

Research Paper

## Childhood Experiences, Recent Traumatic Experiences and Meta-cognition as Correlates and Predictors of Passive-aggressive Behaviour among Clinical Psychology Trainees of India

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### ABSTRACT

**Background:** Passive-aggressive behaviour, categorised as an immature defense mechanism, has long been studied in researches related to workplace, due to its negative impact on overall work environment and work productivity. It has been defined as *a pattern of passive hostility and an avoidance of direct communication* (Schanz, et. al., 2021), and is divided into two types as per research: others-directed, and self-directed. The development of such defense systems is often influenced by traumatic or negative experiences in childhood, recent daily stressful events considered as traumatic, and is often regulated by benevolent experiences in childhood and development of adaptive meta-cognitive abilities or functions. This study focuses on clinical psychology trainees, who are dealing with individuals experiencing mental health issues and illnesses. They undergo rigorous and demanding training course which requires them to constantly shift roles: as a student, a researcher, or a therapist; this causes high amounts to stress in them often considered as traumatic in nature. Thus, engaged in mental health care profession, it is important to study the above-mentioned factors in the development, maintenance or regulation of passive-aggressive behavior. **Method:** Purposive and snowball sampling methods were used to select a total of 107 participants from various RCI recognized institutions across India conducting MPhil, PsyD and PD in Clinical Psychology courses across India. **Results:** Correlation and multiple regression analysis revealed a significant positive correlations and significant predictions between childhood traumatic experiences and recent traumatic experiences with passive aggressive behaviour. Meta-cognition and Benevolent childhood experiences revealed significant negative correlation with passive aggressive behaviour. Gender differences analyzed via Mann Whitney U rank sum test revealed that Male trainees engaged in passive-aggressive behaviour, especially self-directed passive aggressive behaviour more significantly than female trainees. **Conclusions:** The use of passive-aggressive behaviour was more significantly prevalent in the male clinical psychology trainees than female trainees; and both childhood and recent traumatic experiences were found to be positively influencing the same,

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and benevolent childhood experiences and meta-cognitive functions were found to be regulating the behaviour.

**Keywords:** *Passive-Aggressive Behaviour, Meta-Cognition, Childhood Traumatic Experiences, Childhood Positive Experiences, Recent Traumatic Events, Clinical Psychology Trainees*

The mental health of individuals who belong to the mental health field, is of utmost importance as they regularly deal with individuals having various mental health issues or illnesses. It is imperative to understand and explore the mental health and functioning of clinical psychology trainees, who are under training and learning how to treat individuals having mental health issues. Previous researches suggest that, being trainees, they are more vulnerable to developing secondary trauma symptoms or are vulnerable to experience more serious psychopathological effects due to the extreme demands and stress of their training courses. Therefore, it is essential to study the coping and defense pattern of such trainees, especially immature defense style like, passive-aggressive behaviour and its domains: self-directed passive aggressive behaviour, and others-directed passive aggressive behaviour, and factors such as, recent events which are considered traumatic in nature, a history of childhood trauma which might be influencing the development of such immature defense systems. Positive factors like, benevolent childhood experiences and meta-cognition must also be explored in research in relation to passive-aggressive behaviour and its domains, to explore their regulating effects on the same.

**Passive Aggressive behaviour.** Passive Aggressive behaviour has been defined as “a pattern of passive hostility and an avoidance of direct communication” (Whitman, 2017), characterised by *harmful inactivity and omission of active engagement* (Schanz, et. al., 2021). Passive-aggressive behaviour is considered as an ingrained defensive behaviour that was learned during and throughout childhood. As children, they repeatedly went through negative early life experiences and thus tend to have an ingrained passive way of conflict resolution and anger expression, leading to such behaviour patterns in their adulthood (Long & Whitson, 2017; Meyers, 2022; Webb, 2016). This behaviour has often been associated with decreased productivity, lower employee morale, broken deadlines, and miscommunication (Stohl & Cheney, 2001). *Others-directed passive-aggressive behaviour* which has mainly originated from psychodynamic research into defense mechanisms. Passive-aggression has always been defined as an immature defense mechanism and it has often been found in researches that immature defense mechanisms are being associated with childhood trauma or neglect (Nickel and Egle, 2006; Romans et. al., 1999). *Self-directed passive-aggressive behaviour*, which is also referred to as self-harm by omission (Turp, 2007), which is mainly focused on self-control processes in depressive disorders (Rehm, 1977). This often leads to lower levels of self-reward and higher levels of self-punishment.

