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RESEARCH ARTICLE

Personal reformulation during the clinical associate psychologist apprenticeship: Exploratory mixed methods evaluation

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Abstract

Objectives: Clinical associate psychologists (CAPs) train under the auspices of the apprenticeship programme and are a new addition to the psychological workforce. This project sought to evaluate whether a "personal reformulation" (PR) was helpful in terms of personal and professional development during the apprenticeship.

Methods: A mixed methods evaluation containing a longitudinal quantitative element and a "Big Q" qualitative element with a single cohort of $N = 18$ CAPs. A PR consists of a 2-hr one-to-one session and a follow-up session with a cognitive analytic psychotherapist. During a PR, a sequential diagrammatic reformulation is produced to aid recognition and revision of potentially problematic relationship patterns at work. Two outcome measures concerning reflective capacity and professional quality of life were completed at the start of the apprenticeship, pre-PR and at 3-month PR follow-up. The semi-structured interviews ($n = 11$) conducted at the follow-up were analysed using reflexive thematic analysis.

Results: Quantitative changes were limited to significant increases to general confidence and 8/12 apprentices had a reliable increase in confidence in communication. Qualitatively, five overarching themes were found: (1) *gaining insight*, (2) *wellbeing*, (3) *nature of the space*, (4) *being an apprentice*, and (5) *moving forward*.

Conclusions: PRs were generally found to be emotionally challenging, but relatively large amounts of insight are possible from a very brief intervention that can contribute to personal and professional development during clinical

training. More controlled research needs to be conducted and wider applications and evaluations of PRs in different professions would be welcome.

KEYWORDS
CAP, CAT, personal reformulation

Practitioner points

- PRs increase insight into relational patterns, the CAT model, and the patient experience and facilitate some changes to clinical practice.
- PRs are designed as a personal learning experience during which emotional processing appears necessary for creating for relational insight, but is a challenging process.
- Follow-up is an important aspect of PR as the intervention is exceptionally brief.

INTRODUCTION

Despite widespread increases in access to psychological therapies in Primary Care in England, enabled by the Talking Therapies for Anxiety and Depression programme (Clark, 2018), there unfortunately remains slow and limited access to evidenced-based psychological therapies in Secondary Care (Mental Health Taskforce, 2016). In the context of the NHS Five Year Forward View (Mental Health Taskforce, 2016), the clinical associate psychologist (CAP) apprenticeship began to be rolled out in England in 2020, with a remit of improving access in secondary care (Sherman, 2022). CAP training entails an 18-month degree apprenticeship hosted by NHS Trusts alongside a University course, leading to a master's degree qualification (i.e., level 7 of the apprenticeship programme). CAPs deliver direct and indirect work in Secondary Care and inpatient settings under the close supervision and professional guidance of a Health and Care Professions Council (HCPC) registered Practitioner Psychologist (Institute for Apprenticeships, 2022). An evaluation of the introduction of CAPs on a female inpatient ward showed the role was a success with regards to improving access to psychological interventions on such acute wards (Slender & Taylor, 2022).

Apprentice CAPs have noted the rapid role transitions required to be comfortable and able to deliver both direct and indirect interventions effectively in such settings (Psychological Professions Network, 2018). Continuous engagement in personal and professional development (PPD) is a key aspect of the apprenticeship (BPS, 2017; IoA, 2022). PPD is the active engagement in specific activities and cycles of reflection on personal and professional issues and experiences that hope to then help in maximising associated clinical competencies (McLeod & McLeod, 2014). One proposed method of enabling PPD is to undergo a personal reformulation (PR). This is a brief and focused adaptation of cognitive analytic therapy (CAT) offered to professionals around work-related issues (Catalyse, 2021). Whilst CAT originated as a one-to-one integrative psychotherapy, it is increasingly being adapted and then delivered in differing formats to meet the needs of widely divergent clinical and organizational contexts (Ryle et al., 2014).

