relevant studies, Norcross and Connor's (2005) found that American therapists and therapists-in-training who have never sought therapy reported their reasons for doing so as: confidentiality concerns, financial expenses, exposure fears, self-sufficiency desires, time constrains, difficulties finding an appropriate therapist, and considering that they dealt with their problems effectively. Equally, among graduate students, top ranked reasons not to seek treatment involved: "having no need for it", "none has ever recommended it to me", "confidentiality concerns", and "concerns about how it would be viewed by their training program". Interestingly, although students who had undergone therapy felt that their confidentiality was protected, more than half did not discuss their therapy with their clinical supervisor (Holzman et al., 1996). Other studies involving qualified therapists and graduate students (not included in the above review) yielded similar results (Gilroy, Carrol, & Murra, 2001; Liaboe et al., 1989; Strozier & Stacey, 2001).

A recent publication revealed that therapists' reasons not to seek therapy have changed in the last two decades (Norcross et al. 2008). This time, the main reasons given by 119 therapists (16% of N=727) not to pursue therapy involved: "I dealt with my stress in other ways", "I received sufficient support from [other sources]", "I coped effectively with challenges", "I resolved my problems before therapy was undertaken", and "I did not need personal therapy". Contrary to previous research findings, expenses, fear of exposure, and confidentiality concerns, were the lowest ranked reasons for therapists not to seek therapy. The authors concluded that "perhaps the more widely accepted use of personal therapy as a self-care strategy for mental health professionals had reduced its stigma, resulting in less fear of exposure and fewer confidentiality concerns" (p.1375).

All the research evidence looking at why some therapists do not seek therapy involves quantitative methodologies. Unfortunately, no qualitative study has been carried out with

therapists who have never been in therapy. As discussed earlier, quantitative research on this topic has the limitation of providing restricted understanding of the different motivations that some therapists may have not to seek therapy.

In summary, the most cited reasons for therapists to enter therapy regard personal issues. However, other reported reasons include professional issues and training. Therapists who have never undergone therapy report that they did not seek therapy due to confidentiality concerns, exposure fears, and because they felt no need for it. Therapists' reasons not to seek therapy seem to have changed over time. The quantitative nature of most research looking at therapists' reasons to seek therapy has the limitation of not allowing for the complexity of therapists' motivations to enter or not to enter therapy to be fully explored.

DISCUSSION

Although the value of personal therapy for the effectiveness of the therapist professional functioning is yet to be empirically proven, therapists who have undergone therapy describe overwhelming positive benefits to both their personal/professional development and their clinical practice. Yet, some therapists chose to undergone therapy whilst others do not.

Some of the benefits of personal therapy experienced by therapists resemble those observed by clients in the wider population (e.g. improving self-esteem and self-confidence, improving interpersonal relationships). However, what seems to be of particular value to these professionals, compared to any other therapy clients, is that therapy enhanced their professional development and work skills. Likewise, some of the negative experiences in therapy reported by therapists resembled the risks faced by any client who pursues therapy (i.e. therapist's unethical behaviours or incompetence). However, what seems to be different in the negative experiences in therapy between therapists-clients and other clients concerns

professional issues. That is, some therapists worried that the psychological distress experienced through therapy would negatively impact on their clinical work, others expressed concerns about dual relationships and confidentiality; and yet others worried that they could be found to be a "fraud" (i.e. not "well enough") to be a therapist. Unfortunately, only one study exploring therapists' experiences of therapy used theory to guide its research and to interpret their results. This study suggested that more securely-attached and reflective therapists may benefit more from therapy than those who are more insecurely-attached and less reflective therapists.

The main reasons for therapists to seek therapy involve personal issues, among which depression was one of the most important problems. However, some therapists also chose to undergo therapy for professional reasons. Some of the reasons for therapists not to seek therapy resemble the reasons that any client may have not to pursue treatment (e.g. cost and time constrains), whilst others concern professional issues (e.g. concerns about confidentiality). Yet, other reasons why some therapists may refrain from seeking therapy relate to a sense of self-sufficiency (i.e. feeling that they cope well with life challenges and that they do not need PT). Unfortunately, the lack of qualitative research exploring why some therapists decide not to undergo therapy limits our understanding of this topic.

Norcross and Connor (2005) drew on Burton's (1973) ideas, to argue that therapists-healers rely on four main resistances not to seek treatment: a) a paradoxical attitude, by which therapists who seem to be the most firmly convinced about the efficacy of psychotherapy are actually the ones who have the deepest doubts about it; b) a view that self-analysis will be enough to them; c) issues of self-image and narcissism, extreme fears of exposure and of giving up power to another healer; and d) shame – "a kind of damage that is done to a healer when he is forced to become a fellow sufferer of those he regularly treats, that is so subtle and intangible as to defy description" (Burton, 1973, p.100).

Holzman and colleagues (1996) also argued that therapists' decisions to seek therapy may be shaped by the social expectations attached to their roles and professional identities. They claimed that in "the public mind" there is an idea that therapists should have a high level of psychological wellness. This idea may make it difficult for therapists to seek psychological assistance, as needing psychological help could be viewed as a sign of inadequacy or failure (p.450). Similarly, Laliotis and Grayson (1985) argued that the self-image of the therapist and the image of the profession suffer each time a therapist fails. They claimed that the omnipotence attached to the role of the therapist discourages help-seeking.

Drawing on the social identity theory (Tajfel & Turner, 1979), it would be argued that the therapist' self-concept is derived from his membership to the social group of mental health practitioners. This social identity represents a prototype that describes beliefs, attitudes, feelings, and behaviours that minimises in-group differences and maximises out-group differences (i.e. validating the identity of the group). It may be that the above therapists' reluctance to do therapy is based on a need for therapists to differentiate themselves from their clients. The social categorization of people into an out-group (i.e. clients with mental health difficulties) and an in-group (i.e. the therapists, who do not suffer from mental health difficulties but represent psychological wellness) may lead therapists to achieve a sense of positive group distinctiveness. This idea is also supported by the results indicating that some students did not seek therapy due to concerns about how this could be viewed by their training program, or who were in therapy but felt reluctant to share it with supervisors, as if revealing a similarity with the out-group (the clients) would somehow threaten the student's membership to the in-group (the mental health professionals).

Research evidence from diverse countries shows that the majority of therapists worldwide undertake therapy. However, prevalence rates are relatively lower in some countries, such as UK, Canada, and South Korea. The lower proportion of therapists using

therapy in some countries (e.g. South Korea) suggests that stigmatising views about seeking therapy may account (at least in part) for therapists' help-seeking behaviours. Likewise, more or less acceptable views about therapy may also explain differences in therapists' use of therapy across religious groups (as observed in Wiseman & Egozi's study). The change observed in therapists' use of therapy across time further supports the idea that therapists' willingness to do therapy is influenced by different factors, including how therapy is viewed by the wider society.

According to the theory of planned behaviour (Ajzen, 1991), people's actions are determined by their intentions, which, in turn, are determined by three main components: attitudes towards the behaviour in question, perceived control, and subjective norms (i.e. people's perceptions of the extent to which significant others think that they should perform the action / perceived social pressure to engage or not in the behaviour in question). Drawing on this theoretical framework, it could be argued that therapists from cultural groups in which therapy is negatively viewed by the wider society may feel social pressure not to seek therapy themselves. This would explain the findings that South Korean therapists are less prone to seek therapy than their colleagues from Western countries, and that Israeli Jews school counsellors are more prone to seek therapy than their Arab colleagues.

The subjective norms held by specific professional groups may also affect therapists' intentions to seek therapy. Psychoanalytic/psychodynamic therapists may be more willing to engage in therapy because doing so is positively viewed and highly appreciated by their professional group. That is, engaging in therapy is as an important aspect of psychoanalytic/psychodynamic therapists' socially expected code of conduct. However, doing therapy is not an important aspect of cognitive-behavioural therapists' theoretical ethos, for which these therapists may perceive less social pressure from their professional group to engage in therapy, or may even feel pressured not to do so. The endorsement of

subjective norms that either promote or discourage the use of therapy among therapists may also explain why different training institutions and professional bodies hold such diverse views about the need for therapists to undergo therapy.

AREAS FOR FUTURE RESEARCH

There is a clear need for further empirical evidence on the impact of personal therapy on therapeutic outcomes and process. This research should address the methodological and conceptual limitations affecting the evidence published so far.

The above research evidence points to the need of including theory in the exploration of therapists' seeking-behaviours. The theory of planned behaviour could provide a useful theoretical framework to address this topic. One avenue of research could use the element of subjective norms of the theory of planned behaviour model to evaluate how social stigma associated with therapy has a role in determining therapists' seeking behaviour. Likewise, the element of subjective norms could be used to test the hypothesis that psychoanalytic/psychodynamic therapists are more inclined to engage in therapy due to endorsing a professional code of conduct that promotes therapy-seeking behaviours. This would be useful to explain why this professional group is the most likely to engage in therapy. Another avenue for research would be to test how well the theory of planned behaviour allows as to predict therapists' therapy-seeking behaviours, as this would allow us to gain a better understanding of the complex reasons why therapists engage or not engage in personal therapy.

Future research should also be directed to explore prevalence rates of therapy use among therapists from other countries. Holding the idea that stigma associated with therapy may explain cross-national variations in therapists' therapy-seeking behaviours, it would be

interesting to test whether nationality interacts with social stigma in the prediction of therapists' therapy-seeking behaviours.

REFERENCES

Ajzen, I. (1991). The Theory of planned behaviour. Organizational Behavior and Human Decision Processes, 50, 179-211.

Atkins, P. (2006). Personal therapy in the training of therapists. European Journal of Psychotherapy and Counselling, 8, 407-410.

Bellows, K. F. (2007). Psychotherapists' personal therapy and its perceived influence on clinical practice. Bulletin of the Menninger Clinic, 204-226.

Bike, D. H., Norcross, J. C., & Schaltz, D. M. (2009). Process and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. Psychotherapy Theory, Research, Practice, Training, 46, 19-31.

Buckley, P., Karasu, T. B., & Charles, E. (1981). Psychotherapists view their personal therapy. Psychotherapy: Theory, Research, and Practice, 18, 299-305.

Burton, A. (1973). The psychotherapist as client. American Journal of Psycho-analysis, 37, 141-147.

Clark, M. M. (1986). Personal therapy: A review of empirical research. Professional Psychology: Research and Practice, 17, 541-543.

Darongkamas, J., Burton, M. V., & Cushway, D. (1994). The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom. Clinical Psychology & Psychotherapy, 1, 165–173.

Daw, R., & Joseph, S. (2007). Qualified therapists' experience of personal therapy. Counselling and Psychotherapy Research. 7, 227-232.

Derner, G. F. (1960). An interpersonal approach to training in psychotherapy. In N. P. Dellis & H. K. Stone (Eds.) The training of psychotherapists. Baton Rouge: Louisiana State University Press.

Dube, J. E., & Normandin, L. (1999). The mental activities of trainee therapists of children and adolescents: The impact of personal psychotherapy on the listening process. Psychotherapy, 36, 216-228.

Duthiers, L. J. (2006). Countertransference awareness and therapists' use of personal therapy. Dissertation Abstracts International: Section B: The Sciences and Engineering, 66, 5084.

Farrel, W. (1996). Training and professional development in the context of counselling psychology. In R. Woolfe & W. Dryden (Eds.), Handbook of counselling Psychology. London: Sage.

Freud, S. (1964). Analysis terminable and interminable. In J. Strachey (Ed.) The standard edition of the complete psychological works of Sigmund Freud (Vol.23, pp. 216-255). London: Hogarth Press.

Fromm-Reichmann, F. (1950). Principles of intensive psychotherapy. Chicago: University of Chicago Press.

Garfield, S. L., & Bergin, A. E. (1971). Personal therapy, outcome and some therapist variables. Psychotherapy: Theory, Research and Practice, 8, 251-253.

Garfield, S. L., & Kurtz, R. M. (1976). Personal therapy for the psychotherapist: Some findings and issues. Psychotherapy, 13, 188-192.

Gilroy, S., L., Carrol, L., & Murra, J. (2001). Does depression affect clinical practice? A survey of women psychotherapists. Women and Therapy, 23, 13-30.

Gold, S. H., & Hilsenroth, M. J. (2009). Effects of graduate clinicians' personal therapy on therapeutic alliance. Clinical Psychology and Psychotherapy, 16, 159-171.

Greenberg, R. P., & Staller, J. (1981). Personal therapy for therapists. American Journal of Psychiatry, 138, 1467-1471.

Greenspan, M., & Kulish, N. M. (1985). Factors in premature termination in long-term psychotherapy. Psychotherapy, 22, 75-82.

Guy, J. D., Stark, M. J., & Poelstra, P. L. (1988). Personal therapy for psychotherapists before and after entering professional practice. Professional Psychology: Research and Practice, 19, 171-176.

Hamilton, J., & Kivligham, D. M. (2009). Therapists' projection: The effects of therapists' relationship themes on their formulations of client's relationship episodes. Psychotherapy Research, 19, 312-322.

Holt, R. R., & Luborsky, L. (1958). Personality patterns of psychiatrists (Vol. 1). New York: Basic Books.

Holzman, L. A., Searight, H. R., & Hughs, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. Professional Psychology: Research and Practice, 27, 98-101.

