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“It’s like being in a little psychological pressure cooker sometimes!” A qualitative study of stress and coping in pre-qualification clinical psychology

Abstract

Purpose

This paper investigates the stressors involved in pre-qualification clinical psychology as reported by a sample of UK trainee clinical psychologists. The main coping strategies reported by the trainees are also explored.

Design/methodology/approach

One-to-one interviews were conducted with 15 trainee clinical psychologists using qualitative research methods. Themes were established using the main principles of thematic analysis.

Findings

Three themes were identified that described the pressures involved in applying to the course, the support networks available to trainees, and the commonalities in their personal history, experiences and self-reported personality characteristics.

Originality/value

It is important to investigate the sources of stress and coping strategies in trainees to help them cope more effectively. The findings of the study are discussed within the context of clinical psychology training.

Introduction

Stress in mental health professionals

As pressure on mental health services increases, so too does the likelihood of excessive stress impacting on those working and training in the mental health field (Paris and Hoge, 2010; Rossler, 2012). Stress not only has consequences for the individual, but also the organisation in which they work and the clients they seek to help. For example, 30% of sickness absence in the National Health Service is due to stress, with a bill to the service of around £300m-£400m per year (NHS, 2015). Stress has been defined as a “*particular relationship between a person and their environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing*” (Lazarus and Folkman, 1984, p. 19). This definition suggests that stress occurs when an individual perceives an event or situation as threatening, and lacks the appropriate coping strategies to deal with it. Stress has been shown to affect concentration, cause deficits in problem-solving abilities, and impact on learning and memory (Kaplan and Saddock, 2000; Kuoppala *et al.*, 2008). Therefore, stress is an important topic in need of further investigation. This is particularly true in healthcare education settings, where stress has the potential to interfere with trainee learning, functioning and performance.

High stress is related to low self-esteem (Mimura *et al.*, 2008), suicidal thoughts (Hawton *et al.*, 2011), substance abuse (Melaku *et al.*, 2015), psychological ill health (Galvin and Smith, 2015) and burnout (Lizano and Mor Barak, 2012). Burnout is defined as a syndrome consisting of emotional exhaustion, feelings of ineffectiveness, and diminished interest at work (Maslach and Leiter, 1997), and research shows it is most likely to occur in individuals exposed to stressful working conditions (Rosenberg and Pace, 2006). Evidence suggests that working in the field of clinical psychology might be particularly stressful (Cushway and Tyler, 1994; Hannigan *et al.*, 2004), with

many clinical psychologists reporting feeling “stuck”, “overwhelmed”, and “incompetent” in their work (Crowley and Advi, 1999).

Hannigan *et al.* (2004) conducted a systematic review of stress and coping in qualified UK clinical psychologists based on the Carson and Kuipers (1998) stress model. The aim was to identify the stressors, moderators and outcomes in the clinical psychology workforce. Identified stressors included demands, workload, poor quality management and professional self-doubt (Cushway and Tyler, 1994). Moderators included a wide range of coping strategies such as talking to colleagues, a partner or engaging in a support group (Cormack, Nichols and Walsh, 1991). Outcomes included high levels of burnout and psychological distress (Darongkamas *et al.*, 1994). The authors concluded that:

“Mental health professionals are required to attend to the needs of people experiencing a range of mental health difficulties. However, the evidence from this review is that many clinical psychologists practicing in the UK are, themselves, experiencing significant levels of psychological distress.” (Hannigan *et al.*, 2004, p. 239).

It should be noted that some of the stressors reported by mental health professionals are often inherent to the job and are therefore unavoidable. For example, the organisational and administrative tasks, frequent patient contact and the nature of caring for the mentally ill (Nolan and Ryan, 2008). For this reason, researchers have also focused on the coping strategies employed by these groups (Cushway and Tyler, 1994; Tully, 2004). Two broad types of coping strategies were described by Lazarus and Folkman (1984): emotion-focused coping and problem-focused coping. Emotion-focused coping involves reappraising the relational meaning of the problem. An example of this strategy is avoidance coping, whereby the individual avoids a stressful situation, or postpones taking any action to help resolve it (Cohen *et al.*, 2008). This may be the only realistic option when the source of stress is outside the person’s control. On the other hand, problem-focused coping aims to remove or reduce the cause of the stressor more directly (Ben-Zur, 2002). Examples can include taking one step at a time to change the situation, improving time management, and obtaining instrumental social support.