The culmination of PR is the production of a sequential diagrammatic reformulation (SDR). Whilst the reformulation tools of CAT, such as the SDR, have tended to be studied in clinical populations (e.g., Balmain et al., 2021; Rayner et al., 2011; Tyrer & Masterson, 2019), only one single previous study has evaluated PRs during professional training. Hamilton et al. (2021) evaluated the effects of PRs on reflective capacity in $N = 20$ volunteer trainee clinical psychologists. No significant improvements to reflective capacity were found, but trainees found PRs helpful in increasing relational awareness in clinical work whilst also identifying some

negative issues with timing and content of PRs. The current mixed methods study sought to expand on this initial study conducting a follow-up, expanding the range of quantitative measures, and conducting a more detailed qualitative analysis. This project aimed to evaluate the effectiveness of PRs during the CAP apprenticeship quantitatively and to understand the impact of PRs through qualitative analysis.

METHOD

Design and ethics

The study was ethically approved (ref: 037430). A mixed-method design used two outcome questionnaires before, after and at follow-up from PR, and semi-structured interviews at PR follow-up. Quantitatively, the study used a 3-phase longitudinal, pragmatic, within-participants repeated measure design. Trainees were informed that PR was a mandatory aspect of the apprenticeship, but participation in the research study was voluntary. The first round of the quantitative measures was completed at the start of the CAP apprenticeship and second round at 3 months into the apprenticeship. The PR session was conducted 4 weeks after the second-phase measures. The follow-up PR session, qualitative interview, and third administration of the measures were completed 3-months post PR.

Participants

Potential participants were a single $N = 18$ cohort completing the MSc Associate Clinical Psychologist training course. PRs were integrated into the University of Sheffield CAP training course for the 2020/2021 cohort with the aim of supporting PPD. There were 14 women and four men on the apprenticeship with a mean age of 30.0 (SD = 5.63, age range 24–48).

Personal reformulation

The PRs consisted of a 2-hr session with one of two qualified CAT psychotherapists accredited by the Association of Cognitive Analytic Therapists, and a 30-min follow-up session (Catalyse, 2021). PR aims to give professionals insight into relational patterns that they may be enacting at work and then supporting appropriate change. PRs therefore summarize and map connections between developmental experiences and current professional patterns through the SDR with the SDR grounded in the object relations procedural sequence model (Llewelyn, 2003). The SDR is also used to label "exits" that can be practised over the follow-up period, and these are also drawn onto the SDR. All PRs were conducted online via video-conferencing due to COVID-19 restrictions at the time of the study.

Self-report outcome measures

Reflective practice questionnaire (RPQ)

The RPQ (Priddis & Rogers, 2018) is a 40-item measure that assesses the experience and consequences of reflective practice. The measure consists of ten subscales: reflective-in-action, reflective-on-action, reflective with others, self-appraisal, desire for improvement, confidence—general, confidence—communication, uncertainty, stress interacting with clients, and job satisfaction. Each item is rated on a 6-point Likert scale (one not at all to six extremely). Cronbach's alpha values for the ten subscales are between .82 and .91 for the general population (Priddis & Rogers, 2018) and for mental health practitioners the alphas range between .64 and .88.

Professional quality of life scale (PROQOL)

The PROQOL (Stamm, 2010) is a 30-item questionnaire that assesses the positive and negative effects of providing care to others in helping professionals. The measure consists of three subscales including compassion satisfaction, burnout, and secondary trauma stress. Items are rated on a 5-point Likert scale (1 never to 5 very often). All items can be summed to provide an overall score out of 50. Cronbach's alphas for the three subscales range from .75 to .88 (Stamm, 2010).

Data analysis: quantitative

At a group level, one-way repeated measures ANOVAs were computed for subscales of the RPQ and PROQOL with Time (Time 1 vs. Time 2 vs. Time 3) as the independent variable. All participants completed questionnaires at time 1, 13 returned questionnaires at time 2, and 12 returned questionnaires at time 3. ANOVAs were computed for the $n = 9$ participants who returned all three sets of questionnaires. *Post-hoc* pairwise comparisons (Time 1 vs. Time 2, Time 2 vs. Time 3, and Time 1 vs. Time 3) were reported if the main effect of Time was significant. Bonferroni correction of the *p*-values were automatically adjusted to account for multiple comparisons (alpha = .05). Non-parametric alternative to repeated measures ANOVA (Friedman test) was used for subscales where the normality assumption was not met. For questionnaires that were returned, but had missing items, person mean imputation (Heymans & Eekhout, 2019) was used to replace missing items within each subscale or scale with only one item score missing. This was done by summing all other available scores from a particular subscale for a particular individual and dividing by number of available scores. It is advised that if there are more than 20% of data missing within a subscale/scale then the data should be discarded (Peng et al., 2006). This criterion was followed for the PROQOL; however, the limit was extended to 25% for the RPQ as each subscale of the RPQ only has four items so each missing item would account for 25% of a subscale. For all the subscales with items replaced, none of the participants had more than one item missing per scale/subscale. In total, nine data points were prorated, which accounted for .476% of the analysed data (9/1890*100%, note that 1890 is total number of datapoints for 9 participants completing two questionnaires with 30 and 40 items across three timepoints). At an individual level, the reliable change criteria reported in Hamilton et al. (2021) were used to analyse the case-by-case differences between RPQ scores pre- and post-PR.