Katz, M. M., Lorr, M., & Rubinstein, E. A. (1958). Reminder patient attributes and their relation to subsequent improvement in psychotherapy. Journal of Consulting Psychology, 22, 411-414.

Kernberg, O. (1973). Psychotherapy and psychoanalysis: Final report of the Menninger Foundation's Psychotherapy Research Project. International Journal of Psychiatry Medicine, 11, 62-77.

Laliotis, D. A., & Grayson, J. H. (1985). Psychologist heal thyself: What is available for the impaired psychologist? American Psychologist, 40, 84-96.

Liaboe, G. P., Guy, J. D., Wong, T., & Deahnert, J. R. (1989). The use of personal therapy by psychotherapists. Psychotherapy in Private Practice, 7, 115-134.

Lucock, M. P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. Clinical Psychology and Psychotherapy, 13, 123-130.

Macaskill, N. D. (1988). Personal therapy in the training of the psychotherapist: Is it effective? British Journal of Psychotherapy, 43, 219-226.

Macaskill, N. D., & Macaskill, A. (1992). Psychotherapists-in-training evaluate their personal therapy: Results of a UK survey. British Journal of Psychotherapy, 9, 133-138.

MacDevitt, J. W. (1987). Therapist's personal therapy and professional self-awareness. Psychotherapy, 24, 693-703.

Mackey, R. A. & Mackey E. F. (1993). The value of personal psychotherapy to clinical practice. Clinical Social Work Journal, 21, 97-110.

Mackey, R. A., & Mackey, E. F. (1994). Personal psychotherapy and the development of a personal self. Families in Society, 75, 490-498.

Macran, S., & Shapiro, D. (1998). The role of personal therapy for therapists: A review. British Journal of Medical Psychology, 71, 13-25.

Macran, S., Stiles, W. B., & Smith, J. A. (1999). Hoe does personal therapy affect therapists' practice? Journal of Counseling Psychology, 46, 419-431.

McEwan, J., & Duncan, P. (1991). Personal therapy in the training of psychologists. Canadian Psychology, 34, 186-195.

McNair, D., Lorr, M., & Callahan, D. (1963). Patient and therapist influences on quitting psychotherapy. Journal of Consulting Psychology, 27, 10-17.

McNair, D., Lorr, M., Young, H., Roth, I., & Boyd, R. (1964). A three-year follow-up of psychotherapy patients. Journal of Clinical Psychology, 20, 258-264.

Moller, N. P., Timms, J., & Alilovic, K. (2009). Risky business or safety net? Trainee perceptions of personal therapy: a qualitative thematic analysis. European Journal of Psychotherapy and Counselling, 11, 369-384.

Murphy, D. (2005). A qualitative study into the experience of mandatory personal therapy during training. Counselling and Psychotherapy Research, 5, 27-32.

Nierenberg, M. A. (1972). Self-help first. International Journal of Psychiatry, 10, 34-41.

Norcross, J. C., & Connor, K. A (2005). Psychotherapists entering personal therapy. In: J. D. Geller, J. C. Norcross, & D. E. Orlnsky (Eds). *The Psychotherapist's own*

psychotherapy: patient and clinician perspectives (pp.192-200). New York: Oxford University Press.

Norcross, J. C., & Guy, J. D. (2005). The prevalence and parameters of personal therapy in the United States. In: J. D. Geller, J. C. Norcross, & D. E. Orlnsky (Eds). The *Psychotherapist's own psychotherapy: Pa*tient and clinician perspectives (pp.177-200). New York: Oxford University Press.

Norcross, J. C., Bike, D. H., Evans, K. L., & Schatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach? Journal of Clinical Psychology, 64, 1368-1376.

Norcross, J.C., & Guy, J. D. (2007). Leaving it at the Office: A guide to psychotherapist self-care. London: The Guildford Press.

Norcross, J. C., Dryden, W., & DeMichele, J. T. (1992). British clinical psychologists and personal therapy: III. What's good for the goose? Clinical Psychology Forum, 44, 29-33.

Norcross, J. C., Strausser, D. J., & Faltus, F. J. (1988a). The therapist's therapist. American Journal of Psychotherapy, 42, 53-66.

Norcross, J. C., Strausser-Kirtland, D. & Missar, C. D. (1988b). The processes and outcomes of psychotherapists' personal treatment experiences. Psychotherapy, 25, 36-43.

Orlinsky, D. E, Ronnestad, M. H., Willutzki, U., Wiseman, H., Botermans, J-F., et al. (2005). The prevalence and parameters of personal therapy in Europe and elsewhere. In: J. D. Geller, J. C. Norcross, & D. E. Orlnsky (Eds). *The Psychotherapist's own* psychotherapy: Patient and clinician perspectives (pp.177-200). New York: Oxford University Press.

Oteiza, V. (2010). Therapists' experiences of personal therapy: A descriptive phenomenological study. Counselling and Psychotherapy Research, 10, 222-228.

Peebles, M. J. (1980). Personal therapy and ability to display empathy, warmth and genuineness in psychotherapy. Psychotherapy: Theory, research and practice, 17, 258-262.

Plotkin, M. B. (2001). Freud in the Pampas. California: Stanford University Press.

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. Professional Psychology: Research and Practice, 25, 247-258.

Rake, C., & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. Psychodynamic Practice, 15, 275-294.

Rizq, R., & Target, M. (2008a). "Not a little Mickey mouse thing": How experienced counselling psychologists describe the significance of personal therapy in clinical

practice and training. Some results from an interpretative phenomenological analysis. Counselling Psychology Quarterly, 21, 29-48.

Rizq, R., & Target, M. (2008b). "The power of being seen": An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. British Journal of Guidance and Counselling, 36, 131-153.

Strozier, A. L., & Stacey, L. (2001). The relevance of personal therapy in the education of MSW students. Clinical Social Work Journal, 29, 181-195.

Strupp, H. (1973). Psychotherapy: Clinical research and theoretical issues. New York: Jason Aronson.

Strupp, H. H. (1955). The effect of the psychotherapists' personal analysis upon his techniques. Journal of Consulting Psychology, 19, 197-204.

Strupp, H. H. (1958). The psychotherapist's contribution to the treatment process. Behavioral Science, 3, 34-67.

Strupp, H. H., Fox, R., & Lessler, K. (1969). Patients view their psychotherapy. Baltimore: John Hopkins Press.

Tajfel, H., & Turner, J. (1979). An integrative theory of intergroup conflict. In: Austin, W. G., & Worchel, S. The social psychology of intergroup relations. (Eds.) (pp. 94–109). Monterey, CA: Brooks-Cole.

Target, M., & Fonagy, P. (1996). Playing with reality: II. The development of psychic reality from a theoretical perspective. International Journal of Psychoanalysis, 77, 459-479.

Wampler, L., D. & Strupp, H. H. (1976). Personal therapy for Students in Clinical Psychology: A matter of faith? Professional Psychology, 195-201.

Wheeler, S. (1991). Personal therapy: An essential aspect of counsellor training, or a distraction from focussing on the client? International Journal for the Advancement of Counselling, 14, 193-202.

Williams F., Coyle A., Lyons E. (1999). How counselling psychologists view their personal therapy. British Journal of Medical Psychology, 72, 545-555.

Wiseman, H., & Egozi, S. (2006). Personal therapy for Israeli school counsellors: Prevalence, parameters, and professional difficulties and burnout. Psychotherapy Research, 16, 332-347.

Wiseman, H., & Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional development. Psychotherapy: Theory, Research, Practice, Training, 38, 129-141.

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Section B

Clinical Psychology Students' Perceived Social Stigma and Attitudes Towards Seeking Therapy: A Cross-national Study

Word Count: 7,979

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

Department of Applied Psychology
CANTERBURY CHRIST CHURCH UNIVERSITY

This research will be submitted to (Psychotherapy: Theory, Research, Practice, Training.)

ABSTRACT

Drawing on the theory of planned behaviour, this study explored the influence of subjective norms (social stigma) on clinical psychology students' attitudes towards seeking personal therapy. A total of 462 students from Argentina (n = 121), England (n = 211), and the US (n = 211) completed a survey on demographic characteristics, well-known predictors of seeking therapy, perceived social stigma for receiving therapy, and attitudes towards seeking therapy. Results revealed significant cross-national differences, with Argentinean students showing the lowest levels of perceived social stigma for receiving therapy (M = 5.02, SD = 1.60), followed by English (M = 4.57, SD = 1.61) and Americans (M = 3.22, SD = 2.35). English students showed significantly less positive attitudes towards seeking therapy (M = 22.60, SD = 2.97) than their Argentinean (M = 24.89, SD = 2.94) and American (M = 24.27, SD = 3.17) counterparts. Hierarchical multiple regression analyses revealed that perceived social stigma predicts students' attitudes towards seeking therapy, even after controlling for the effects of other predictors of therapists' therapy-seeking behaviours, among English (ß = -.26, $p < .001$), and American (ß = -.34, $p < .001$) students but not among Argentinean students. The hypothesised role of nationality as a moderator of the relationship between perceived social stigma for receiving therapy and attitudes towards seeking therapy was confirmed. Implications for research and training are discussed. Suggestions are made for English and American clinical psychology training programs to raise awareness on social stigma associated with receiving therapy.

Key words: social stigma, attitudes towards seeking therapy, clinical psychology students, cross-national differences, personal therapy.

Introduction

The vast majority of psychotherapists have been in therapy at least once in their lives (Orlinsky et al., 2005), and most of them (86-90%) have found it extremely helpful (e.g. Darongkamas, Burton, & Cushway, 1994; Norcross, Dryden, & DeMichelle, 1992; Williams, Coyle, & Lyons, 1999). Both qualified and student-therapists who have engaged in personal therapy report that their personal therapy was highly beneficial to their clinical practice, with student-therapists emphasising the benefits of learning from the therapist as a role model, learning from being in the client role, and increasing work competence (e.g. Bellows, 2007; Daw & Joseph, 2007; Holzman, Searight, & Hughes, 1996; Macaskill & Macaskill, 1992; Moller, Timms, & Alilovic, 2009). Therapists also report that their experiences in personal therapy fostered their professional development, by allowing them to develop a secure sense of professional self-identity (e.g. Mackey & Mackey, 1993, 1994; Murphy, 2005), and by helping them to deal with issues arising from their training (Williams et al. 1999). Moreover, therapists attest to the value of personal therapy to address personal problems, such as relationship difficulties and depression (e.g. Liaboe, Guy, Wong, & Deahnert, 1989; Holzman et al., 1996; Norcross & Connor, 2005). However, some therapists and student-therapists refrain from pursuing personal therapy, due to exposure fears or confidentiality concerns, or because they feel that they cope well with life challenges and they do not need therapy (Norcross & Connor, 2005).

Most research exploring therapists' therapy-seeking behaviours has focused on qualified therapists. Only one published study investigated the predictors of student-therapists' therapy-seeking behaviours (Dearing, Maddux, & Tangney, 2005). Although this study provided some insight into what variables are related to students' decisions to seek therapy, their results were limited in that they used retrospective reporting of therapy-seeking behaviour as the outcome variable. Thus, their findings do not provide information about how

a set of variables may explain student-therapists' intentions or attitudes towards seeking therapy in the future.

Student therapists are in a unique position as to benefit from what personal therapy has to offer. Since they are acquiring skills to work in clinical practice, having the opportunity to learn from a therapist as a role model and getting the experiential learning of being in the client's chair is particularly relevant to them. Equally, since students are going through the process of becoming a therapist, having a space to reflect on the development of their professional identity appears timely. Students would also benefit from using personal therapy as a means for self-care. Dearing and colleagues (2005) observed that, on top of the normal stressors that qualified therapists are presented with, students usually face the additional challenges of having to juggle with multiple roles (i.e. student, therapist, partner), often having to move to an unfamiliar geographical area during training, and sometimes losing contact with their social support network. Therefore, it is important to understand what accounts for student-therapists' therapy-seeking behaviours in order to facilitate their use of personal therapy.

Research evidence shows that some therapists are more inclined to pursue personal therapy than others, depending on their professional activity and their theoretical orientation (Norcross & Guy, 2005). Yet, other research findings suggest that the way in which therapy is viewed by a society (i.e. whether a social group has stigmatising/ accepting views about therapy) may also have a role in shaping therapists' decision to engage in therapy or not. In the only international study on therapists' personal therapy published to-date, Orlinsky et al. (2005) reported that the proportion of therapists from America, Europe, and elsewhere was about 80%. Conversely, only 36% of South Korean therapists had been in therapy at least once in their lives. The authors claimed that, in South Korea, "special circumstances prevail" (p. 183), as there seemed to be a "relative lack of social acceptance regarding counselling and

therapy until recently." (Orlinsky et al., 2005, p.191). Similarly, Wiseman and Egozi (2006) found that Jewish counsellors (58% of the Jewish sample) were significantly more likely than Arab counsellors (22% of the Arab sample) to having sought personal therapy. According to the authors, this result is due to the fact that "Jewish (Western) culture grants grater legitimacy to turning to therapy than the more traditional cultures" (p. 342). They also found that new counsellors (43%) were significantly more likely than senior counsellors (20%) to report personal therapy. Such a result was interpreted in terms of a change in society, for which "seeking therapy is deemed more acceptable" (p.341). Further support to the idea that a society's view of therapy may influence therapists' therapy-seeking behaviours is provided by research findings regarding American therapists across time. Norcross, Bike, Evans, and Schatz (2008) noticed that American therapists' reasons not to seek therapy have changed in the last two decades. Whilst early studies revealed that therapists' main reasons not to seek therapy involved confidentiality concerns, exposure fears, and difficulties finding an appropriate therapist (e.g. Liaboe et al., 1989; Norcross & Connor, 2005), more recently, therapists reported that their main reason not to seek therapy was not having the need for it. The authors stated, "perhaps the more widely accepted use of personal therapy as a self-care strategy for mental health professionals has reduced its stigma, resulting in less fear of exposure and fewer confidentiality concerns" (p.1375).