Stress and coping in pre-qualification clinical psychology

The journey towards becoming a clinical psychologist in the UK is extremely hard work. Individuals pursuing this career path must have at least a 2.1 psychology undergraduate degree or conversion course and some experience in terms of clinical (e.g. assistant psychologist) or research (e.g. research assistant) before being considered for a place on a three year Doctorate in Clinical Psychology (DClinPsy) training course (CHPCCP, 2015). The scientist-practitioner model is the core philosophy behind clinical psychology training, and states that science and practice must continually inform each other (Belar and Perry, 1992). For this reason, once on the course, trainees are expected to complete both academic and clinical work during their training programme. The academic component of the course typically includes teaching days, essays, reports, and a doctoral-level thesis, while the clinical component includes undergoing clinical placements in the NHS.

As demonstrated by a recent review of the area, there has been a distinct lack of published literature focusing on stress and coping in trainee clinical psychologists internationally (Pakenham and Stafford-Brown, 2012). In this review, the authors found only one study that examined the sources and levels of stress in trainees and, for this reason, mainly focused on findings from other mental health practitioners in an attempt to generalise these findings. The sole study that did focus on trainees was a questionnaire study by Cushway (1992), who found that 59% of trainees in the United Kingdom (UK) were reporting high levels of stress. The factors associated with stress were workload, lack of social support, client difficulties and distress, self-doubt, course structure and poor supervision.

A more recent survey study by Galvin and Smith (2015) also found that many UK trainees were reporting significant levels of psychological distress. However, trainees in this study reported more protective factors, such as higher social support and greater resources at their disposal, than other groups in training. It was found that trainees who were more relationship-focused (i.e. more inclined to seek out and build relationships with others) reported fewer mental health problems and higher job satisfaction. It was also found that individual differences, such as personality, were the factors most strongly associated with mental health and job satisfaction outcomes, rather than training-related factors such as the demands of the course.

The Alternative Handbook for Postgraduate Training Courses in Clinical Psychology (British Psychological Society, BPS, 2015) surveys trainees' experiences on each of the BPS accredited clinical training courses every year. This is a helpful guide for prospective applicants to get a flavour of the courses available and to help them decide where to apply. However, the usefulness of this data when it is applied to our understanding of stress in trainees is somewhat limited. For example, the questions in this survey do not allow the trainees to elaborate on the stressors they report, or explain how, if at all, they would manage these stressors. The data also fails to account for the complex nature of stress, which includes a complex web of stressors, resources, coping strategies, and individual differences (Mark and Smith, 2008). A richer account of stress in trainee clinical psychologists is therefore needed.

Rationale for the study

The limited number of available studies that have focused on stressors and coping strategies in trainee clinical psychologists have tended to adopt questionnaire-based methods. However, there are a number of limitations when using quantitative-based research methods to investigate stress. For example, when constructing their instruments, investigators often assume that they know which stressors they should assess (Razavi, 2001; Beiske, 2002). This can lead researchers to ignore a variety of variables that are meaningful for the population under investigation (Cresswell, 2003). Therefore, qualitative research methods can play an important role in the discovery of stressors in a particular group that were not originally considered by researchers using structured quantitative-based methods. To our knowledge, there are currently no published qualitative studies that consider stress and coping in trainee clinical psychologists. The Alternative Handbook (BPS, 2015) does include some qualitative data in its report, but this is limited to written responses to structured questions and, as previously mentioned, this does not allow for a rich account of stress in trainees.

The specific aims of this study were to consider:

- 1) What are the pre-qualification stressors reported by trainee clinical psychologists?
- 2) What are the coping strategies employed by the trainees to help them deal with these stressors?

Method

Participants

Semi-structured one-to-one interviews were conducted with 15 trainee clinical psychologists enrolled on the DClinPsy training course at Cardiff University. Ethical approval was given from the School of Psychology Ethics Committee. The participants gave informed consent, were made aware that they could refrain from answering any questions they did not feel comfortable answering, and could withdraw from the study at any time. At the end of the interview, participants were debriefed and provided with contact details for the university support services should they be required.

Recruitment involved purposive sampling, with the trainees being invited to interview via their university e-mail accounts. In line with principles of data saturation in qualitative research, interviews were terminated after n=15 interviews as the collection of new data did not provide any more useful information. Demographic information is available in table 1.

<Insert table 1 >

Procedure

Interviews lasted between 45-60 minutes and were audio recorded. Transcripts were prepared, rendered anonymous, read and coded. Participants were made aware that while confidentiality is protected, this protection had its limits. For example, if any disclosures of malpractice or suboptimal care of clients was reported, then the researcher would have to breach confidentiality and report these disclosures to others.