**Childhood experiences.** Researches conducted in the last few years have demonstrated that, both positive and negative experiences in the childhood shapes personality development, development of behaviour patterns and overall health, throughout the life span (Hoppen et. al., 2018; Lanb & Lerner, 2015; Masten & Barnes, 2018). *Benevolent Childhood Experiences* refer to the positive experiences that have occurred before the age of 18, as the child is growing, exposure and presence of safe, reliable, nurturing relationships and environment are important for development of adaptive coping and behavioural patterns in the adulthood (Sege & Browne, 2017). *Childhood traumatic Experiences* refers to a series of harmful experiences that have occurred before 18 years of age (Merrick et. al., 2018). Children who

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are exposed to these experiences repeatedly, e.g., absence of a safe environment or caregivers, are at risk of developing maladaptive behaviour or coping patterns in adulthood (Boyce, 2019; Essex, 2013; Jones, Greenberg & Crowley, 2015). Some studies focused on the effect of early neglect on development of aggression. A traumatic event is usually characterised by a frightening event and is perceived as dangerous or violent, which usually poses a threat to child's life and overall wellbeing. Due to lack of understanding of adaptive coping methods to process and regulate these emotions, they often try to suppress these feelings which leads to development of an immature defense mechanism. These learned immature defense systems, such as passive-aggressive behaviour later is produced as unhelpful and maladaptive behaviour patterns as adults. This often has significant negative social impact and often leads to social isolation and poor interpersonal relationships (Elliot, 2022). However, there is still a lack of studies exploring the direct effects of various childhood experiences in the development of passive-aggressive behaviour.

**Recent Traumatic experiences.** Recent traumatic events include major upheavals in life, such as, death of a family member or a close friend, separation from spouse or partner, any major illness or sickness, any change in workplace, that has happened within the last 3 years.

**Meta-cognition.** is an umbrella term that is used to define the abilities to understand and reflect one's own or other's various internal mental states, and therefore build an intricate depiction of self and others which includes all components of human experience, desires, emotions, intentions and behaviour (Carcione, 2010; Candini, 2018; Dimaggio et. al., Gumley, 2011; Semerari et. al., 2012). The concept of meta-cognition is often used to describe how such depictions of oneself and others' internal mental states guide an individual's behaviour and actions, especially in stressful situations. Although there is limited research, evidence shows that impaired meta-cognitive functions is often related to aggression (Abu-Akel, 2004; Bo, et. al., 2015; Fonagy, 2004). An impairment in the development of these abilities since childhood, might lead to maladaptive management of emotions, stressful situations, social skills and might harm interpersonal relationships, and might end up risking aggression related behaviours as a conflict resolution strategy. It has been seen that individuals who possess passive-aggressive traits, might show emotionally-unstable features, complain frequently and are more likely to express aggression in an indirect manner, followed by expressions of regret (Craig, 2003).

**Clinical Psychology trainees.** A student, referred to as a 'trainee', who is currently enrolled in a professional course that includes extensive first-hand training in dealing with people with mental illnesses. These trainees constantly go through the challenging demands and stresses of their training courses. They usually spend long hours dealing with people with various mental health issues and illness and deal with impactful emotional material of their clients. Along with this, they are required to constantly switch roles: as a student, as a researcher and as a therapist, which leads to great deal of stress and burnout on a daily basis and might be considered traumatic in nature (Adams & Riggs, 2008). Thus, a main objective of the study was formulated:

To assess the role of childhood traumatic experiences (CTE), Benevolent Childhood Experiences (BCE), Recent Traumatic Experiences (RTE) and Meta-cognition in passive-aggressive behaviour, as well as its two domains: Self-directed passive aggressive behaviour (SDPA) and others-directed passive aggressive behaviour (ODPA) among clinical psychology trainees.

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**Author Note:** This is an original work by the authors. The ethical approval was sought from the ethics committee board, as well as the Departmental Research committee (DRC) of Amity Institute of Behavioural (Health) and Allied Sciences (AIBHAS), Amity University, Uttar Pradesh, Noida, India. Necessary permissions required for using the tools were adequately obtained from the developers of the respective tools. All participants were briefed about the study and they participated in the study after informed consent was sought. Appropriate consent from authors of the questionnaires/tools used for the study was sought. No funding from external sources was granted by any authorities.