Public/social stigma is "what a naïve public does to the stigmatized group when they endorse the prejudice about that group" (Corrigan, 2004). Vogel and Wade (2009) explain that there are two types of social stigma: Social stigma associated with having a mental illness, and social stigma associated with seeking therapy. They argue that the simple behaviour of seeking therapy (whether it is to deal with a psychological problem or for personal growth) carries its own mark of disgrace. Because student-therapists may have various reasons to enter therapy, which may or may not include the treatment of a mental

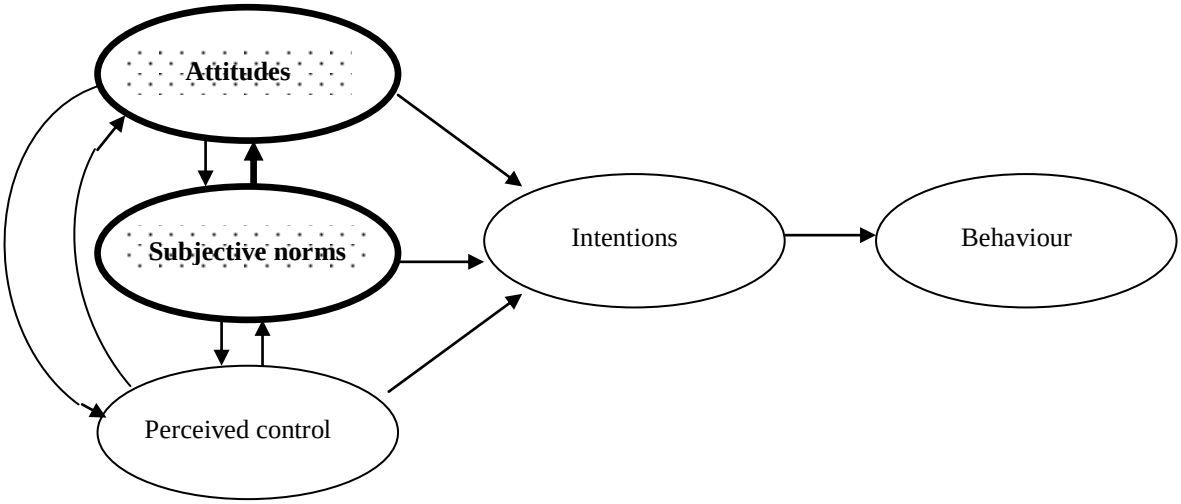
illness, it seems important to evaluate students' perceptions of the social stigma associated with seeking therapy rather than that associated with experiencing a mental illness.

The empirical evidence showing how stigma affects lay people's therapy-seeking behaviours is vast (e.g. Kessler et al., 2001), with much of this evidence showing that stigma affects people's attitudes towards seeking professional help (e.g. Hackler, Vogel, & Wade, 2010; Ludwikowski, Vogel, & Armstrong, 2009). Thus, it seems important to address the link between attitudes towards therapy and social stigma in order to understand student-therapists' therapy-seeking behaviours.

The Theory of Planned Behaviour

The theory of planned behaviour (TPB) (Ajzen, 1991) provides a useful framework to understand therapists' therapy-seeking behaviours. TPB has been developed for the particular purpose of predicting behaviour. According to this theory, behaviour is preceded by intention, which, in turn, is preceded by three main elements: Attitudes towards the behaviour in question, perceived control over the behaviour, and subjective norms. Attitudes towards the behaviour refer to the person's appraisal of whether the behaviour in question would lead to positive or negative consequences. Perceived control over the behaviour refers to the person's appraisal of how easy or difficult it would be to engage in the behaviour in question. Subjective norms refer to the person's perceptions of whether significant people around them will think that the behaviour in question should or should not be performed. That is, a person's perceived social pressure to engage or not in the behaviour in question. Moreover, these predictors are thought to influence one another. In terms of the TPB model, the present study is particularly focused on exploring the link between the elements of attitudes and subjective norms. This is illustrated in Figure 1.

Figure 1. The Relationship Between Attitudes Towards Seeking Therapy and Perceived Social Stigma for Receiving Therapy in the Theory of Planned Behaviour.



In line with the terminology used in most research on therapists' personal therapy (Norcross & Guy, 2007), here, the term "therapy" is used as a generic term to refer to the psychological treatment of a therapist and therapists-in-training by means of any theoretical orientation, format, or duration. For the sake of simplicity, the term "students" (rather than "graduate students", or "trainees") is used throughout this paper to refer to students undergoing a clinical psychology training program.

The Present Study

The present study aimed to explore how perceived social stigma for receiving therapy affects clinical psychology students' attitudes towards seeking therapy across three different countries: Argentina, England, and the US. The rationale to compare these three national groups is two-fold.

Firstly, these countries share significant commonalities, which allow comparisons to be made. In each country, the discipline of psychology was introduced at the beginning of the twentieth century and began with a focus on psychological assessment with little attention to

treatment. The first courses in clinical psychology were set up in the late 1940's and early 1950's. Today, clinical psychology is a well-recognised profession in these countries.

Secondly, these countries appear to differ from each other in terms of how therapy is seen and used by their populations, which suggests that social stigma associated to receiving therapy may take very different forms across these three national groups. On the one hand, Argentina is a strikingly particular country in terms of its demand and offer of therapy services. It has the largest number of psychologists per capita in the world, with 106 psychologists per 100,000 population (WHO, 2005), and the most enthusiastic consumers of therapy worldwide. Argentineans regard therapy as a valuable service and encourage each other to take advantage of what therapy has to offer (Gomez, 2007). In Argentina, therapy is seen as a normal aspect of people's everyday lives. People from other countries are often surprised to hear Argentinean lay people "talk about going to their therapist as openly as they discuss going to the butcher…" (Krauss, 1998). Unfortunately, data regarding the number of therapists or students that engage in personal therapy is lacking. However, it appears reasonable to assume that most therapists and student-therapists would engage in therapy at some point in their lives, as most Argentineans (Plotkin, 2001).

England, however, has only nine psychologists per 100,000 population (WHO, 2005), and the English do not seem to be particularly inclined to consume therapy services. Orbach (1996) explains that, in England, people do not engage in therapy unless they are "in incredible difficulty. [Therapy] is not a recreation. It's not a piece of cultural development" (p.27). Furthermore, the author describes how England differs from other countries, such as America, in which therapy has been more widely accepted by their populations. "Therapy was for the intellectual elite in Britain, in the inter-war period, and then it was one option for the distressed. But it never entered the culture in the same way it did in the United States" (p.28).

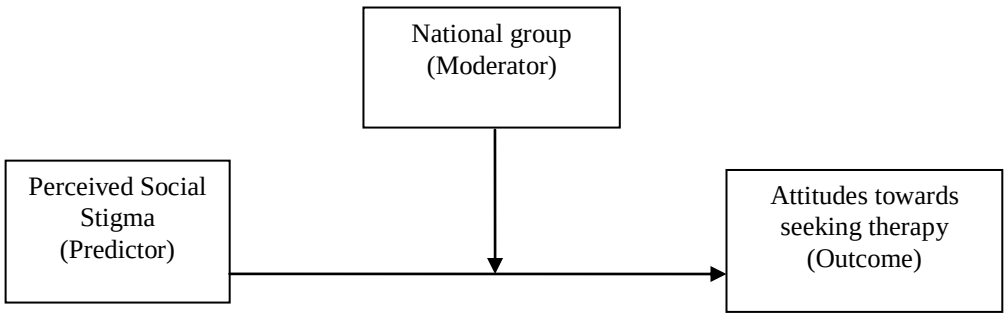
America seems to be in the middle of the two extremes represented by Argentina and England. The country has 31 psychologists per 100,000 population (WHO, 2005). New York and Buenos Aires have been said to be neck-to-neck for the merit of being the city with the highest number of therapists per capita, including both psychologists and psychiatrists (Krauss, 1998). Metropolitan cities such as New York, San Francisco, Chicago, and Philadelphia have been described to represent a "therapeutic culture", which contrasts with the English culture (Orbach, 1996, p.27). However, therapy seems to be less commonly used in America than it is Argentina, indicated by scarcity of therapy services in some states.

Based on the cross-national differences described above, it was hypothesised that: Hypothesis 1: Students from Argentina, England, and America would show different levels of social stigma for receiving therapy. Hypothesis 1.1: In particular, the relative level of social stigma for receiving therapy would be Britain > America > Argentina. Hypothesis 2: Students from Argentina, England, and America would endorse different attitudes towards seeking therapy. Hypothesis 2.1: In particular, the relative levels of positive attitudes towards seeking therapy would be Argentina > America > England.

Based on the evidence demonstrating the link between social stigma and attitudes towards seeking therapy presented earlier, it was hypothesised that the link between those variables would also hold true among clinical psychology students. Furthermore, because there is no research exploring the role of social stigma as a predictor of therapists' attitudes towards therapy, it seemed important to test its predictive power by controlling for the effects of other variables that are thought to predict therapists' attitudes towards seeking therapy. Hypothesis 3: Social stigma for receiving therapy would predict student's attitudes towards seeking help, even after controlling for well-known predictors of attitudes towards seeking therapy.

Finally, given that the three countries seem to hold very different views about therapy (i.e. less stigmatising views about therapy in Argentina and America than in England) and they seem to differ in terms of their use of therapy services (i.e. illustrated by three countries having different numbers of psychologists per 1000,000 population), it was hypothesised that the link between the social stigma and attitudes variables would take different forms across groups. Hypothesis 4: The relationship between attitudes towards seeking therapy and perceived stigma for receiving therapy will be moderated by national group. Hypothesis 4.1. In particular, it is expected that social stigma will predict attitudes towards seeking therapy in all three countries, but that this prediction will be stronger in England and America than in Argentina. This hypothesis is illustrated in Figure 3.

Figure 1. National Group as a Moderator of the Relationship Between Perceived Social Stigma for Receiving Therapy and Attitudes Towards Seeking Therapy.



METHOD

Recruitment

Directors of clinical psychology training programmes from Argentina, England and America were contacted and asked for permission to invite their students to participate in this study (see Appendix 3). In Argentina, all 33 Directors of licenciatura en psicologia university degree programs accredited by the Ministry of Education of the Argentinean Nation (MENA,

2010) were considered to be contacted. Contact details of 14 directors (42%) were not available. The remaining 19 (57%) directors were contacted, of which four (21%) replied and granted permission to contact their students. In England, all 26 directors of doctorate in clinical psychology training programs (Clearing House, 2010) were contacted. Of them, 18 (70%) responded and 17 (65%) granted permission to contact students. In the US, all 61 directors of APA-accredited clinical psychology programs (PsyD) located in the United States (APA, 2010) were considered to be contacted. Contact details of 17 (28%) directors were not available. The remaining 44 directors were contacted, of which 15 (25%) responded and granted permission to contact their students.

When permission was granted, an e-mail was sent to the universities for them to forward it to all the students enrolled in the clinical psychology course. This e-mail contained an invitation for students to take part in the study, a brief description of the project, a description of an incentive to participate, a link to an on-line survey, and contact details of the project's author (see Appendix 4).

The recruitment of Argentinean participants proved to be challenging, as some Argentinean universities do not provide university e-mail addresses to their students. In these cases, the advertisement for the study was done by posting flyers in the university sites (see Appendix 5). Additionally, two directors granted permission to administer a paper-based version of the survey.

Participants

A total of 555 students participated in this study. Participants were included in the study if they were currently undergoing a clinical psychology training program in Argentina, England, or the US. Participants were excluded if they reported nationalities other than Argentinean, English, or American. Ninety-nine participants (17%) were excluded because they did not meet the nationality criterion (14%) or because they failed to complete the entire

survey (3%). The usable sample involved 462 participants (Argentinean n = 121, English n = 211, American n =130). A summary of the participants' characteristics is presented in Table 1.

Table 1. *Summary of Participants' Demographic Characteristics.*

Characteristic	Argentinean (n = 121)	English (n = 211)	American (n = 130)
Age			
Mean	26	29	31
(SD)	7.9	4.1	9.6
Minimum	18	24	21
Maximum	53	46	67
Gender			
Male	24%	14%	18%
Female	76%	86%	82%
Religion			
Buddhist	-	1%	4%
Hindu	-	1%	-
Jewish	1%	1%	8%
Mormon	-	-	2%
Muslim	-	1%	-
Protestant	1%	13%	15%
Roman Catholic	59%	7%	15%
Christian other	1%	10%	8%
No religious affiliation	36%	63%	42%
Other	2%	3%	6%
Religion practice[a]			
Yes	24%	39%	68%
No	76%	61%	32%
Year of study			
First	50%	35%	18%
Second	34%	38%	24%
Third	12%	27%	20%
Fourth	1%	-	19%
Fifth	1%	-	11%
Sixth	2%	-	7%
Seventh	-	-	1%

[a] percentages calculated among participants who described a religious affiliation (Argentinean n = 77; English n = 79; American n = 75).