Qualitative interviews

Interviews were carried out by the two CAT therapists who had conducted the PRs; each therapist interviewed apprentices who had completed their PR with the other therapist. Eleven participants (10 women; $M_{age} = 29.90$, SD = 3.01) were interviewed. Interviews covered six main topics: (1) exploring the overall experience of PR; (2) whether or not changes had occurred since the PR; (3) what any changes were attributed to; (4) helpful aspects of PR; (5) problematic aspects of PR; and (6) suggestions for how to improve PR. The average length of the interviews was 24 min (range: 12–32 min). Interviews were audio-recorded and transcribed verbatim.

Data analysis: qualitative

Transcripts were analysed using Braun and Clarke's (2006) six-phase approach to reflexive thematic analysis. KB was responsible for the qualitative analysis. Consistent with a "Big Q" qualitative approach (Kidder & Fine, 1987), reflexive thematic analysis centres on researcher subjectivity and recursive

coding processes and involves deep reflection and engagement with the data (Braun & Clarke, 2019). Reflexive thematic analysis was chosen to generate themes that constructed patterns of meaning across the dataset. NVivo 14 (Release 1.7.1; QSR International Pty Ltd, 2022) was used to support data organization and analysis. Final themes and subthemes were drafted into a thematic map to display the hierarchical and inter-relationships between themes (Braun & Clarke, 2006). Thematic maps are used to simplify a large volume of qualitative data in a meaningful way (Daley, 2004).

KB kept a reflexive journal detailing their positioning, assumptions, and key decisions, which were made throughout the analysis (Braun & Clarke, 2019; Long & Johnson, 2000). To ensure different interpretations were introduced into the analysis and to question KB's assumptions, another trainee clinical psychologist independently coded 25% of the transcripts. These codes and themes were then compared with the author's preliminary codes and themes. Findings were discussed to allow triangulation of interpretations, constructing consensually agreed final themes and sub-themes.

RESULTS

Quantitative outcomes: group and individual

The descriptive, inferential statistics, and pairwise comparisons on the outcome meaures are presented in Table 1. There was a significant decrease in desire for improvement ($F(2, 16) = 9.27$, $p = .002$, $\eta_p^2 = .537$) and this occurred between Time 1 ($M = 5.47$, SD = .363) and Time 3 ($M = .461$, SD = .435, $p = .001$). There was a significant increase in general confidence ($F(2, 16) = 10.9$, $p = .001$, $\eta_p^2 = .577$), and this occurred between Time 1 ($M = 3.50$, SD = .395) and Time 3 ($M = 4.53$, SD = .507, $p = .011$). All other measures were insignificant ($ps > .05$). Individual change analyses are summarized in Table 2;

TABLE 1 Descriptive and inferential statistics for RPQ and PROQOL.