Analysis

Thematic analysis (Braun and Clarke, 2006) was the analysis strategy employed. The flexibility of thematic analysis allows data to be analysed under a number of different qualitative frameworks and, for this study, the framework chosen was grounded theory (Strauss and Corbin, 1998). Therefore, theoretical developments were made in a bottom up manner in order to be anchored to the data. An inductive approach to data analysis was chosen as the most appropriate, as this kind of analysis is data-driven, and allows for unexpected themes to be identified (Braun and Clarke, 2006). The increasing popularity of this approach to data analysis in health research (e.g. Crawford *et al.*, 2008; Galvin *et al.*, 2015) is largely due to researchers wanting to extract themes from data without having to subscribe to the theoretical commitments of a “full-fat” grounded theory (Braun and Clarke, 2006).

Due to the focus of this study being on the participants’ pre-qualification experiences, the questions in the interview schedule asked participants about their experiences from undergraduate level up until the present day. To give an idea of the questions posed to

participants, the initial interview schedule is described in table 2. However, in line with a ground theory framework, participant responses in earlier interviews informed new questions to be asked in future interviews. In addition, the semi-structured nature of the interviews allowed flexibility for the researcher to ask follow up questions where necessary.

<Insert table 2 >

The first author examined the transcripts on a line-by-line basis to look for common themes. All data was then re-examined following the discovery of a new theme. This iterative process was repeated until theoretical saturation was achieved. In terms of validity and reliability, there are four criteria that are essential when evaluating qualitative research; credibility, authenticity, criticality and integrity (Whittemore *et al.*, 2001).

Credibility refers to how well the results of the study truly reflect the experience of participants (Whittemore *et al.*, 2001). In this study, the identified themes were later discussed with participants who had previously indicated a willingness to be involved in additional inquiry at a later date. This discussion was achieved through an email exchange. This allowed the researcher to clarify the findings further and, if the feedback questioned the conclusions, the researcher refined the themes where necessary. All 15 of the participants indicated a willingness to cooperate in this additional stage. However, it was decided that two trainees from each cohort would be sufficient (total n = 6), and these participants were selected at random from the total sample.

A reflective awareness of the researcher's preconceptions, whilst acknowledging the possibility of being surprised by the findings, was how the authenticity criteria were addressed. Upon completion of each interview, the researcher made brief field notes which identified the key points relating to each interview. These notes were later used to develop a reflective log, which summarised the initial interpretations developed during the interview. This log was referred to during data analysis.

For criticality and integrity, these two criteria refer to the possibility that a number of different interpretations could be made and this will largely depend on the previous knowledge and assumptions of the researcher (Whittemore *et al.*, 2001). To address these criteria, an individual who had just completed their training reviewed the emerging themes and conducted credibility checks of the findings. Further, a colleague within the university but external to the project and the clinical psychology department reviewed the transcripts.

Results

Three themes emerged from the analysis. These were 1) application procedures, 2) personal and professional relationships, and 3) commonalities in personal history, experiences and self-reported personality characteristics.

Theme 1: Application procedures

The initial application process and gaining a place on the course in the first place was reported as being one of the most stressful aspects of pre-qualification clinical

psychology. Upon her fourth time of applying, one trainee described the lead up to her interview as follows:

Participant 11: *I guess I thought by that point I really have to fight for my place and I kind of really realised how competitive it was and that I couldn't let anything slip. Like, I couldn't show signs that they wouldn't want me on the course, so it felt like a huge pressure beforehand and I was really nervous about doing it.*

An often-cited pressure for individuals applying for training was the lack of job security from their assistant psychologist role. Indeed, a high number of applicants for clinical training will often be working on a 12-month assistant psychologist/research assistant contract, which can often expire around the time of their application for clinical training.

Participant 7: *I'd got the idea in my head that if I don't get on then what am I going to do? You know, it's going to be another year, I need to find another job because this one might come to an end and I started to get a bit stressed out. So that was the most anxiety provoking bit I think, waiting for that letter to come through.*

However, the trainees recognised that they themselves brought on a lot of their stress during the application process. Determination to get on to the course was a contributing factor.

Participant 13: *I am aware that I put a lot of stress on myself. And so, I would imagine that I was quite a big part of that pressure, or self-pressure... Applying for any job is stressful, but for me, the importance of getting on this course was probably the single most important thing I'll have to do again in my life, and, yea, that was definitely my mind set at the time.*

Theme 2: Personal and professional relationships

The second theme describes the personal and professional relationships that the trainees were engaged in. Participants frequently discussed their exchanges with others in relation to stress and/or support. Specifically, trainees viewed a number of their interactions with others as a source of stress while other interactions were viewed as a source of support.