Unfortunately, the proportion of students that self-selected to participate in this study against the total number of potential participants was not determined. To ensure anonymity of the data, participants were not asked to provide the name of their training institution. All English and American students who participated in this study did so by completing the on-line survey. However, of the 121 Argentinean participants, 22 (20%) completed the on-line

version of the survey, and 99 (80%) completed the paper-based version. The paper-based survey data was collected from two Argentinean universities.

Ethics

Ethical approval was granted by the University Ethics Committee (see Appendix 6). A commitment was given to students and directors of training programs that they would receive a copy of the report describing the research findings once the study was completed. Permission to use copyrighted material was sought when needed (see Appendix 7). The chance to participate in a prize draw with the opportunity to win a £25 voucher to buy books through the Internet was offered to students as an incentive to take part. In order to keep responses to the survey anonymous, interested participants were asked to e-mail the author to state their wish to participate in the prize draw.

Measures

The first section of the survey addressed demographic information. The second section involved questions about therapy-seeking behaviours, including: previous experience of personal therapy, length in therapy, type of therapy undertaken, the main therapy approach taught at the student's training program, the student's preferred therapy approach, and the students' perceived faculty view on the importance of therapy for therapists (Appendix 8).

Attitudes towards seeking therapy. Participant's attitudes towards seeking therapy were measured with the Attitudes Towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Fischer & Farina, 1995). The ATSPPH-SF is a 10-item scale for assessing general attitudes towards seeking therapy. Based on the longer 29-item ATSPPH scale (Fischer & Turner, 1970), this shortened version was developed with college students. In the normative sample, ATSPPH-SF demonstrated internal consistency of .84, one-month test-retest reliability of .80, convergent validity (correlation of .87 with the longer scale), and criterion-related validity (correlations with previous therapy-seeking behaviour). Reliability

.77 and .78 and validity where further confirmed by Elhai, Schweinle, and Anderson, 2008. Items were rated on a 4-point Likert-type scale (from 0=disagree to 3=disagree). Five of the 10-items needed reverse scoring. Total scores ranged from 0 to 30, with higher scores indicating more positive attitudes towards therapy.

Perceived Social Stigma for Receiving Therapy. Participants' perceived social stigma attached to receiving therapy was measured using the Social Stigma for Receiving Psychological Help scale (SSRPH) (Komiya, Good, & Sherrod, 2000). This is a 5-item self-report scale, devised to evaluate individuals' perceptions of how stigmatizing it is to receive professional psychological help. Items were scored on a 4-point Likert-type scale (from 0=strongly disagree to 3=strongly agree). Total scores ranged from 0 to 15, with higher scores reflecting higher endorsement to the view of there being social stigma attached to seeking therapy. In the normative sample, it demonstrated adequate internal consistency of .72, construct validity (with one factor accounting for approximately 100% of variance in scores) and construct validity (a negative correlation with the ATSPPH-SF).

The measures were translated from English to Spanish using the method of back-translation (Brislin, 1970; Geisinger, 1994) (see Appendix 9). Following the advice of the department's Research Review Panel, minor modifications were made to the wording of some of the items on the ATSPPH-SF scale, to ensure that the language was culturally sensitive for the participants of this study, and to keep a consistent terminology throughout the survey (e.g. the terms "psychological help" and "psychotherapy" were changed for "therapy"). Similarly, the term "graduate students" was used in the American version of the survey, whilst the term "trainees" was used in the English version. A small pilot study was conducted with seven international clinical psychology students who were enrolled in a UK program. Students provided their feedback on the on-line survey and corrections were made accordingly.

Procedure

Interested students who entered the on-line survey were provided with further information about the research project, and were asked to provide their consent to take part in the study by clicking in the relevant link. Equally, in the administration of the paper-based version of the survey, the students were asked to read through the information sheet and to provide their informed consent by ticking the relevant box. Following that, students were presented with the survey, which took between 5-10 minutes to complete. Participation was voluntary and surveys were completed anonymously. At the end of the survey participants were invited to share their comments about the study in an open-ended format.

RESULTS

Reliability of the scales

Despite the good psychometric properties of the ATSPPH-SF and the SSRPH scales reported in previous studies, in the current samples, the internal reliability coefficients of these scales were lower than expected. For the ATSPPH-SF scale, internal reliability coefficients were: Argentina = .60 (C.I.: $.49 < \alpha < .70$), England = .69 (C.I.: $.62 < \alpha < .75$), and America = .68 (C.I.: $.59 < \alpha < .76$). For the SSRPHS scales, internal reliability coefficients were: Argentina = .67 (C.I.: $.57 < \alpha < .75$), England = .65 (C.I.: $.56 < \alpha < .72$), and America = .67 (C.I.: $.57 < \alpha < .75$). An exploration of the inter-item correlations revealed that items of the two scales were moderately to poorly correlated, across all groups. The possibility of removing items to increase the overall reliability of the scales was considered; however, the overall reliability of the scales would not have improved with the deletion of any particular item. The reliability coefficient obtained for the ATSPPH-SF with the American sample of clinical psychology students (.68) is particularly surprising, given that

the Cronbach alpha reported in a previous study with American clinical and counselling psychology students was .75 (Dearing et al., 2005). One explanation to this finding is that the Cronbach alphas obtained in the two samples may be within certain confidence interval (Fan & Thompson, 2001). Another explanation to the low reliability coefficients obtained in this study may be related to the administration of the scales through an on-line survey. It may be that students completed the scales in situations that were inappropriate for testing conditions (e.g. while talking to someone else), thus increasing error into the reliability of the instrument. An explanation for the low reliability coefficients obtained in the Argentinean sample is inaccuracy in the translation of the scales. However, the fact that the reliability coefficient for the SSRPH scale was the same in the Argentinean than in the English-speaking samples rejects this conjecture.

Preliminary Analyses

Participants' characteristics on variables related to therapists' therapy-seeking behaviours are presented in Table 2.

Assumptions testing

Hypotheses 1 and 2 were tested using Analysis of Variance (ANOVA). Prior to running the analyses, some tests were employed to evaluate whether the data met the assumptions underlying the use of ANOVA. Outliers were found and removed from the database. Histograms revealed slight deviations from normality in both the social stigma and attitudes variables, across all three national groups. The Kolmogorov-Smirnov and the Shapiro-Wilk tests yielded significant results. However, these tests tend to yield significant results with large sample sizes and small deviations from normality (Field, 2009). In order to evaluate the extent to which the normality assumption was violated, z-scores for skewness and kurtosis were calculated using the formula z-score = skewness/ standard error, kurtosis/ standard error. All z-score values were between the absolute value of 3.29, indicating that

there were no major violations to normality for the comparison of means, given that all three sample sizes were 50 < n < 150 (Field, 2009). Levene's test for homogeneity of variances yielded a statistically significant ($p < .001$) result, indicating that the data violated this

Table 2. *Participants' Characteristics on Variables Related to Therapists' Therapy*-Seeking Behaviours.

Characteristics	Argentina (n = 121) (%)	England (n = 181) (%)	America (n = 130) (%)
Experience in personal therapy			
Yes	70	48	85
No	30	52	15
Length in therapy[b]			
Less than 6 months	39	48	24
Between 6 and 12 months	16	25	19
Between 12 and 18 months	14	11	12
More than 18 months	31	16	45
Type of therapy undertaken[b]			
Cognitive Behavioural Therapy	19	5	5
Psychoanalytic/Psychodynamic	61	32	22
Humanistic	11	19	9
Integrative/ Eclectic/ Mix of approaches	6	26	51
Systemic	3	0	8
Cognitive Analytic Therapy	0	8	0
Other	0	10	5
Predominant therapy approach taught at university			
Cognitive Behavioural Therapy	9	36	37
Psychoanalytic/Psychodynamic	54	1	6
Humanistic	4	0	1
Integrative/ Eclectic/ Mix of approaches	27	58	52
Systemic	3	4	2
Other	3	1	2
Preferred therapy approach			
Cognitive Behavioural Therapy	15	3	13
Psychoanalytic/Psychodynamic	42	3	9
Humanistic	11	1	5
Integrative/ Eclectic/ Mix of approaches	25	85	71
Systemic	1	5	1
Other	6	3	1

[b] percentages calculated among participants who had had an experience of personal therapy (Argentinean n = 85; English n = 101; American n=110).

assumption in regards to the social stigma variable. As recommended by Field (2009), in that case, the Welch's test was used to evaluate F-ratios, because it is thought to be robust to violations of homogeneity of variances. Additionally, post-hoc comparisons were conducted

by using Games-Howell Procedure, which does not assume homogeneity of variances and it is robust to unequal sample sizes.

Hypothesis 3 was tested using multiple regression analyses. Univariate and multivariate outliers were found and removed from the database. The data from all three national groups met the assumptions underlying the use of multiple regression analyses. The only exception was for the Argentinean group; there was evidence suggesting heteroscedasticity. Therefore, the results of the hierarchical multiple regression analysis will be interpreted with caution.

Hypotheses testing

Hypothesis 1: One-way between-groups analysis of variance (ANOVA) was conducted to explore the impact of national group on levels of social stigma for receiving therapy, as measured by the SSRPH scale. Hypothesis 1 was confirmed. There was a statistically significant difference in levels of social stigma for receiving therapy across the three national groups, as evaluated by Welch's test [$F(2,351) = 23.73$, $p < .001$]. The effect size, calculated using eta squared, was .18, indicating a large effect. Hypothesis 1.1 was partially confirmed. Post-hoc comparisons using the Games-Howell procedure indicated that the mean score for the three groups were significantly different from each other ($p < .05$), but in a different way than initially expected: American group ($M = 5.02$, $SD = 1.60$) > English group ($M = 4.57$, $SD = 1.61$) > Argentinean group ($M = 3.22$, $SD = 2.35$).

Hypothesis 2: One-way between-groups ANOVA was conducted to explore the impact of national group on levels of attitudes towards seeking therapy, as measured by the ATSPPH-SF scale. Hypothesis 2 was confirmed. The ANOVA revealed a statistically significant difference in levels of attitudes towards seeking therapy across the three national groups [$F(2,435) = 24.32$, $p < .001$]. The effect size, calculated using eta squared, was .10, indicating a medium effect. Given the unequal sample sizes, post-hoc comparisons were

calculated using the Hochberg's GT2 test, as recommended by Field (2009). Hochberg's GT2 results indicated that the mean score for the Argentinean group (M = 24.89, SD = 2.94) was significantly different from the English group (M = 22.60, SD = 2.97), and that the mean score for the American group (M = 24.27, SD = 3.17) was significantly different to the English group's mean score. However, Argentinean's and American's mean scores were not significantly different from each other. These results confirmed hypothesis 2.1 only in part. That is, Argentinean = American > English.

Hypothesis 3: This hypothesis was tested using hierarchical multiple regression analyses. These analyses were computed separately for each national group, in order to test how well the model fitted the data from each country. Prior to computing the multiple regression analyses, some predictor variables were re-coded. Perceived faculty view was re-coded into a categorical variable with two levels (i.e. scores 2 and 3 were re-coded as 0 = personal therapy is irrelevant/ may be desirable for some therapists; and scores 4 and 5 were re-coded as 1= personal therapy is definitely desirable/ it is essential and should be required. Note that there was no observation in the whole sample of a score of 1). For categorical predictors that had more than two levels, dummy variables were created. Drawing on previous research showing significant differences among psychoanalytic/psychodynamic vs. cognitive-behavioural therapy (CBT) therapists in their use of personal therapy (Orlinsky et al., 2005), the variables 'predominant therapy approach taught in the program' and 'students' preferred therapy approach' were first grouped into three levels: psychoanalytic/psychodynamic, CBT, and mix of approaches (including integrative, eclectic, systemic, humanistic, and others), and these levels were used to create the dummy variables: psychoanalytic/psychodynamic vs. CBT (1= psychoanalytic/psychodynamic, 0= all other values) and mix of approaches vs. CBT (1= mix of approaches, 0= all other values).

When the identified multivariate outliers were removed from the dataset, some of the dummy variables became constant (e.g. in both the English and American groups, there were no observations for participants' predominant therapy approach taught at program = psychoanalytic/psychodynamic. This variable no longer met the assumption of non-zero variance for the multiple regression analysis, as it showed constant scores of 0). Consequently, these predictors were removed from the multiple regression analyses in the English and American national groups.

In the computation of the hierarchical multiple regression analyses, attitudes towards seeking psychological help was used as the criterion variable. Predictors of seeking therapy were entered in the first block of the multiple regression. These were: Experience of undergoing personal therapy, perceived faculty view, predominant approach taught, and participant's preferred therapy approach. The predictor perceived social stigma for receiving therapy was entered in the second block of the multiple regression analysis. Results are presented in Table 3.