Subscale	Time 1 *M* (SD)	Time 2 *M* (SD)	Time 3 *M* (SD)	F/χ^2	*p*	η_p^2	Pairwise comparisons
RPQ							
Reflective-in-action	3.03 (.701)	3.58 (.573)	3.75 (.573)	2.24[a]	.356	–	–
Reflective-on-action	4.28 (.592)	4.28 (.605)	4.31 (.300)	.500[a]	.837	–	–
Reflective with others	4.53 (.507)	4.97 (.441)	4.44 (.671)	4.06[a]	.133	–	–
Self-appraisal	4.08 (.586)	4.14 (.574)	4.33 (.451)	.598	.562	.070	–
Desire for improvement	5.47 (.363)	5.33 (.573)	4.61 (.435)	9.27	.002	.537	1vs2 = 1.00 1vs3 = .001 2vs3 = .066
Confidence—general	3.50 (.395)	3.72 (.458)	4.53 (.507)	10.9	.001	.577	1vs2 = .461 1vs3 = .011 2vs3 = .061
Confidence—communication	1.92 (.545)	2.14 (.686)	2.56 (.610)	3.02	.077	.274	–
Uncertainty	3.69 (.622)	3.86 (.849)	3.19 (.788)	2.97	.080	.271	–
Stress interacting with clients	3.25 (.810)	3.44 (.917)	3.03 (.852)	1.30	.299	.140	–
Job satisfaction	4.81 (.635)	4.72 (.824)	4.58 (.857)	.521	.604	.061	–
PROQOL							
Compassion satisfaction	34.7 (3.08)	34.9 (4.95)	37.0 (6.50)	1.35[b]	.285	.144	–
Burnout	24.4 (4.3)	24.7 (4.50)	23.6 (5.13)	.157[b]	.856	.019	–
Secondary trauma stress	18.8 (7.40)	19.0 (4.90)	18.4 (5.57)	.412[a]	.861	–	–

[a]Friedman tests were used due to normality assumption being violated; X^2 statistics were reported instead of *F* statistics for these tests.

[b]Greenhouse-Geisser statistic was used for Compassion Satisfaction and Burnout subscales due to sphericity assumption being violated.

1vs2 = Time 1 versus Time 2. 1vs3 = Time 1 versus Time 3. 2vs3 = Time 2 versus Time 3.

TABLE 2 Reliable change indices for RPQ subscales between Time 1 and Time 3.

	Reliable change criterion[a]	Reliable deterioration	No reliable change	Reliable improvement
		n	*n*	*n*
Reflective-in-action	1.25	0	8	4
Reflective-on-action	1.16	0	12	0
Reflective-with-others	.56	3	8	1
Self-appraisal	.68	2	7	3
Desire for improvement	.54	5	7	0
Confidence—general	.61	1	5	6
Confidence—communication	.55	1	3	8
Uncertainty	.56	0	6	6
Stress interacting with clients	.66	2	5	5
Job satisfaction	.66	4	6	2

[a]Reliable change criterions were retrieved from Hamilton et al. (2021). *n* = number of participants. Total of participants included was *n* = 12.

4/12 had a reliable improvement on reflection-in-action, 6/12 in general confidence, 8/12 in confidence in communication, and 6/12 in tolerating uncertainty. Five had a reliable deterioration in desire for improvement.

Qualitative outcomes

Five themes encompassing eleven subthemes were found and are summarized in Figure 1.

Theme 1: Gaining insight

PR created insight into (a) personal roles and patterns and facilitated exits, (b) the CAT model itself, and (c) the patient's experience of intervention.

1.1 Into patterns and exits

Every apprentice expressed increased awareness of personal relational patterns: "I think I have a lot better understanding of myself and my ways of relating with others" (Participant; P5). This facilitated better understanding of the impact of these patterns on their personal and professional relationships: "It's helped me to think about kind of what's going on for me and how that might influence on what's happening in the dynamic in sessions, but not just in sessions, in personal relationships as well" (P4). Awareness of the stages maintaining patterns also helped to support exit work. Apprentices felt that knowing they have "options" or "choices" (P1) made problems more manageable and facilitated a shift in perspective (see theme 5.1).

1.2 Into the CAT model

Six apprentices reflected that having a PR increased their knowledge of CAT. Seeing personal relational patterns in CAT-specific language increased understanding: "It's something that I know about quite well and I think it was useful to see it from a CAT perspective" (P2). Experiencing the CAT model in practice facilitated the learning process: "I get what that teaching meant now, and I see how that applies in practice" (P11).