Supervisor/trainee relationship

Trainees described how the relationship with their supervisor could either increase or decrease their stress levels on the course. Helpful contributions included the supervisor being seen as a source of support.

Participant 7: *She was always available for lots of discussion around things, so I felt really supported.*

However, trainees reported that placements were more stressful when this support was unavailable from their supervisor.

Participant 12: *I found my child placement very difficult because my supervisor was so busy.*

Negative offerings to stress levels included the pressure to get on with the supervisor. Trainees would often feel vulnerable around their supervisor, as their progress largely depended on their opinions of them.

Participant 11: *You feel quite vulnerable as a trainee because they've got all the power in that they can pass or fail you.*

Client/trainee relationship

The client relationship gave the trainees a sense of purpose in their work. Trainees often described their relationships with clients as the highest source of reward.

Participant 9: *It's really rewarding, seeing someone who had a lot of difficulties in their life and then at the end of the placement to see how much happier they were.*

However, the trainees also described how the relationship with clients could be a significant source of stress. A strong sense of responsibility towards their clients provoked worries in their dealings with them, and increased self-doubt.

Participant 2: *With therapy it almost seems as though someone wants you to think their life is in your hands sometimes... It's having such an impact in changing their life that it does make me think about what I do and how I do it.*

First year trainees described how they felt unprepared the first time they engaged in a particular therapy with a client, provoking high levels of stress.

Participant 6: *You do have a bit of teaching, but nothing the course could do in those six weeks is going to prepare you for the reality of going into a room with someone and starting a therapy you've never had experience with before and, yea, I think that's been quite difficult, the level of responsibility you have.*

Trainees placed additional workload upon themselves to over compensate for their perceived lack of experience.

Participant 3: *I think my supervisor used the word over-diligent because I was going home and reading loads of books. But I thought, oh god, these people have been waiting on a waiting list for such a long time and then they kind of, in the beginning it did feel like they were almost like "oh no, I've been given the trainee" and I don't think the clients saw it like that at all, but I think I felt that.*

Cohort/trainee relationship

The trainees' relationships with their cohort could also help reduce stress on the course. A sense of getting through the course together was evident across the transcripts.

Participant 9: *It's been really good to kind of share our experiences and go through this together.*

However, a negative offering to stress levels was the trainees seeing their peers as a source of competition.

Participant 8: *It's interesting, you're all kind of sizing each other up.*

This sense of competitiveness with their peers was coupled with worries of not being competent enough compared to other trainees.

Participant 9: *I remember thinking, "how can I match these people?"*

External support networks

Support networks external to the course were deemed as particularly important to the trainees. Members of their family, friends and partners were often mentioned as a source of support at busy times.

Participant 10: *The fact is I spend a lot of my time working on weekends and evening, so we have less time to do things for ourselves as a couple... And she's very accepting of that and I think it's a credit to her because without that, without that support from her, then I don't know what I would do.*

However, for some trainees there was additional strain in these relationships. A number of trainees described how the people closest to them would be glad to see the back of the course.

Participant 15: *I think he (her partner) can't wait for it to be over, and yea, I think most of my friends probably can't wait for it to be over too.*

The trainees described how they would often have to stay over in accommodation when allocated an away placement. This resulted in a lack of support and added to their stress on placement.

Participant 11: *I was on a child placement so I was dealing with families who were in abusive situations and in a lot of distress. I think one of the ways with managing that is when you go home and just being able to go into your own environment and see friends and family and things, and not being able to do that was really difficult.*

Interestingly, trainees described how they themselves have always had friends and family turn to them in times of need. Many participants took pride in their approachability.

Participant 10: *I've always been somebody where people have come to talk to me about their problems... That's always been my role in some ways; people have always come to me for advice.*

Trainees reported that friends and family would now, more than ever, see them as a

source of support. Trainees described how they could easily find themselves taking on the role of a psychologist in their social networks.

Participant 12: *Someone in my family was diagnosed with depression and I think I found myself kind of taking on the role offering them alternatives to the kind of anti-depressants that kind of, rather than the medical model that they were being fed by the GP.*

However, trainees would often express that they would do their best to avoid becoming a therapist outside of work.

Participant 6: *I think it's a really dangerous territory and people can start to want to use you a bit like a therapist. Friends and things start to ask your advice and I think I just try and keep it the same kind of advice I would have given them before.*

NHS staff/trainee relationship

Working with other NHS staff was an often-cited source of stress for trainees.