Results of the hierarchical multiple regression analyses indicate that the accuracy of the initial model in predicting clinical psychology students' attitudes towards seeking therapy varied across national groups. Specifically, the model significantly predicted the outcome for Argentinean and English students ($\Delta R^2 = .18$, $p < .001$; $\Delta R^2 = .07$, $p < .01$ respectively). However, it did not predict the outcome for American students ($\Delta R^2 = .06$ns). For the Argentinean, only perceived faculty view on the importance of personal therapy for therapists (ß = .26, $p < .01$) and experience of undergoing personal therapy (ß = .28, $p < .01$) significantly predicted their attitudes towards seeking therapy. For the English group, only perceived faculty view on the importance of personal therapy for therapists (ß = .25, $p < .001$) predicted the outcome. For the American group, the only variable that significantly predicted attitudes towards seeking help was experience of undergoing personal therapy (ß = -.25, p <

.05). Participants' preferred therapy approach and predominant therapy approach taught at their clinical course did not predict attitudes towards seeking therapy in any of the national groups.

Table 3. *Hierarchical Multiple Regression Analysis Predicting Clinical Psychology Students'* Attitudes Towards Seeking Therapy From Perceived Social Stigma For Receiving Therapy.

	Perceived Social Stigma for Receiving Therapy[c]					
	Argentinean		English		American	
Predictor	ΔR^2	ß	ΔR^2	ß	ΔR^2	ß
Step 1	.18***		.07**		.06	
Control variables[a]						
Perceived faculty view on the importance of personal therapy for therapists		.26**		.25***		-.09
Predominant therapy approach taught at clinical course (Psychoanalysis/Psychodynamic)		-.15		--		--
Predominant therapy approach taught at clinical course (Mix of approaches)		-.14		.01		-.02
Preferred therapy approach (Psychoanalytic/Psychodynamic)		.12		--		.01
Preferred therapy approach (Mix of approaches)		.10		--		.07
Experience of undergoing personal therapy		-.28**		-.07		-.25*
Step 2	.00		.06***		.11***	
Perceived Social Stigma for Seeking Therapy[b]		-.04		-.26***		-.34***
Total R^2	.18		.13***		.17***	
N	117		182		113	

Note. SSRPH = Social Stigma for Receiving Psychological Help; ATSPPH-SF = Attitudes Towards Seeking Professional Psychological Help- Short Form.

[a] Control variables included perceived faculty view on the importance of personal therapy for therapists, predominant therapy approach taught at clinical course, participant's preferred therapy approach, and experience of undergoing personal therapy.

[b] As measured by the SSRPH.

[c] As measured by the ATSPPH-SF.

* $p < .05$. ** $p < .01$. *** $p < .001$.

One of the possible explanations for the findings suggesting that the predictors regarding theoretical orientation are not significant among students is lack of power. Since most of the students described the predominant approach taught at their universities and their own preferred theoretical approach as 'mix of approaches/integrative/eclectic', there were not enough observations on the levels 'psychoanalytic/psychodynamic' or 'CBT' in the dummy variables created for the multiple regression model. In fact, some of these predictors could not be included in the initial models for the English and American groups because they represented constant variables.

The findings confirmed hypothesis 3 only in part. Although perceived social stigma was still able to predict English and American students' attitudes towards seeking therapy when the effects of well-known predictors of therapy seeking have been controlled for, it was not a significant predictor of Argentinean students' attitudes towards seeking therapy.

Results indicate that adding the predictor social stigma for receiving therapy to the initial model improves the predicting power of the model as a whole for the English and American groups ($\Delta R^2 = .06$, $p < .001$; and $\Delta R^2 = .11$, $p < .001$, respectively). Among English students, when all other variables are held constant, 1 standard deviation unit (1.65 points) lower on the social stigma scale would lead to a change of 0.26 standard units of more positive attitudes towards seeking therapy ($ß = -.26$, $p < .001$). Similarly, among American students, when all other variables are held constant, 1 standard deviation unit (1.58 points) lower on the social stigma scale would lead to a change of 0.34 standard units of more positive attitudes towards seeking therapy ($ß = -.34$, $p < .001$). However, among Argentinean students, perceived social stigma for receiving therapy does not improve the accuracy of the initial model in predicting attitudes towards seeking therapy ($\Delta R^2 = .00$ns). Finally, results show that the entire model, including participants' perceived social stigma for seeking

therapy, explains 13% and 17% of the variance of attitudes towards seeking therapy among English and American students, respectively. Conversely, this model does not accurately explain the variance of attitudes towards seeking therapy among Argentinean students (Total R^2 = .18ns)

Hypothesis 4: Baron and Kenny's (1986) method to test for moderation models was used to test for this hypothesis. Their method involves two steps: First, computing separate regression analyses for each level of the categorical moderator variable to test whether the continuous variable significantly predicts the outcome variable across all groups. Second, in the case of finding that the continuous variable significantly predicts the outcome variable across all groups, further tests are needed to evaluate whether the regression coefficients obtained in those predictions are significantly different from each other. However, if the continuous variable significantly predicts the outcome in one group but not in others, the moderation model is confirmed. The results of the step 2 in the hierarchical multiple regression analyses computed to test hypothesis 3 revealed that perceived social stigma for receiving therapy significantly predicts attitudes towards seeking therapy in the English and American groups but not in the Argentinean group. Following Baron and Kenny's method, this finding confirms hypothesis 4, by demonstrating that the relationship between social stigma and attitudes is moderated by national group. A multiple regression analysis was then conducted to test whether the prediction of social stigma on attitudes was significantly different across the English and American groups. The entire database was used for this analysis. Attitudes towards seeking help was used as the outcome variable. Social stigma for receiving therapy, national group (England=1, America=0, Argentina=missing), and the interaction term social stigma x national group were used as the predictors. Results showed that the interaction social stigma x national group was not significant (ß = .12ns), indicating that the regression coefficients of the prediction of social stigma on attitudes are not

significantly different across the English and American groups. Hypothesis 4.1. was confirmed. As expected, the prediction of perceived social stigma for receiving therapy on attitudes towards seeking therapy was stronger in the English and American groups than in the Argentinean group.

DISCUSSION

Considering the benefits of personal therapy reported by therapists and therapists-in-training who have had the experience of undergoing therapy themselves, this study evaluated some of the predictors that account for clinical psychology students' therapy-seeking behaviours with the aim of providing training institutions with practical ideas on how they could promote the use of personal therapy among their students.

Drawing on the TPB, this study was particularly focused on exploring whether perceived social stigma for receiving personal therapy could represent the element of subjective norms in the TPB model for predicting clinical psychology students' therapy-seeking behaviours. This was done by looking at the influence that perceived social stigma for receiving therapy had on student's attitudes towards seeking help across three countries. Results showed that social stigma for receiving therapy is a significant predictor of English and American students' attitudes towards seeking therapy, and that social stigma is still able to predict attitudes when the effects of other variables have been controlled for. As such, it was demonstrated that social stigma for receiving therapy could be considered as the subjective norms element of the TPB model to predict English and American students' therapy-seeking behaviours.

As initially speculated, the relationship between perceived social stigma and attitudes towards seeking therapy is moderated by national group. Specifically, results showed that social stigma associated with receiving therapy significantly predicts students' attitudes

towards seeking therapy in America and England but not in Argentina. This finding gives support to the idea that therapists from some countries may refrain from seeking therapy due to perceiving high levels of social stigma associated with seeking help. For example, the fact that South Korean therapists showed the lowest proportion of therapy use in Orlinsky and colleagues' (2005) sample of therapists from 14 countries may be explained (at least in part) by their perceived social stigma associated with receiving therapy.

The differences in levels of perceived social stigma and attitudes towards seeking therapy found across groups are consistent with previous research, showing that whilst the majority (about 80%) of therapists from America and other countries undergo personal therapy (Norcross & Guy, 2005; Orlinsky et al., 2005), a relatively low (39-66%) proportion of British therapists do so (Norcross et al., 1992; Darongkamas et al., 1994, Daw & Joseph, 2007).

An unanticipated finding was that American students showed the highest levels of perceived social stigma for receiving therapy across all three national groups. This is surprising given that some American cities are thought to represent a "therapeutic culture" that England does not have (Orbach, 1996). Yet, Americans (along with the Argentineans) also had significantly higher levels of positive attitudes towards seeking therapy than the English. One explanation to this result may be that, whilst Argentinean clinical psychology students view therapy in a way that mirrors the wider population's views of therapy (i.e. they value therapy and they are very open to the idea of undertaking therapy themselves), American clinical psychology students may hold more positive attitudes towards seeking therapy than the wider population of American lay people. Norcross and Guy (2005) noted that the prevalence of personal therapy among American therapists (72-75%) was substantially higher than that of the general adult population (25-27%). Thus, it may be that American students (and therapists), develop positive attitudes about seeking therapy

throughout their training, despite of perceiving that there is social stigma associated with receiving therapy in the wider society.

Another interesting finding was that the predictors of students' attitudes towards seeking therapy varied significantly across countries. Argentinean students' attitudes towards seeking therapy are, in part, predicted by their previous experiences in therapy and by their perceived faculty view on the value of personal therapy for therapists. However, perceived social stigma for receiving therapy does not predict Argentinean students' attitudes towards seeking therapy in the Argentinean group. One possible explanation to this finding is that levels of perceived social stigma for receiving therapy need to reach a threshold point in order to have an effect in people's attitudes towards seeking therapy. Given the widespread acceptance and use of therapy by the Argentinean population, it may be that social stigma associated with receiving therapy becomes irrelevant to Argentinean students' attitudes towards seeking therapy.

English students' attitudes towards seeking therapy are predicted by their perceived faculty view about the importance of personal therapy, and their perceived social stigma associated with seeking therapy. However, among English students, having had an experience of personal therapy does not account for their positive attitudes towards seeking therapy. These results suggest that, English students' appraisal of how beneficial it would be for them to seek therapy is affected by what they perceive that other people (i.e. faculty members, and the wider society) think of those who receive therapy.

What accounts for American's attitudes towards seeking therapy is less clear. In the current sample, perceived social stigma appeared to be the strongest predictor of American's attitudes towards seeking therapy, making the regression model significantly accurate for the American group. However, given that American students hold highly positive attitudes towards seeking therapy, there must be other important predictors counteracting the effects of

social stigma and making American students think that undergoing therapy will be beneficial to them. Results revealed that previous experience of personal therapy contributes to the explanation of the positive attitudes that American students have about seeking therapy. However, perceived faculty views about personal therapy for therapists do not contribute to the prediction model. This is consistent with the findings obtained by Dearing et al. (2005), who found that attitudes towards seeking therapy predicted therapy use during training, whilst perceived faculty view about the value of personal therapy did not. These results may suggest that American students do not rely on the views of faculty members to make decisions about their therapy-seeking behaviours. This idea is supported by previous research reporting that, although American students who had undergone therapy felt that their confidentiality was protected, more than half (56%) did not discuss their therapy with their clinical supervisors (Holzman et al., 1996). American students may rely more on their own views about how important it is for therapists to have an experience of therapy. In Dearing et al.'s (2005) study, American students' own views about the importance of personal therapy significantly predicted their use of therapy during training whilst perceived faculty view did not. Other factors accounting for American students' positive attitudes towards therapy may be their need to address personal problems, to deal with issues arising from training, and to use the therapy space as a means for self care, as it is reflected in American qualified therapists' reports of their reasons for seeking therapy.

The present study has important strengths. First, it is the first international study looking at the predictors of clinical psychology students' attitudes towards seeking therapy. Cross-national comparisons in the field of clinical psychology are rare; which prevents us from learning from the experiences of how therapists from other countries deal with issues around training, clinical practice, and professional development. Second, this is the first study drawing on a theoretical framework to better understand therapists' therapy-seeking

behaviours. Although there is vast research evidence addressing the topic of therapists' personal therapy, most studies are mainly descriptive and their findings are not understood in terms of theory (e.g. Norcross, et. al. 1992; Orlinsky et al, 2005). Third, this is the first study addressing how social/contextual variables may have a role in shaping therapists' therapy-seeking behaviours. Specifically, this study demonstrated that perceived social stigma associated with seeking therapy affects the attitudes towards seeking therapy of students from some countries.

Limitations

The main limitation of this study regards the moderate reliability of the SSRPH and the ATSPPH-SF scales in the current samples. Given the good psychometric properties of these scales reported in previous research, it was difficult to predict that these measures would not be as reliable in the samples included in this study. It would have been helpful to run a pilot study in each one of the participating national groups to evaluate the psychometric properties of these measures prior to the conduction of the study. However, due to time constrains, this was not possible.

Implications

This study has important implications for future research. In the introduction section, a rationale is presented on how the TPB model for predicting behaviour could be used to evaluate therapists' (and therapists-in-training's) therapy-seeking behaviours. Then, by showing the predictive power of perceived social stigma on students' attitudes towards seeking therapy, this study demonstrates that social stigma could represent the subjective norms element. It would be important to evaluate how useful the whole TPB model is to understand therapists' therapy-seeking behaviours, as this would allow us to develop strategies to further promote the use of personal therapy among both qualified and student therapists.