1.3 Into the client's experience

Seven apprentices noted that PR allowed them to experience being on the "receiving end" of a psychological intervention (P10). This allowed better understanding of how challenging this might be for

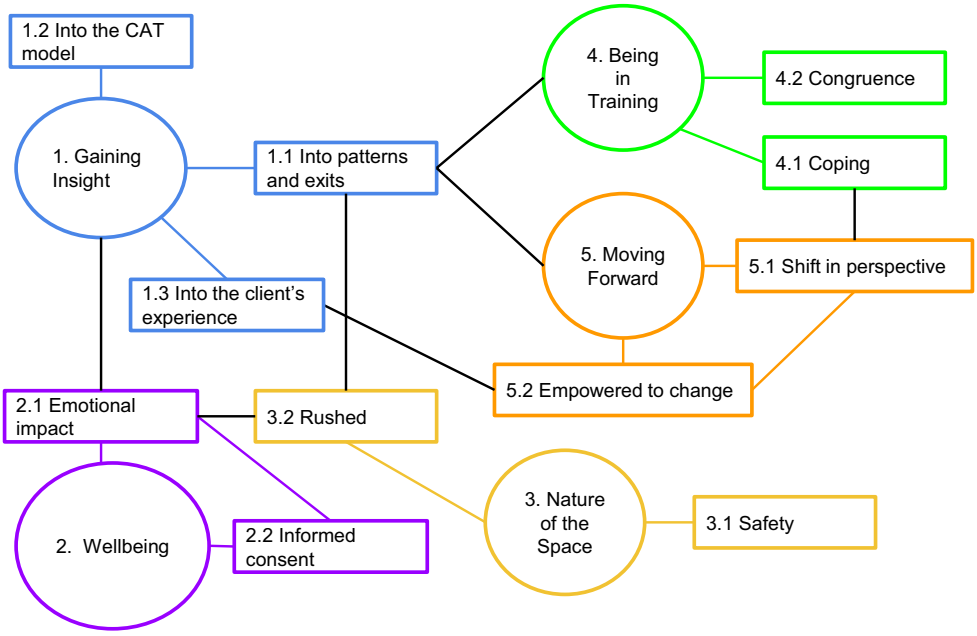

FIGURE 1 Thematic map illustrating the identified five themes and 11 subthemes. Black lines represent relationships between components of different overarching themes. Coloured lines represent relationships between subthemes of the same overarching theme. CAT, cognitive analytic therapy.

a client and also increased empathy: "You kind of get a sense of what you're asking other people to do further down the line because you've done it yourself" (P9). Understanding the patient's "perspective" (P8) led to thinking about how to change clinical practice (see theme 5.2).

Theme 2: Well-being

All but one of the apprentices talked about a marked emotional impact and informed consent was a subtheme.

2.1 Emotional impact

Apprentices described the experience as "revealing" (P10) and "uncomfortable" (P3), leaving apprentices feeling "naked" (P2). These feelings were attributed to the process of having to speak about personal or difficult previous experiences: "I probably put [previous experiences] to the back of my mind, and I think tapping into that was hard" (P6). Although PR was described as emotionally challenging, apprentices noted that the process was worth the discomfort and that the discomfort was necessary to gain insight:

> The process itself can be uncomfortable and yet somehow if it's done skilfully that discomfort has got a benefit … the fact you are thinking about something difficult can be a good thing in the end if it leads to more insight or more awareness.
>
> (P3)

One apprentice described feeling comfortable with the process of having the PR, and attributed this to the absence of discussing personal experiences: "I think because we were talking about work … I wasn't really super emotionally involved" (P1).

2.2 Informed consent

Apprentices expressed a need to have more information prior to the PR. Apprentices were not aware what the process would involve: "I think I was quite anxious about it beforehand because I just didn't really know what to expect" (P7). Furthermore, they were surprised when conversations focused on past personal experiences: "It went down the path that I didn't really expect and envisage" (P4). Given the emotional impact of discussing past experiences, apprentices felt that the PR should be accompanied by a "health warning" (P4) to make individuals aware of the potential challenges: "I think maybe it might be helpful to say to people that this could bring up some really difficult things for you, in advance, just so people are aware of it" (P6). One apprentice explicitly stated that having a PR should be a "choice" (P2) rather than a course requirement.

Theme 3: Nature of the space

Apprentices spoke about the nature of the space within the session, discussed safety and the rapid nature of PR.