Participant 7: *More often than not if I've had a stressful day it's more about the people I work with. Like, more about other members of staff and systems that tend to frustrate me.*

Colleagues not understanding or recognising the role of a trainee was common. In particular, poor role definition within the team often resulted in trainees feeling unappreciated or undervalued. Participants attributed this to the “trainee” label.

Participant 13: *I think it's the “trainee” label on the front of it that people just don't understand what it is. One girl from our year had one of the nurses say to her “oh, did you know we've got an assistant psychologist in our team? You should go and chat to her and find out how she got her job, maybe she can help you along.” And she was just like “oh, ok then!” (laughs). So I just think people don't understand what you are, because the whole process of training to be a psychologist is so alien to most people that I don't know why people would understand that you go do your undergraduate, then you go have a job, then you go back to university. So if anything, you're perceived as lower than an assistant by most people.*

Participants described how colleagues could become irritated if they found out that trainees were on a higher wage band than them.

Participant 15: *It could become a bit of an issue for some people, that the trainee was getting more money than them... Sometimes people could be really funny about that.*

The changes in placements, and changes in working relationships, were frequently reported as stressful. A constant feeling of uncertainty was mentioned by participants during the early stages of a new placement.

Participant 10: *You've got the change in placement, so the physical change in placements and what that system and team is designed like and how it works. So you've got, from admin processes being quite different, the set up being quite different, the relationships being quite different. You've then got your supervisor who is new and you're not quite sure how they might respond to who you are and how you respond to them and their style. So you've got to develop that new relationship, you've also got the clients which are new, with different issues which are new and how they fit within the new system with a new supervisor and your new fresh relationship. So that's quite a demand, and that requires a lot of engagement, and that, over time, is tiring.*

Theme 3: Commonalities in personal history, experiences and self-reported personality characteristics.

The third theme identified a number of commonalities in the trainees' personal backgrounds, experiences and self-reported personality characteristics. The trainees described how their own or a significant others psychiatric history had led them to be interested in psychology.

Participant 5: *We've had quite a lot of mental health in my family and things like that so I guess from that side of things it has been quite a bit of background, and yea, it gives you a bit of an insight. I think a lot of people find psychology quite interesting but then if you've seen it first-hand then it gives it a personal edge.*

This trainee described how discussions with her peers had led her to the conclusion that a high number of psychologists have had similar experiences.

Participant 5: *I think it's the nature of it. Sometimes people who come into psychology have had like past stuff that's happened and that's led them to psychology, in a similar way to me but more like traumatic stuff that's happened to them, or they've had drug and alcohol stuff that's going on with them.*

Trainees described how they believed these experiences had increased their empathy towards clients. However, it was also acknowledged that these experiences could increase the stress of training.

Participant 15: *I think the experiences I've had with my sister definitely make me more empathetic. Yea, I think I'm more hardwired than most people to really try and make a difference to people in similar situations to her. It's definitely changed who I am as a person, and what I want to achieve in my career... I think overall that's a positive thing, but it can of course make some things more difficult. Like, sometimes you can see and hear things that are a bit too close to home.*

Trainees reported that at times they felt as though they have become consumed by psychology. Specifically, that training has led them to over-analyse everything.

Participant 1: *I think there are some times when I think "argh if I could just look at something like a normal person rather than analysing or fitting it to some theory!"*

A number of trainees described how this “side-effect” of studying psychology was difficult to switch off at times.

Participant 10: *At this stage I find it more I have to actively intervene to sort of, you know, that's it, I'm not at work now, and I'm not paid for this. So yea, trying to shut that down is difficult.*

Another trainee attributed this change to the reflective practice that is encouraged in the profession.

Participant 3: *My parents were having a little bicker the other evening and I came in as the diplomat saying “oh I can understand where you're coming from, but I also see where you're coming from” and they were like “oh god, she's got her psychology head on.” So I suppose other people see you as changing a lot more than perhaps you identify yourself, but I do think it does make you, because of all the reflection and things you have to do and on placement you're frequently asked to reflect on your practice and what different emotions people bring up in you. So I do think you become a lot more analytic, or self-aware perhaps.*

However, other trainees described how too much reflective thought could be exhausting.