Another venue for future research is suggested by the findings showing that the effect of perceived social stigma on attitudes towards seeking therapy is moderated by national group. Testing this moderation model among qualified therapists from South Korea and other countries would help us to gain a better understanding of the outstanding discrepancies in prevalence rates of personal therapy found by Orlinsky and colleagues (2005). Finally, the low reliability coefficients obtained in the current samples indicate that the psychometric properties of the SSRPH and the ATSPPH-SF scales should be further investigated.

This study also has important implications for the training of clinical psychology students. The finding showing the role of perceived social stigma in shaping American and English students' attitudes towards seeking therapy points to the need for training institutions to incorporate seminars aimed at raising awareness of social stigma associated with receiving therapy into their teaching programs. It would be helpful to teach students about the link between stigma and therapy seeking behaviours, and to encourage them to reflect on these issues. This is thought to be of paramount importance, not only to encourage students to seek therapy if they wish but also to encourage them to reflect on how the link between social stigma for receiving therapy and attitudes towards seeking therapy may be relevant for their clients as well.

The findings regarding English students points out to the need for training institutions to implement strategies to promote the use of personal therapy among their students. Considering the effect that perceived faculty view has on English students' attitudes towards seeking therapy, faculty members have the responsibility to educate students on the benefits of undergoing personal therapy. This could be done by including seminars into the teaching program aimed to explore the research evidence on therapists' personal therapy and its effect on clinical practice and professional development. Additionally, lectures could model openness to talk about experiences in personal therapy and share with their students the

lessons learnt from them. Furthermore, English training programs could facilitate the pathway for students to undertake therapy if they wish; for example, by making available a list of therapists who could offer a confidential therapy service to students at a reduced fee.

REFERENCES

Ajzen, I. (1991). The Theory of planned behaviour. Organizational Behavior and Human Decision Processes, 50, 179-211.

American Psychological Association (APA). (2010). Accredited programs in Clinical Psychology. Retrieved on 2 March 2010 from http://www.apa.org/ed/accreditation/programs/clinical.aspx.

Bellows, K. F. (2007). Psychotherapists' personal therapy and its perceived influence on clinical practice. Bulletin of the Menninger Clinic, 204-226.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. Journal of Personality and Social Psychology, 51, 1173-1182.

Brislin, R. W. (1970). Back-translation for cross-cultural research. Journal of Cross-cultural Psychology, 1, 185-216.

Clearing House. (2010). Clearing House for Postgraduate Courses in Clinical Psychology. Retrieved on 4 March 2010 from http://www.leeds.ac.uk/chpccp/Courses.html

Corrigan, P. (2004). How stigma interferes with mental health care. American Psychologist, 59, 614-625.

Darongkamas, J., Burton, M. V., & Cushway, D. (1994). The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom. Clinical Psychology & Psychotherapy, 1, 165–173.

Daw, R., & Joseph, S. (2007). Qualified therapists' experience of personal therapy. Counselling and Psychotherapy Research. 7, 227-232.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005), Predictors of psychological help seeking in clinical and counseling psychology graduate students. Professional Psychology: Research and Practice, 36, 323-329.

Elhai, J. D., Schweinle, W., & Anderson, S. M. (2008). Reliability and validity of the Attitudes Towards Seeking Professional Psychological Help Scale-Short Form. Psychiatry Research, 159, 320-329.

Fan, X., & Thompson, B. (2001). Confidence intervals about score reliability coefficients, please: An EPM guidelines editorial. Educational and Psychological Measurement, 61, 517-532.

Field, A. (2009). Discovering Statistics Using SPSS (3rd Ed). London: Sage.

Fischer, E. H., & Farina, A. (1995). Attitudes towards seeking professional psychological help: A shortened form and consideration for research. Journal of College Student Development, 36, 368-373.

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 33, 79-90.

Geisinger, K.F. (1994). Cross-cultural normative assessment: Translation and adaptation issues influencing the normative interpretation of assessment instruments. Psychological Assessment, 6, 304-312.

Gomez, B. (2007). Psychotherapy in Argentina: a clinical case from an integrative perspective. Journal of Clinical Psychology, 63, 713-723.

Hackler, A. H., Vogel, D. L., & Wade, N., G. (2010). Attitudes towards seeking professional help for an eating disorder: The role of stigma and anticipated outcomes. Journal of Counseling & Development, 88, 424-431.

Holzman, L. A., Searight, H. R., & Hughs, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. Professional Psychology: Research and Practice, 27, 98-101.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., et al. (2001). The prevalence and correlates of untreated serious mental illness. Health Service Research, 36, 987-1007.

Komiya, N., Good, G.E., & Sherrod, N.B. (2000). Emotional openness as a predictor of college students' attitudes towards seeking psychological help. Journal of Counseling Psychology, 47, 138-143.

Krauss, C. (1998). Buenos Aires journal: Doctor, why do I keep dreaming of Argentina? Retrieved on 7 September from http://www.nytimes.com/1998/05/29/world/buenos-aires-journal-doctor-why-do-i-keep-dreaming-of-argentina.html.

Liaboe, G. P., Guy, J. D., Wong, T., & Deahnert, J. R. (1989). The use of personal therapy by psychotherapists. Psychotherapy in Private Practice, 7, 115-134.

Ludwikowski, W. M. A., Vogel, D., & Armstrong, P. I. (2009). Attitudes towards career counseling: The role of public and self-stigma. Journal of Counseling Psychology, 56, 408–416.

Macaskill, N. D., & Macaskill, A. (1992). Psychotherapists-in-training evaluate their personal therapy: Results of a UK survey. British Journal of Psychotherapy, 9, 133-138.

Mackey, R. A. & Mackey E. F. (1993). The value of personal psychotherapy to clinical practice. Clinical Social Work Journal, 21, 97-110.

Mackey, R. A., & Mackey, E. F. (1994). Personal psychotherapy and the development of a personal self. Families in Society, 75, 490-498.

Ministerio de Educacion de la Nacion Argentina (MENA). (2010). Secretaria de Políticas Universitarias (SPU): Lista de universidades que ofrecen la carerra de Licenciado en Psicologia. Retrieved on 9 March 2010 from http://www.me.gov.ar/spu/.

Moller, N. P., Timms, J., & Alilovic, K. (2009). Risky business or safety net? Trainee perceptions of personal therapy: a qualitative thematic analysis. European Journal of Psychotherapy and Counselling, 11, 369-384.

Norcross, J. C., & Connor, K. A (2005). Psychotherapists entering personal therapy. In: J. D. Geller, J. C. Norcross, & D. E. Orlnsky (Eds). *The Psychotherapist's own* psychotherapy: patient and clinician perspectives (pp.192-200). New York: Oxford University Press.

Norcross, J. C., & Guy, J. D. (2005). The prevalence and parameters of personal therapy in the United States. In: J. D. Geller, J. C. Norcross, & D. E. Orlinsky (Eds). The *Psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp.177-200). New York: Oxford University Press.

Norcross, J. C., Dryden, W., & DeMichele, J. T. (1992). British clinical psychologists and personal therapy: III. What's good for the goose? Clinical Psychology Forum, 44, 29-33.

Norcross, J.C., & Guy, J. D. (2007). Leaving it at the Office: A guide to psychotherapist self-care. London: The Guildford Press.

Norcross, J. C., Bike, D. H., Evans, K. L., & Schatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach? Journal of Clinical Psychology, 64, 1368-1376.

Orbach, S. (1996). Psychoanalysis. In: B. Mullan (Ed). Therapists on therapy. London: Free Association Books.

Orlinsky, D. E, Ronnestad, M. H., Willutzki, U., Wiseman, H., Botermans, J-F., et al. (2005). The prevalence and parameters of personal therapy in Europe and elsewhere. In: J. D. Geller, J. C. Norcross, & D. E. Orlnsky (Eds). *The Psychotherapist's own* psychotherapy: Patient and clinician perspectives (pp.177-200). New York: Oxford University Press.

Plotkin, M. B. (2001). Freud in the Pampas. California: Stanford University Press.

Vogel, D. L., & Wade, N. G. (2009). Stigma and help-seeking. The Psychologist, 22, 20-23.

Williams F., Coyle A., Lyons E. (1999). How counselling psychologists view their personal therapy. British Journal of Medical Psychology, 72, 545-555.

Wiseman, H., & Egozi, S. (2006). Personal therapy for Israeli school counsellors: Prevalence, parameters, and professional difficulties and burnout. Psychotherapy Research, 16, 332-347.

World Health Organization (WHO). (2005). Mental Health Atlas. Geneva: WHO.

MALENA DIGIUNI Lic MSc

Section C

Critical Appraisal

Word Count: 1,900

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

Department of Applied Psychology
CANTERBURY CHRIST CHURCH UNIVERSITY

Critical appraisal

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

By working on the literature review presented in section A, I further developed my ability to summarise the key findings of several studies as to present a comprehensive review of the existent research evidence in a structured, clear, and synthetic manner. I also became more confident in identifying gaps in the literature, and in drawing on different theoretical frameworks to make sense of the existent research findings and to develop avenues for future research.

By carrying out the empirical study, I acquired some new research skills and further developed my knowledge and abilities to work with quantitative methods. Although I already had some experience in working with analysis of variance and multiple regression analyses, working on this project allowed me to become more confident in using these tests to address different types of research questions. Furthermore, by facing the obstacle of finding out that the data did not meet some of the underlying assumptions to use parametric tests, I became familiar with different tests (e.g. Welch's test, and Games-Howell's test) that can be used when assumptions are violated. In addition, I learnt about different methods of testing for moderation models when the predictor is a continuous variable and the moderator is a categorical variable with more than two levels (e.g. Frazier, Barron, & Tix, 2004; Holmbeck, 1997), their strengths and limitations, and the procedures needed to carry them out. I also learnt about different ways of coding categorical predictors with more than two levels, and about the appropriateness of each of these types of coding to address different research questions. Baron and Kenny's (1986) method was chosen over the latter methods because it provided the clearest way of interpreting the results.

I would benefit from learning more about Structural Equation Model (SEM), as it provides another way of testing for moderation models. I would also welcome the opportunity to work with qualitative methodologies, as most of my research experience so far has involved quantitative methods.

If you were able to do this project again, what would you do differently and why?

If I had the opportunity to do this project again, there are three main things I would do differently. First, I would include two additional measures into the study: A measure of self-stigma (i.e. the self-stigma of seeking help scale, SSOSH; Vogel, Wade, & Haake, 2006), and a question addressing students' own view of the importance of personal therapy for therapists. My rationale for focusing on social and contextual variables (i.e. measuring social stigma instead of self-stigma associated to seeking therapy, and measuring the students' perceived faculty view on the importance of personal therapy for therapists instead of students' own view) was that I was interested in exploring the influence that the wider social context had on students' attitudes towards therapy-seeking across countries. Because the study was designed to compare national groups, it was thought more relevant to test these variables than to focus on the individual perceptions that students within each national group could have. However, in hindsight, I see the value of including these individual-level variables into the study. Knowing about students' own views about the importance of personal therapy for therapists would have allowed me to test if American students' own view about the importance of personal therapy is more important in determining their attitudes towards seeking therapy than their perceived faculty view; and whether English and Argentinean students' attitudes towards seeking therapy are better explained by their perceived faculty view or by both the views of faculty members and their own opinions on the matter. Similarly, knowing about students' level of self-stigma would have allowed me to

test the extent to which students internalised the social stigma associated to seeking therapy that they perceived is held by their society. This would have been of particular value to understand the findings obtained with the American group. It may be that American students perceive high levels of social stigma in the wider society, but that they do not internalise that stigma within themselves (i.e. in the form of self-stigma), for which they can still hold highly positive attitudes towards seeking therapy.

Second, I would use other scales to measure the social stigma and attitudes variables. Other scales measuring attitudes towards psychological help-seeking (e.g. Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS), Mackenzie, Knox, Gekoski, & Macaulay, 2004; Beliefs About Psychological Services (BAPS), Egisdottir, & Gerstein, 2009) were considered at the time of designing the study. However, I chose the Attitudes Towards Seeking Professional Psychological Help Short-Form (ATSPPH-SF, Fischer, & Farina, 1995) over those measures for four main reasons: Firstly, the ATSPPH-SF is the most widely used measure of attitudes towards seeking therapy. Secondly, it had demonstrated good psychometric properties among participants similar to those included in the present study (i.e. reliability coefficients were .75 in a sample of American counselling and clinical psychology graduate students, Dearing, Maddux, & Tangney, 2005). Thirdly, it had proven good psychometric properties among diverse national, religious, and cultural groups (Cronbach alphas were: .78 among American Filipino descendents, Baello, & Mor, 2007; .85 among Asian American college students, Kim, & Omizo, 2003; .83 among American students of colour, Constantine, 2002; and .83 among Puerto Rican and Cuban young adults, Rojas-Vilches, Negy, & Reig-Ferre, 2011). Fourthly, the ATSPPH takes less time to complete than any of the other measures. Likewise, other measures of social stigma were considered (see Brohan, Slade, Clement, & Thornicrof, 2010 for a review). However, the Social Stigma for Receiving Psychological Help scale (SSRPH, Komiya, Good, & Sherrod,

2000) was chosen over all those measures because it was the only one particularly focused on exploring social stigma associated with seeking therapy rather than social stigma associated with experiencing a mental illness. Furthermore, previous research provided evidence that this scale had good psychometric properties among students from diverse cultures. The scale had a Cronbach alpha coefficient of .84 among Cuban and Puerto Rican university students (Rojas-Vilches et al. 2011). Given this research evidence, I felt confident that the scales would be appropriate for the population included in my study. Due to cost and time constrains, it was not possible to run pilot studies with students from Argentina, the US, and the UK. Ideally, I would have conducted such studies, and I would have used those data to examine the psychometric properties of the social stigma and attitudes scales among the specific samples included in my study. Running a pilot study with international students attending a clinical psychology course in the UK allowed me to get feedback and to make corrections to the format and structure of the on-line survey accordingly; however, because participants were students from different countries, the sample was not suitable for pilot-testing the reliability of the scales.