3.1 Safety

Ten reported that they felt safe to share. Apprentices reflected that they felt supported in a novel situation: "Sharing with somebody certain things that I hadn't really shared before and it felt quite safe, and I felt quite understood" (P2). Several apprentices compared the PR to having "therapy" (P3, P4, P6, P11), leaving sessions feeling "supported" (P6) and "validated" (P7). Three noted that having the PR online made them feel less safe due to for example still living in the family home.

3.2 Rushed

Nine noted that the PR process was a rapid expereince:

> Obviously, there's only so much you can cover in a 2-hour session and all that [therapist] had to go off was what came to my mind to tell her … I keep thinking like 'alright, I wonder what she'd have said if I'd have told her that' and what more links could have been drawn.
>
> (P10)

The expeditious nature of PR often made it more emotionally challenging: "Like how to support people if they do bring things to the session that, you know, is a difficult experience for them because you only had two hours … It's like you're kind of opening a can of worms" (P11). However, the follow-up session was found to be a helpful and containing opportunity to "check in about how things have been since" (P2), and an opportunity to reflect: "It felt useful to have the follow up … having had the chance to reflect on it to then discuss it together" (P1).

Theme 4: Being in training

Apprentices emphasized that the PR interacted with their experience of the CAP course, reflecting on the subthemes of (a) coping and (b) congruence.

4.1 Coping

Three reflected that the PR allowed them to better tolerate course demands. For example, by being able to notice when the course led to an enactment of a pattern:

> I think that's really helpful at university when naturally on a course you're gonna be evaluated, and not always getting the best feedback, and I think that triggers those feelings of, you know, actually can I do this? Am I good enough for this?
>
> (P11)

Apprentices felt that having this understanding helped them to be less critical of themselves when finding the course challenging (see theme 5.1).

4.2 Congruence

Five spoke about the PR and the structure of the CAP course. Apprentices highlighted that having a PR earlier in the apprenticeship meant that they had limited clinical and organisational experiences to reflect on: "I don't have as many relationships at work because the nature of when I started my job and, starting at a new service, new course, new job, all of that, it's harder to see the relational patterns" (P1). However, one spoke about how the PR helped them to adapt to their new apprentice role: "Fitting myself into this new role, having something like the PR it's really helped me form that new understanding of what I am" (P8).

Participants also spoke about how PR repeated other aspects of the apprenticeship. Apprentices felt they had numerous opportunities to "practice self-reflection" (P6) and "experience the patient's perspective" (P8) on the CAP course, and reflected on the impact of prior experience on the utility of the PR: "I've not kind of found it that impactful … if people didn't have the same experience as me of having thought about this stuff a lot, it could be really helpful" (P1).

Theme 5: Moving forward

Apprentices commented on moving forward with a shift in perspective and feeling empowered to change.

5.1 Shift in perspective

Five discussed how PR created a more compassionate and non-blaming approach to self management: "I think just having that awareness … rather than just feeling bad, being able to like, oh well this is why and this is kind of what's going on now because of my previous experience" (P6). Apprentices let themselves "off the hook" (P4), "normalized" experiences (P3) and suggested that compassion was the first step in changing behaviour:

> It gave me a shift in perspectives, rather than being judgmental if I feel anxious with a person, more kind of like 'how do I use that' which is still something I need to sort of, skill up … but it gave me a new perspective on how to approach it.
>
> (P6)

5.2 Empowered to change

All apprentices noted that PR empowered changes to their clinical work: "I've really implemented what we went through within the PR into my clinical practice and now I'm actually finding that I actually have more time to do stuff and I'm not stressed out" (P9). Common changes were how "ruptures" (P4) were managed, working with "perfectionist" traits (P3, P5) and in setting more effective "boundaries" (P10). Furthermore, apprentices explained how sharing their SDR with others was helpful in facilitating change: "I shared that with my supervisor … If she notices that I'm kind of getting stuck and I have not noticed it, then she can support me with noticing that." (P6). All apprentices also noted some change to their personal lives: "For me it's never that isolated experience … I tried to think about how I can use it kind of across the board, so I've done that personally and professionally" (P4).