Participant 5: *Sometimes psychology can be a bit exhausting and that kind of feeling that everything you say, the people that you're with are kind of going “oh what's that about?” and “what are you feeling?” and “bla bla bla” and that can be a bit exhausting. It's just too intense, like being in a little psychological pressure cooker sometimes!*

Discussion

This study provides insight into stress and coping in pre-qualification clinical psychology as described by trainees on a DClinPsy training course in the UK. The results of the study met with the objectives by providing a richer account of stress in pre-qualification clinical psychology. The main coping strategies, particularly in relation to social support, have also been identified. To provide a context for the study, it is important to examine the findings in relation to the existing research literature on stress and coping in clinical psychology.

Application procedures

The current perception of many individuals applying for clinical psychology is one of great fear and anxiety. Indeed, the training programme is often placed on a pedestal, is seen as the “holy grail” of psychology training, and often implicitly or explicitly promotes the idea that only the few can survive (O'Shea and Byrne, 2010). The possibility that a high number of promising early-career psychologists may avoid pursuing a career in the clinical domain should be taken into consideration by training providers. More information for, and further engagement with, undergraduate

psychology students could be one way to help change this perception among future candidates.

A number of books and articles have been written to give advice to clinical psychology applicants (e.g. Knight, 2002; Phillips *et al.*, 2004; Papworth, 2004; Papworth 2007). These are useful resources that can help reduce the stress of applying for training. However, are there other ways applicants can be supported? A minimum expectation of applicants to clinical training is that they have completed a BPS accredited psychology degree. Therefore, focusing interventions at an undergraduate audience could, even at such an early stage, be a useful endeavor. Indeed, the incorporation of self-care strategies is recommended at the earliest opportunity in clinical training (Christopher and Maris, 2010), and it has been suggested that an ethos of career-long learning can take the pressure off the three years of pre-qualification training (Kuyken *et al.*, 2003). Therefore, there is no reason why self-care cannot be incorporated even earlier in the psychology learner's career.

Integrating mindfulness-based courses into the psychology undergraduate curricula is one option. There is increasing evidence that mindfulness-based courses can reduce anxiety and teach new ways to manage stress (Grossman *et al.*, 2004; Eberth and Sedlmeier, 2012). De Vibe *et al.* (2013) found that female psychology students experienced significant positive improvements in mental distress, study stress, and subjective well-being after participating in a mindfulness-based stress reduction (MBSR) programme. Furthermore, Shapiro *et al.* (2005) found that healthcare professionals who participated in an MBSR programme reported increases in self-compassion and quality of life.

A good leader in this regard is Bangor University, who has offered their undergraduate psychology students a credited module in mindfulness-based approaches for a number of years. This module involves the students actively participating in an MBSR course, therefore gaining the benefits of mindfulness practice while they learn. Clinical psychology trainers, who are normally associated with a university institution, are in an ideal position to work with undergraduate teaching staff to make such enterprises a possibility. Equipping psychology students with self-care tools early in their psychology education is likely to be helpful not only for future clinical psychology applicants, but also to the psychology workforce more generally.

Professional self-doubt

Previous research has shown that professional self-doubt is a significant stressor for both qualified and trainee clinical psychologists (Cushway, 1992; Cushway and Tyler, 1994), and the results of this study confirmed this to still be the case. For trainees, it has been shown that feelings of self-doubt are most likely to peak around the time they first begin to treat clients (Millon *et al.*, 1986). Recent changes in application criteria may have increased self-doubt in the more recent cohorts of trainees, as training programmes are now considering applicants with a wider range of experiences. For example, applicants with PhDs or other research-oriented experiences are now more readily considered for places on training courses (CHPCCP, 2015). Supervisors should therefore be aware that this might increase the likelihood of self-doubt in some of the newer cohorts of trainees, with many entering training with potentially less client contact than ever before. This point should be addressed during the early stages of

supervision. That is, supervisors should take an active interest in the previous experiences of the supervisee, and discuss their perceptions of the quantity and quality of experiences they have had with clients. Reflecting on these experiences can help address the self-doubt being experienced by the trainee, and hopefully go some way to help reduce any associated stress.

Personal and professional relationships

Previous research has shown how the nature of “people work” can be inherently stressful (Edwards *et al.*, 2000; Hannigan *et al.*, 2004). In the present study, the trainees’ responses reflected this, with many describing how the relationship-focused nature of their work has caused them stress. Issues with other members of staff on placement were described, and these issues were often attributed to the “trainee” label. More specifically, the “trainee” label was seen as being problematic when working with colleagues who may not understand their role. Role difficulties, including role conflict and role ambiguity, have been found to be predictive of work-related stress and job dissatisfaction in trainees (Olk and Friedlander, 1992), and participants in this study described how they felt undervalued due to a lack of role understanding among colleagues. In addition to feeling undervalued, the trainees also reported worries surrounding the clients’ perceptions of being allocated a trainee, and discussed how the “trainee” title added pressure on them to perform.