Third, I would also include a question regarding ethnicity in the demographic section of the survey. At the time of designing the study, I was not aware of the evidence suggesting that ethnicity could be an important factor influencing therapists' therapy-seeking behaviours (Wiseman and Egozi, 2006). Furthermore, I was interested in exploring cultural differences across countries rather than across ethnic groups. However, in hindsight, I see that it would have been useful to include this additional variable. Knowing about students' ethnicity could have provided further understanding of the findings of the American group, as there is some evidence suggesting that the link between social stigma and attitudes towards help-seeking varies across ethnic groups in American university students (Goldberstein, Eisenberg, Gollust, 2008).

Clinically, as a consequence of doing this study, would you do anything differently and why?

I have always been interested in the topic of therapists' personal therapy. My curiosity around the topic comes, in part, from my own experiences of undergoing personal therapy (in Argentina and in England) throughout the journey of becoming a clinical psychologist. I have always valued personal therapy as a means for self-care, as a way of working through my personal issues, and as a space to reflect about my personal and professional lives and the relationship between the two of them. By carrying out the present project, I became more convinced about the utility of personal therapy for therapists. This means that, as a therapist, I will want to engage in personal therapy at different points in my life, as I go through different life stages. I am deeply aware that working with distressed people is a complex and demanding task, which can, at times, feel very overwhelming and distressing for the therapist. Thus, I will want to continue to benefit from the experience of undergoing personal therapy, at different points, throughout my career as a clinical psychologist.

As a future clinical supervisor/ lecturer/ manager, I would take responsibility for educating clinical psychology trainees on the benefits of personal therapy for therapists. I would share with them the lessons I have learnt through my own experience of being in therapy whilst in training, and I would encourage them to consider the possibility of undergoing personal therapy themselves. I would be interested in promoting discussions around what may be the benefits and costs of doing personal therapy during training, and discussions around social stigma associated to seeking therapy. I believe that it is important to raise awareness on the significance of cultural/ societal variables affecting people's therapy seeking-behaviours. Thus, I would be interested in providing a space for trainees to reflect on how therapists (and clients) from different cultures may have different views about therapy,

and how these views may influence their therapy-seeking behaviours as well as the use that they make of the therapy if they pursue it.

If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

If I were to undertake further research in this area, I would be interested in exploring two research areas. First, I would be interested in evaluating how well does the theory of planned behaviour model for predicting behaviour explain therapist's and student-therapists' therapy-seeking behaviours? In order to address this research question, I would consider the research evidence provided by previous research and by my project, to represent the different elements of the model in predicting the intentions of therapists to seek therapy. This would provide us valuable information about the elements of the model that represent the strongest promoters/ barriers in seeking therapy among therapists. Furthermore, it would be interesting to see whether the model takes different forms among therapists and student-therapists. Secondly, I would also be interested in exploring the meanings associated with therapy that prevail in different cultures. The findings of previous research, as well as those of the present study, suggest that personal therapy is seen and used in very different ways across countries. In order to gain further understanding of this topic, I would be interested in exploring the views on therapists from different countries on "what is therapy for?" and "who is it for"? I would want to use in-depth interviews and a qualitative methodology (such as grounded theory or interpretative phenomenological analysis) to address these research question. The results of such a study would allow us to gain a better understanding of the cross-national differences found in therapist's use of personal therapy.

References

Baello, J., Mor, L. (2007). Asian Values Adherence and Psychological Help-Seeking Attitudes of Filipino Americans. Journal of Multicultural, Gender and Minority Studies, 1, 1-14.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. Journal of Personality and Social Psychology, 51, 1173-1182.

Brohan, E., Slade, M., Clement, S., & Thornicrof, G. (2010). Experiences of mental illness stigma, prejudice and discrimination: a review of measures. Retrieved from http://www.biomedcentral.com/content/pdf/1472-6963-10-80 on January 10th 2011.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: racial and ethnic minority clients' attitudes towards counseling and raitings of their counselors' general and multicultural competence. Journal of Counseling Psychology, 49, 255-263.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005), Predictors of psychological help seeking in clinical and counseling psychology graduate students. Professional Psychology: Research and Practice, 36, 323-329.

Egisdottir, S., & Gerstein, L. H. (2009). Beliefs About Psychological Services (BAPS): Development and psychometric properties. Counselling Psychology Quarterly, 22, 197-219.

Fischer, E. H., & Farina, A. (1995). Attitudes towards seeking professional psychological help: A shortened form and consideration for research. Journal of College Student Development, 36, 368-373.

Frazier, P. A., Barron, K., & Tix, P. A. (2004). Testing moderator and mediator effects in counseling psychology. Journal of Counseling Psychology, 51, 115-134.

Goldberstein, E., Eisenberg, D., Gollust, S. E. (2008). Perceived stigma ad mental health care seeking. Psychiatric Services, 59, 392-399.

Holmbeck, G. (1997). Towards terminological, conceptual, and statistical clarity in the study of mediators and moderators: Examples from the child-clinical and pediatric psychology literatures. Journal of Consulting and Clinical Psychology, 65, 599-610.

Kim, B. S. K., & Omizo, M. M. (2003). Asian cultural values, attitudes towards seeking professional psychological help, and willingness to see a counselor. The Counseling Psychologist, 31, 343-361.

Komiya, N., Good, G.E., & Sherrod, N.B. (2000). Emotional openness as a predictor of college students' attitudes towards seeking psychological help. Journal of Counseling Psychology, 47, 138-143.

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the Attitudes Towards Seeking Professional Psychological Help Scale. Journal of Applied Social Psychology, 34, 2410-2435.

Rojas-Vilches, A. P., Negy, C., & Reig-Ferre, A. (2011). Attitudes towards seeking therapy among Puerto Rican and Cuban American young adults and their parents. International Journal of Clinical and Health Psychology, 11, 313, 341.

Vogel, D. L., Wade, N. G., Haake, S. (2006). Measuring self-stigma associated with seeking psychological help. Journal of Counseling Psychology, 53, 325-337.

Wiseman, H., & Egozi, S. (2006). Personal therapy for Israeli school counsellors: Prevalence, parameters, and professional difficulties and burnout. Psychotherapy Research, 16, 332-347.

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Section D

Appendices

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

Department of Applied Psychology
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: Literature review - Search strategy

In order to review the published literature addressing the topic of personal therapy for therapists, two electronic engines: Ovid (including the databases PsycINFO, PsycARTICLES, British Nursing Index, and all EBM Reviews) and Web of Knowledge (including Web of Science, Medline, and Journal of Citation Reports) were searched using the following terms: therapists* AND personal therapy*. If available, the "explode" option was used for the search to include related terms. Otherwise, searches were done by combining the following search words: "Therapists" ("therapist", "psychotherapist", "psychotherapists", "psychologist" , "psychologists", "counselor", "counselors", "counsellor", "counsellors", "mental health practitioner", "mental health practitioners", "psychology graduate student", "psychology graduate students", "trainees", "trainee"); AND "personal therapy*" ("personal psychotherapy", "personal counselling", "personal counselling", "own therapy", "own psychotherapy"). Abstracts of the obtained results were screened and studies were selected according to their relevance to the present report. Further searches were done through the Internet (using Google Scholar) and by cross-checking references.

Results

A total of 366 articles and books were obtained through the above searches, and further articles were found through the Internet and the cross-checking strategy. The abstracts of all these articles were screened and the inclusion and exclusion criteria described below were used to select the relevant papers.

Inclusion and exclusion criteria

Articles were included if they a) presented prevalence and parameters of the use of therapy among therapists from any country; b) described the reasons for therapists to seek (or not to seek) therapy; c) presented empirical results of therapeutic outcomes and/or process obtained by therapists who had received therapy and those who had not; d) presented qualitative or quantitative results of therapists' satisfaction with their personal therapy, their perceived value of personal therapy, and/or their lessons learnt through personal therapy; e) presented theoretical and/or practical arguments for or against the use of personal therapy among therapists.

Articles were excluded if they: a) referred to the therapist's personal therapy in terms of vocational assessments, remediation for ethics violations, rehabilitation, or other purposes rather than professional development or clinical practice; b) presented single or case studies describing the role of personal therapy in becoming a therapist with a particular orientation (e.g. Jungian); c) described anecdotal accounts of therapists' experiences in personal therapy and its impact on other issues rather than professional development or clinical practice (e.g. cultural identity); d) defined personal therapy as other than a course of psychological therapy between a therapist and a client (e.g. supervisor-led reflective discussions); e) used the term of personal therapy to refer to the client's therapy rather the client-therapist's; f) described the therapists' therapist rather than the client-therapist; g) were not written in English.

Appendix 2: Empirical evidence addressing the impact of therapists' personal therapy on therapeutic outcomes and processes.

	Study	Outcome variable	Main finding
Positive results	Greenspan and Kulish (1985)[o]	Patients' premature termination of therapy.	Therapist' experience of personal therapy was associated to lower patients' premature termination rates
	Kernberg (1973)[o]	Patient's improvement.	Therapists who had completed therapy obtained grater patient improvement than inexperienced therapists who were still undergoing therapy.
	Strupp (1955)[3]	Therapists' use of therapeutic techniques.	Analysed therapists were more active and used more interpretations, silences and structuring responses than unanalysed therapists.
	Hamilton and Kivlighan (2009)	Therapists' projection of core conflictual relationship themes on their formulation of clients' relationship episodes.	Therapists who had received more personal therapy were less likely to project their own issues on their formulations of clients' situations.
Mixed or inconclusive results	Derner (1960)[o123]	Competence in therapy (as judged by senior therapists).	Senior staff's judgement of therapist's competence was unrelated to whether the therapist had undergone therapy or not.
	Holt and Luborsky (1958)[o12]	Trainees' improvement in their competence throughout residency.	Trainees who applied for therapy but did not have it, showed the least improvement through their residency. However, those who did not feel the need of having therapy improved without it.
	Katz, Lorr and Rubenstein (1958)[o123]	Patient's improvement in therapy.	Therapist's experience or lack of experience in therapy had no relation with patients' outcome.
	McNair, Lorr and Callahan (1963)[o12]	Patients' premature termination of psychotherapy	Patients' premature termination of psychotherapy was unrelated to whether therapists had had personal therapy or not.
	McNair, Lorr, Yung, Roth and Boyd (1964)[o1]	Patients' outcome (3-year follow-up).	There was no significant relationship between therapists' experience of personal therapy and patient final status.
	Strupp (1958)	Therapists' conscious attitudes towards their clients.	Personal analysis had no significant effect on therapists' conscious attitudes towards their clients. However, those with more therapy experience were more able to empathise with their clients regardless or in spite of negative attitudes towards them.

Keys: [o]= reviewed by Macran and Shapiro (1998); [1]= reviewed by Clark (1986); [2]= reviewed by Macaskill (1988); [3]= reviewed by Garfield and Kurtz (1976)

Empirical evidence addressing the impact of therapists' personal therapy on therapeutic outcomes and processes. (Cont.)

	Study	Outcome variable	Main findings
Mixed or inconclusive result	Strupp, Fox and Lessler (1969)[o2]	Patients' satisfaction with their therapy experiences (1 to 2 years post-treatment)	Patients who received therapy from analysed experienced therapists vs. those who received therapy from unanalysed inexperienced residents were equally satisfied with their experiences in therapy.
	Strupp (1973)[1]	Therapist's verbal behaviour.	Therapists with more experience in analysis gave significantly fewer silent responses than unanalysed therapists.
	MacDevitt (1987)	Counter-transference awareness (CA)	There was no difference on CA between therapists who had or had not received personal therapy. However, there was a significant relationship between CA and length of therapy received.
	Peebles (1980)	Therapist's ability to display empathy, warmth and genuineness.	No differences were found between therapists who had undertaken therapy and those who had not. However, length of therapist's personal therapy was associated to greater levels of genuineness and empathy.
	Dube and Normandin (1999)	Trainees' counter-transference.	Trainees who had had personal therapy were less likely to block out or act on their first impressions, and produced more elaborate formulations of the inner world of the patient and of therapeutic interplay. However, personal therapy did not impact on trainees' reactive counter-transference (i.e. blind spots, impulsive reactions).
	Duthiers (2006)	Counter-transference management.	Therapists' personal therapy was unrelated to any aspect of counter-transference management.
	Gold and Hilsenroth (2009)	Client-rated and therapist-rated therapeutic alliance.	Whether therapists had or had not had personal therapy did not make any difference in client-rated therapeutic alliance. However, therapists who had received personal therapy scored significantly higher on therapist-rated alliance scores (involving confidence, goal and task agreement, and overall alliance). The latter also kept their clients in therapy for longer.
Negative results	Gardfield and Bergin (1971)[o123]	Clients' outcome.	Therapists' amount of personal therapy was associated with poorer client outcome.
	Wheeler (1991)	Therapeutic alliance.	Amount of counsellor's personal therapy was negatively associated with therapeutic alliance achieved with their clients.