DISCUSSION

This study has evaluated, using a mixed methods approach, the effectiveness of PRs for apprentice CAPs, focusing on whether this brief intervention was helpful in terms of improving reflective capacity and professional quality of life. There was a mismatch between the qualitive and the quantitative outcomes in that the qualitative results in the main were positive, but this was not reflected in any

broad quantitative changes. Quantitative change at an individual level suggests that PRs are effective for some apprentices and less effective for others. It may be the case that the measures used here were poorly selected and they were therefore insensitive, and/or the short follow-up time did not effectively capture change. In using the RPQ, there is now evidence across two studies of lack significant changes in reflective capacity pre- and post-intervention at the group level. A possible explanation for these null findings is that reflective capacity of mental health professionals in training are possibly already at a higher level compared to the general population, and closer to the norms of qualified mental health professionals (Priddis & Rogers, 2018). Selection for the apprenticeship and clinical doctorate training courses requires candidates to demonstrate at least some ability to reflect on their own practice, and the PR experience may not have immediately increased this capacity.

There was a significant increase at the group level in general confidence following the PR and 6/12 apprentices had a reliable increase in general confidence. Though not significant at the group level, almost half of the apprentices showed reliable improvements in communication confidence, reduced stress interacting with clients and tolerating uncertainty. Confidence can be overestimated and may not necessarily predict change in practice or clinical competency (Ames & Kammrath, 2004; Hamilton et al., 2021). It is noteworthy that the desire for improvement subscale significantly decreased over time, with almost half of the participants showing reliable deterioration. This may have been a context effect, in that the apprentices were sitting a demanding clinical training and therefore their desire for improvement may have been taxed across multiple spheres. A recent study of practicing psychologists found that higher client related stress was associated with lower confidence, lower certainty, higher desire for improvement, and higher burnout (Sadusky & Spinks, 2022). PRs did not appear to affect professional quality of life and so the findings suggest that a brief PR intervention is unlikely to improve professional quality of life on its own. Effective management of the clinical workload, self-care, having appropriate support, good clinical supervision, and close and supportive teamworking may be of equal importance for improving and maintaining professional quality of life.

The qualitative arm of the mixed methods approach used a "Big Q" qualitative approach to analyse the data and the associated reflexive thematic analysis found five themes and 11 subthemes. These themes mirrored Hamilton et al. (2021) but were analysed more rigorously. On balance, PRs were perceived as a rapid and emotionally challenging process that facilitates a wide range of personal and professional insights. Apprentices attributed the emotional challenge of PR to be related to the need to share personal and historical experiences to make sense of their current work relationships. This is consistent with the PR approach in that professional issues are seen through the lens of early relationships, and the reciprocal roles and associated procedures enacted at work being an expression and reflection of these early relational templates (Catalyse, 2021). This emotional processing was seen to be a necessary aspect by apprentices as it enabled insight. The therapists made it clear at the outset of PR that the apprentice was in control of what and how much they shared and a close eye was kept on levels of emotional processing. The natural demand characteristic of PR is that the more open a professional can be, the more they stand to gain from the experience. Apprentices reflected that increased insight created changes to their clinical practice. Examples of helpful clinical changes included better management of therapeutic ruptures and boundaries with patients. Given the importance of the therapeutic relationship to clinical outcomes (Cameron et al., 2018; Murphy & Hutton, 2018), and more specifically, how therapists manage ruptures (Falkenström et al., 2013), such clinical changes represent important advancements in PPD.

It is worth underlining the ratio of the brevity of the PR approach and the degree of insight that appeared to be enabled. This is achieved via a single brief 2-hr meeting that maps the way the PR participant is likely to re-enact the dynamics of their early relationships with peers, colleagues, and patients. For example, a health professional who had conditionally caring parents, and who had sought to win their approval through high performance and achievement, is likely to re-enact this pattern of striving and unrelenting standards in their workplace relationships. There have been two systematic reviews of the effectiveness of personal therapy during clinical training (Haikal, 2022; Macran & Shapiro, 1998). Both point to the methodological weaknesses in the evidence base, little evidence that personal therapy influences patient outcomes, a raft of common professional and personal benefits akin to those reported here, and some

training therapists reporting negative experiences. Therefore, whilst PRs are clearly not personal therapy and have a clear work focus, they also appear to be working with the same dynamics as a personal therapy during clinical training, albeit working at much greater speed and having a specific focus.