Could a simple change in the role title be helpful here? For example, the title ‘trainee doctor in clinical psychology’ instead of the more familiar ‘trainee clinical psychologist’ could provide greater role understanding among colleagues and clients. Albeit a small change, this emphasis on the doctoral role could have multiple benefits. For example, it could (1) provide more clarity on the doctoral role of clinical psychology training, (2) help other health professionals understand the high level of training undertaken by trainees, (3) help other health professionals understand why a trainee might be on a higher salary band than them, (4) allow the trainee to feel more valued in the mental health team, (5) present a more accurate account of the training being undertaken, and (6) help clients feel more confident in the abilities of the trainee. The historical role title of clinical psychologists in training may, in itself, need updating. The current BPS guidelines state that trainee psychologists enrolled on a Health and Care Professions Council approved training course are able to use the titles ‘Trainee’ or ‘In-Training’. However, for other groups of psychologists, such as in the case of research psychologists, the doctorate element of training is often made more explicit. We argue that awareness surrounding the doctorate level of clinical psychology training is low among people outside the realms of psychology, and more could be done to promote the high level of training undertaken by trainees.

Social support coping

Having supportive social networks are considered essential to helping trainees cope (Kuyken *et al.*, 1998). Brooks *et al.* (2002) investigated personality style, social support and psychological adaptation in a sample of trainees and found that trainees were more inclined to try to change their environment rather than try to adapt to it, were more outgoing than retiring, and would draw on others rather than themselves for information. Galvin and Smith (2015) reported similar findings, with trainees who were more inclined to seek out and build relationships with others reporting fewer mental

health problems and higher job satisfaction. These findings make sense in the context of our data, which suggested a prominent coping strategy employed by trainees was seeking social support when needed. In particular, the participants described the importance of social support and took a pro-active approach to seeking it out. This finding could be related to application processes, with courses taking on trainees with similar personality profiles. Alternatively, it could be due to the training itself, with courses encouraging the trainees to seek out and utilise the support available to them. Either way, these results are promising and suggest that with appropriate support systems available, many trainees can, and do, adapt to the stresses of the course.

It should be noted that a number of support systems already exist for trainees. For example, the role of supervision is now considered crucial in clinical psychology training, and systems have been put in place to ensure good quality supervisory practices (Fleming and Steen, 2012). Other available support systems include tutor systems, appraisals, reflective groups, and therapy networks to name only a few. In other words, clinical psychology trainers are generally approaching support issues in an appropriate and considerate manner, and according to the most recent data from the Alternative Handbook (BPS, 2015), trainees do report feeling very well protected during their training programme. However, it is important not to get complacent, and in an ever-changing NHS workforce it is essential to continually update and review existing support structures.

Personal history, family experiences and self-reported personality characteristics

The “wounded healer” introduced by Jung (1963) is a well-established phenomenon in the academic literature and popular culture and suggests that mental health professionals are often compelled to treat clients due to their own personal experiences. Indeed, it has been suggested that mental health professionals could be more susceptible to mental health problems due to a higher prevalence of problems in their home life (Elliot and Guy, 1993; Gilbert and Stickle, 2012). In the present study, there was evidence of trainees having such experiences, with many reporting mental health issues of their own, a family member, or a significant other. However, participants did not generally report these experiences as having negative connotations for their professional performance, with many discussing their experiences in a positive light and as improving empathy towards clients. Similar findings have been found elsewhere. For example, in a study of 425 psychologists, Gilroy *et al.* (2002) found that of the participants reporting previous depression, 32% reported that the experience had increased their empathy towards clients.

It was interesting that the trainees invoked the wounded healer idea in order to explain their own stress, as well as also calling on another stereotype of psychologists, the “natural listener”. That is, a number of trainees described how they are seen in their social circles as someone to turn to in a time of need. Both these findings appear to link to a broader sense of how the trainees identified themselves as being ‘*ready made to do this job*’. That is, that their personality characteristics and experiences are an ideal mix to prepare them for this job, and these factors can help them in their career as a clinical psychologist.