Keys: [o]= reviewed by Macran and Shapiro (1998); [1]= reviewed by Clark (1986); [2]= reviewed by Macaskill (1988); [3]= reviewed by Garfield and Kurtz (1976)

Appendix 3: Letter to directors asking for permission to invite their students to take part in the study

Dear [NAME OF DIRECTOR]

Re: Trainees' participation in a cross-national research study

My name is Malena Digiuni. I am a second year trainee at the Doctorate in Clinical Psychology programme, Department of Applied Psychology, Salomons Campus, Canterbury Christ Church University, UK.

I am contacting you with the aim of asking if you would consider granting me permission to contact your current Clinical Psychology trainees to request their participation in my doctoral research project.

My project aims to explore whether trainees from different countries endorse different views and perceptions about undertaking personal therapy, and whether those views and perceptions affect their attitudes towards seeking psychological help themselves.

Trainees from various countries will be invited to take part in this study on a voluntary basis. They will be asked to complete an on-line survey, which can be accessed through an Internet link. All those who complete the survey will then be given the option to participate in a prize draw for the chance to win an Amazon Gift Card worth £25. One Amazon Gift Card per country will be awarded. Recruitment of participants will take place between the end of July and October 2010.

This project is being supervised by Dr Paul Camic and Dr Fergal Jones, Clinical Psychology staff in the department. The proposal for this project has been approved by a Research Review Panel, and the University's Ethics Committee. The information regarding participating trainees will be anonymous and confidential. I will be happy to send you the research proposal if you require further information about the study. I will also be pleased to share the results of this project with you and your trainees once it is completed.

If you agree to grant me permission to invite your trainees to take part in this study, I would be grateful if you could let me know who would be the best person for me to contact to, in order to ask him/her to circulate an e-mail among all the trainees enrolled in your Clinical Psychology training program.

If you have any queries about my research project please do not hesitate to contact me at md214@canterbury.ac.uk .

I look forward to hearing from you.

Best Wishes,

Malena Digiuni
Trainee Clinical Psychologist
Clinical Psychology Programme
Department of Applied Psychology
Canterbury Christ Church University
Tunbridge Wells, Kent, United Kingdom

Appendix 4: Letter to students inviting them to take part in the study

Dear colleague,

Re: Invitation to take part in a cross-national research study and the chance to win an Amazon Gift Card worth £25.

My name is Malena Digiuni. I am a Clinical Psychology trainee at the Department of Applied Psychology, Salomons, in Canterbury Christ Church University.

I would like to invite you to take part in an anonymous study that I am conducting for my doctoral dissertation, which is entitled "Views, perceptions, and attitudes towards therapy. A cross-national study among clinical psychology trainees". Dr Paul Camic and Dr Fergal Jones are the project's research supervisors.

The broad aim of the study is to explore the views and perceptions that trainees from different countries have about personal therapy.

Participation involves completing a survey, which takes no longer than 5 minutes. Participation in this project is voluntary and anonymous, and your information will be kept confidential to the researchers.

You will also be given the possibility to participate in a prize draw for the chance to win an **Amazon Gift Card worth £25.** If you decide to sign up for it, I will ask you to provide an e-mail address where I could send you the Amazon Gift Card if you won. In order to keep responses anonymous, you will be asked to do this separately, after the survey has been completed. However, you do not have to register to the prize draw if you are not interested.

I will be pleased to share the results of this research with you and your university once it is completed.

If you have any questions about this research project, please feel free to contact me at md214@canterbury.ac.uk.

Interested? You can access the survey through the link below:

https://www.surveymonkey.com/s/CPUK

Thank you for your interest in this study!

Best Wishes,

Malena

Malena Digiuni
Trainee Clinical Psychologist
Department of Applied Psychology
Canterbury Christ Church University
Tunbridge Wells, Kent, United Kingdom

Appendix 5: Recruitment of participants in Argentina - flyer

"OPINIONES, PERCEPCIONES Y ACTITUDES HACIA LA TERAPIA. UN ESTUDIO CROSS-CULTURAL ENTRE ESTUDIANTES DE PSICOLOGÍA".

Este es un estudio internacional, conducido por la estudiante de Doctorado Malena Digiuni, y supervisado por el Dr. Paul Camic y el Dr. Fergal Jones, quienes trabajan en Canterbury Christ Church University, en Inglaterra.

El objetivo de este estudio es explorar las opiniones y percepciones que tienen los estudiantes de Psicología de distintos países respecto de la terapia personal.

La participación es voluntaria y anónima, y solo requiere que contestes un cuestionario en internet que se completa en no más de 5 minutos. Las respuestas al cuestionario son tratadas en forma confidencial.

Y al finalizar el cuestionario, tendrás la posibilidad de participar en un sorteo de un voucher de Amazon, para comprar libros, por el valor de $143 (U$S 37).

https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi	https://www.surveymonkey.com/s/ARGENTINAPsi

Appendix 6: Ethical approval letter

[LETTER]

Appendix 7: Permission to use the SSRPH scale

AMERICAN PSYCHOLOGICAL ASSOCIATION

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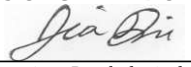

for the American Psychological Association

March 22, 2010
Date

Appendix 8: Survey – English version

[SURVEY ENGLISH VERSION]

Appendix 9: Survey – Spanish version

[SURVEY SPANISH VERSION]

Appendix 10: Letter to directors sharing the results of the study

Dear [NAME OF DIRECTOR]

Re: Trainees' participation in a cross-national research study

As you may recall, I contacted you around July 2010 to ask you for permission to contact your clinical psychology trainees in my doctoral research project. I am writing to you now to share with you and your students the results of my study. The abstract of the paper is below.

Clinical Psychology Students' Perceived Social Stigma and Attitudes Towards Seeking Therapy: A Cross-national Study

Drawing on the theory of planned behaviour, this study explored the influence of subjective norms (social stigma) on clinical psychology students' attitudes towards seeking personal therapy. A total of 462 students from Argentina (n = 121), England (n = 211), and the US (n = 211) completed a survey on demographic characteristics, well-known predictors of seeking therapy, perceived social stigma for receiving therapy, and attitudes towards seeking therapy. Results revealed significant cross-national differences, with Argentinean students showing the lowest levels of perceived social stigma for receiving therapy (M = 5.02, SD = 1.60), followed by English (M = 4.57, SD = 1.61) and Americans (M = 3.22, SD = 2.35). English students showed significantly less positive attitudes towards seeking therapy (M = 22.60, SD = 2.97) than their Argentinean (M = 24.89, SD = 2.94) and American (M = 24.27, SD = 3.17) counterparts. Hierarchical multiple regression analyses revealed that perceived social stigma predicts students' attitudes towards seeking therapy, even after controlling for the effects of other predictors of therapists' therapy-seeking behaviours, among English (ß = -.26, $p < .001$), and American (ß = -.34, $p < .001$) students but not among Argentinean students. The hypothesised role of nationality as a moderator of the relationship between perceived social stigma for receiving therapy and attitudes towards seeking therapy was confirmed. Implications for research and training are discussed. Suggestions are made for English and American clinical psychology training programs to raise awareness on social stigma associated with receiving therapy.

If you would like to read the entire paper, please, let me know. I would be very pleased to share it with you. I would appreciate it much if you could please forward this e-mail to your students, in order to share the results with them too.

Thank you very much, once again, for your collaboration with this study!

Best Wishes,

Malena Digiuni
Trainee Clinical Psychologist
Clinical Psychology Programme
Department of Applied Psychology
Canterbury Christ Church University
Tunbridge Wells, Kent, United Kingdom

Appendix 11: Letter to the Ethics Panel sharing the results of the study

Dear Dr Callanan
Chair of Salomons Ethics Panel

Re: Clinical Psychology Students' Perceived Social Stigma and Attitudes Towards Seeking Therapy: A Cross-national Study

As you may recall, I applied for the University's Ethics Panel approval in February 2010 to carry out my major research project. I am now writing to you to share with you the results of my study. The abstract of the paper is below.

Drawing on the theory of planned behaviour, this study explored the influence of subjective norms (social stigma) on clinical psychology students' attitudes towards seeking personal therapy. A total of 462 students from Argentina (n = 121), England (n = 211), and the US (n = 211) completed a survey on demographic characteristics, well-known predictors of seeking therapy, perceived social stigma for receiving therapy, and attitudes towards seeking therapy. Results revealed significant cross-national differences, with Argentinean students showing the lowest levels of perceived social stigma for receiving therapy (M = 5.02, SD = 1.60), followed by English (M = 4.57, SD = 1.61) and Americans (M = 3.22, SD = 2.35). English students showed significantly less positive attitudes towards seeking therapy (M = 22.60, SD = 2.97) than their Argentinean (M = 24.89, SD = 2.94) and American (M = 24.27, SD = 3.17) counterparts. Hierarchical multiple regression analyses revealed that perceived social stigma predicts students' attitudes towards seeking therapy, even after controlling for the effects of other predictors of therapists' therapy-seeking behaviours, among English (ß = -.26, p < .001), and American (ß = -.34, p < .001) students but not among Argentinean students. The hypothesised role of nationality as a moderator of the relationship between perceived social stigma for receiving therapy and attitudes towards seeking therapy was confirmed. Implications for research and training are discussed. Suggestions are made for English and American clinical psychology training programs to raise awareness on social stigma associated with receiving therapy.

If you would like to read the entire paper, please, let me know. I would be very pleased to share it with you.

Thank you very much for making this study possible!

Best Wishes,

Malena Digiuni
Trainee Clinical Psychologist
Clinical Psychology Programme
Department of Applied Psychology
Canterbury Christ Church University
Tunbridge Wells, Kent, United Kingdom

Appendix 12: Requirements for submission to the journal: Psychotherapy: Theory, Research, Practice, Training

Information for Authors

Psychotherapy publishes a wide variety of articles relevant to the field of psychotherapy. We strive to foster interactions among training, practice, theory, and research since all are essential to psychotherapy. We welcome the widest scope of orientations to inform our readers. Authors are asked to submit theoretical contributions, research studies, novel ideas, the controversial, as well as examples of practice relevant issues that would stimulate other theorists, researchers, and/or practitioners. Manuscripts submitted to this Journal must have a very clear statement on the implications for psychotherapy, as well as use psychotherapy terminology. Thus, we are most interested in manuscripts that are specifically related to the therapeutic setting and treatment interventions in an applied manner. As such, papers would need to have very clear and accessible implications for therapists in applied clinical practice.

Directly related to the main aims of this Journal we also encourage submission of articles to a pair of ongoing special series. The first being Practice Review articles that summarize extant research in a clinically accessible manner. The second, parallel in purpose to the Practice Review articles, are Evidence-Based Case Studies that integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment. More information on both of these types of articles can be found in this issue and at the Psychotherapy Author and Reviewer Resources webpage: http://www.apa.org/pubs/journals/ pst/resources.aspx. This webpage also contains links to several different resources to help authors conduct their research, including free statistical programs, as well as a range of formatting aids to help authors present their findings.

Brief reports are published and should be no longer than 15 pages, including text, references, tables and figures, but not abstract or title page.

Book reviews are published and authors of new books should contact Dr. Lisa Wallner Samstag, Book Review Editor, for further information regarding this process at: Lisa.Samstag@liu.edu Please visit Psychotherapy's Website at: http://www.apa.org/ pubs/journals/pst/index.aspx for additional information about this Journal as well as instructions and resources for authors.

Manuscript preparation. Manuscripts should be prepared according to the requirements of the Publication Manual of the American Psychological Association (6th ed.) and accompanied by an abstract of no more than 250 words. Also, with the abstract please provide up to five key words to aid in indexing. Manuscripts that do not meet these requirements will not be considered for review.

Authors of empirical manuscripts should incorporate recommendationsin the American Psychological Association (APA)Working Group on Journal Article Reporting Standards (JARS) report (2008, American Psychologist, 63, 839–851; or http:// www.apa.org/pubs/authors/jars.pdf). In addition, empirical manuscripts must report standard effect size measures (e.g., r, Cohen's d, Hedges g, etc) for statistical results. Aids to do so are located at our Author and Reviewer Resources webpage (see above). In order to permit anonymous review, all authors' names, their affiliations, and contact information should be removed from the manuscripts itself and included

in the cover letter to the Editor. This cover letter should also address any necessary APA publication policy or ethical principles that may exist (see below).

Figures. Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint. High-quality printouts or glossies are needed for all figures. The minimum line weight for line art is 0.5 point for optimal printing. When possible, please place symbol legends below the figure image instead of to the side. Original color figures can be printed in color at the Editor's and publisher's discretion and provided the author agrees to pay $255 for one figure, $425 for two figures, $575 for three figures, $675 for four figures, and $55 for each additional figure.

Submission. Submit manuscripts electronically via the Manuscript Submission Portal at: www.apa.org/pubs/journals/pst/

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