The addition of more follow-ups to a PR (e.g., in addition to the 3-month follow-up in the current project) would not change PRs into a personal therapy and might be useful in further supporting change. The CAT model, regardless of the duration of the therapy (i.e., 8, 16, or 24 sessions), all contain a follow-up, and the number of follow-ups increases as the treatment session duration increases. The 8-session model has a single 1-month follow-up, the 16-session model has a single 3-month follow-up, and the 24-session model has four follow-up sessions (i.e., 1-, 2-, 3-month, and final 6-month follow-up). Follow-up sessions are focal to reviewing the therapy and revisiting the narrative and diagrammatic reformulations (and the exits) and are therefore not additional therapy sessions that work on new material. Like any psychological intervention, PR carries a risk of potential harm (Parry et al., 2016). A PR might also be the context in which the professional receiving the brief intervention realizes that there is a need for more support and therefore a need to engage in a longer personal therapy. In a training context, it would be inappropriate to use PRs as a stepped-care approach to then allocating to personal therapy.

Practical implications

The following four recommendations are considered for PRs in training contexts. Firstly, recipients of PRs should be explicitly informed that having a PR involves the discussion of personal and historical experiences including the possible associated advantages and disadvantages of this. This would ensure that recipients are able to make a more informed decision about what they share during a PR and whether they want to engage (BPS, 2021). There was an information session about the project prior to the PRs taking place but this appears to have been insufficient. Secondly, whilst PRs were delivered "per protocol", the apprentices experienced the process as quite rushed. Having a longer session or multiple sessions to develop an SDR may enable training recipients to reflect more deeply, as well as feeling more emotionally contained. Adding to the numbers of sessions, however, risks turning PR into CAT, and then becoming a training therapy. The brevity of PR places a boundary around the emotional depth of processing, so a longer or more sessions risks continuation, without the proper safeguards of a training therapy. Thirdly, training recipients may benefit from having a PR in person, as having a PR online made it more difficult at times to discuss aspects of personal life and history. Finally, the PR itself might be placed later in training programmes, as this would enable more experience of work relationships and clinical dilemmas to have occurred.

Limitations

The lack of comparison or control group meant that was impossible to firmly conclude whether any changes over time were specific to PR. The sample size was small due to limited number of apprentices on the CAP course and dropout during the study. The demographic information collected from participants was limited. The length of follow-up was short. All but one apprentice who took part in the interviewing aspect were women. Although apprentices identified subsequent changes to their clinical practice, it cannot be known from this evaluation how these changes were experienced by the clients and whether changes influenced clinical outcomes (Haikal, 2022).

CONCLUSIONS

Training in a psychological profession demands personal awareness, relational insight, openness to learning, and a large reflective capacity. This project was therefore conducted to assess whether PR was

useful in facilitating the PPD of apprentice CAPs. The CAP role has been identified as challenging due to the clinical complexity with which CAPs are expected to work (Psychological Professions Network, 2018) and the position itself, which comes with a degree of role uncertainty. The gains observed in relation to increased insight provide initial evidence that PRs can facilitate PPD and be a component in how PPD is supported during clinical training. Apprentices experienced the PR as helpful in the main and described that the PR led to changes in perspective, coping skills, and clinical approaches. The quantitative results were far less convincing, but PRs do appear to increase confidence. This study provides some preliminary support that PR could be incorporated into the training of psychological professionals. Whilst PRs are not designed to replicate personal therapy, the brevity of PR is appealing, as it is less demanding of time and funding than personal therapy and no other model has an approach to personal learning that is so focal and brief. Future studies should consider selecting different more sensitive and fit-for-context outcome measures. More controlled research would be welcome, and it may be possible to conduct a waitlist randomized control trial as the next step in building an evidence base for PRs. This would mirror the burgeoning evidence base for CAT in terms of its adaptability (Ryle et al., 2014), efficacy (Hallam et al., 2021), and acceptability (Simmonds-Buckley et al., 2022). Future implementation efforts would also be welcome in enabling and evaluating PRs in wider professional groups, such as during psychiatric training or the training of NHS Talking Therapies staff.

AUTHOR CONTRIBUTIONS

SK: grant funding, methodology, project administration, ethics and write up. KB: qualitative analysis. SKAY: quantitative analysis. VT: project administration. GP: project administration, methodology and writing.

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

The data and the analysis are available from the corresponding author on request.

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