However, some participants described how personal experiences could add to the stress of the course. Previous research has shown that when faced with personal problems,

trainee health professionals with a lack of social and professional resources are prone to use maladaptive coping strategies (Prymachuk and Richards, 2007). Not surprisingly, these patterns are related to higher levels of stress, lower academic achievement, dropout, and burnout for trainees (Skodova and Lajciakova, 2013; Costa *et al.*, 2014). It is therefore essential to examine the kinds and degree of support trainees receive from their family and peers, in addition to ensuring suitable professional support is available. Encouraging self-care, promoting available support services, and improving dialogue surrounding issues such as alcohol and drugs, can also help trainees cope with the personal stressors they might face during training (Christopher and Maris, 2010; Galvin and Smith, 2015; Galvin *et al.*, 2015).

Limitations and conclusions

We had a relatively small sample (n=15) and therefore analysis was focused on individual perceptions of training, rather than providing a broader social-structural analysis. This makes it difficult to generalise beyond the specific training programme from where the sample was drawn. However, we do claim a broader relevance for this study, in that our findings are consistent with research drawing from larger sample sizes, such as those identified throughout this paper.

This paper focused on the sources of stress in pre-qualification clinical psychology as reported by a sample of UK trainee clinical psychologists. The main coping strategies employed by the trainees have also been considered. Previous research has found stress to be an inevitable feature of pre-qualification clinical psychology, yet no published studies have investigated this using qualitative research methods. The present study suggests that although pre-qualification clinical psychology is clearly a stressful process, trainees with appropriate support and coping strategies can, and do, adapt to the stresses involved in the course. The data presented here can feed into the effective management of clinical psychology training, and will be of interest to clinical psychology trainers, present and future trainees, and any person or organisation interested in helping those in pursuit of qualified status.

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Biographical Details

John Galvin's research focuses on stress in health professions. This is investigated through the use of both qualitative and quantitative research methods.

Andrew Smith conducts research in occupational and health psychology. The research involves a variety of methods: laboratory studies of mood, performance and physiology; surveys; field testing using portable cognitive tasks; and secondary analyses of databases.

Sex	Age range (mean)	Year of training (n)	Ethnicity (n)
Females = 11	23-44	Year 1 (n = 7)	White British
Males = 4	(M = 29)	Year 2 (n = 5)	(n = 15)
		Year 3 (n = 3)	

Table 1. *The participants' demographic information.*

Introductory questions
<ol style="list-style-type: none"> 1. What made you want to become a clinical psychologist? 2. What made you choose this career path? 3. At what point did you realise you wanted to become a clinical psychologist? 4. Were there any other career paths you considered other than clinical psychology?
Developmental questions – undergraduate experiences to present day
<ol style="list-style-type: none"> 5. Did you do your undergraduate degree in psychology? 6. Where did you do your undergraduate degree? 7. How was your undergraduate experience for you? 8. What, if anything, did you find particularly stressful about your undergraduate experience? 9. What did you do career wise immediately after graduation? (e.g. was a masters programme undertaken? Did you find work?) 10. How was this experience for you? 11. What, if anything, did you find particularly stressful about this experience? 12. What did you do after this? Different job/educational opportunity? 13. How was this experience for you? 14. What, if anything, did you find particularly stressful about this experience? ** The researcher would then repeat this cycle (Q12-14) of finding out about the participants experiences during the different stages of their career up until they got onto the DClinPsy course** 15. How many times did you apply for the course? 16. How were these experiences for you? 17. What, if anything, did you find particularly stressful about this experience?
Questions related to experiences on the DClinPsy course
<ol style="list-style-type: none"> 18. How was/is your first year of training? 19. How were the placements during this year? 20. How was the academic side of the course during this year? 21. How was/is your second year of training? (if applicable) 22. Repeat questions 19 and 20 here. 23. How was/is your third year of training? (if applicable) 24. Repeat questions 19 and 20 here. 25. Is there anything specific about the stage of training you are currently at which is particularly stressful? 26. Is the training harder or easier than you expected so far? 27. Overall, do you feel like you belong or 'fit in' on the course? 28. Overall, do you feel like you fit in academically? 29. Overall, do you feel like you fit in on placements? 30. Do you feel more like a student or an employee of the NHS? 31. Have you ever been close to giving up on your training? If so, why were you thinking of giving up? What made you stay? 32. How is your work/life balance? 33. Do you think the training has impacted your personal life? Or, the other way round, has your personal life interfered with the course in any way? 34. How are the support systems on the course? Have you used any? If so, how did you find these experiences? 35. Do you feel like you have changed in any way since commencing training? 36. Do you feel like any of your experiences have been particularly important in shaping the person/clinician you have become? 37. Is there anything that hasn't been mentioned, related to training or anything else, which you think might be relevant to the topic of this study? Specifically, to do with the topic of stress?

Table 2. *The initial interview schedule.*