### **MATERIALS AND METHOD**

**Sample.** This study was conducted on a total of 107 participants via Hybrid mode: face-to-face interaction with clinical psychology trainees and Google forms (online) sent to participants via e-mail or social media platforms (LinkedIn). The participants belonged from various institutions offering PsyD/MPhil/PDCP in Clinical Psychology, regulated by the Rehabilitation council of India (RCI: <https://rehabcouncil.nic.in/>), across India. The data was collected through Purposive and snowball sampling methods. Inclusion criteria was, trainees who were currently enrolled in PsyD/MPhil/PDCP in clinical psychology courses regulated by the Rehabilitation council of India (RCI). Exclusion criteria was, Trainees enrolled in non-clinical psychology RCI courses.

**Study design.** A single group cross-sectional study design.

#### **Variables:**

##### **Independent variables:**

- Childhood traumatic experiences.
- Recent traumatic experiences.
- Benevolent Childhood experiences.
- Meta-cognition.

##### **Dependent variables:**

- Passive aggressive behaviour- self-directed and others-directed.

#### **Study tools**

**Background information.** A Personal Information sheet, which is a semi-structured socio-demographic performa, was prepared and administered to record relevant participant information such as, name, sex, age, marital status, current RCI course enrolled into, and duration of training. Appropriate categories were inserted and participants were required to select the most applicable one to them.

**Childhood Traumatic events and Recent Traumatic Events.** The Childhood Traumatic Events Scale (CTES) and the Recent Traumatic Events Scale (RTES) by Pennebaker & Susman, (1988) is commonly used, to assess the presence and impact of traumatic events in life. The CTES was used to assess childhood traumatic events that occurred prior to the age of 17. Domains included: death of a family member or a very close friend, parental divorce or separation, traumatic sexual experience (e.g., raped, molested), victim of violence (e.g., child abuse, mugged or assaulted), been extremely ill or injured, and other major upheavals during childhood. The RTES assesses the same domains as CTES with certain exceptions: the timeframe of the traumatic event is within the last 3 years; parental separation was

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replaced with separation/ divorce from a spouse or significant other, and a new category of job change is added. The CTES and RTEs use rating scales to assess the severity of trauma perceived by the participants. Each domain is scored from 0 to 7, 0=no exposure, 1=not at all traumatic, 4=somewhat traumatic, 7=extremely traumatic. The ratings on each of the 6 domains on the CTES to gives a score of total childhood traumatic burden that ranged from 0 to 42 (6 domains, rating up to 7 for each domain). Similarly, the recent traumatic burden was derived from ratings on the RTEs. The CTES and the RTEs have been found to have good reliability and validity (Pennebaker & Susman, 1988. Due to the binary nature of event reporting, Cronbach's alpha was not calculated.

**Passive-aggressive behaviour.** The Test of Passive Aggression (TPA) by Schanz, et. al. (2021) assesses two types of passive-aggression: self-directed passive aggression, and others-directed passive aggression, it consists a total of 24 items divided into 12 items for SDPA and 12 items for ODPA, responses are collected in a 5-point Likert scale ranging from 1= very unlikely to 5= very likely. Scores of the self-directed and other-directed passive aggression scales are calculated by averaging the item scores of the respective scale. For this purpose, the sum score of the items of the respective scale is divided by the number of items answered on this scale. The TPA scales show good to excellent internal consistency using Cronbach's alpha ( $\alpha = 0.83- 0.90$ ) with a strong 4-week retest reliability ( $r_{tt} = 0.86$ ).

**Benevolent Childhood Experiences.** The Benevolent Childhood Experiences Scale (BCEs) by Narayan, Ghosh, Ippen et al., (2015) is a 10-item checklist of positive experiences between ages 0–18 years of life. Items pertained to perceived relational and internal safety and security (e.g., at least one safe caregiver, beliefs that gave comfort), positive and predictable quality of life (e.g., liking for school, predictable home routine like, meals and bedtime), and interpersonal support (e.g., a supportive teacher, a caring non-caregiver adult). Positively reported items produced a total BCEs score. The BCE scale has demonstrated high test-retest reliability,  $r = 0.80$ ,  $p < 0.01$ , good cultural sensitivity and generalizability, and good predictive validity (Narayan et. al., 2018). Positively endorsed items were summed for a total BCEs score ( $M = 8.70$ ,  $SD = 1.68$ , range = 1–10), in which higher numbers reflect more positive childhood experiences.

**Meta-cognition.** The Meta-cognition self-assessment scale (MSAS) by Pedone et. al., (2018), is composed of 18 items and was built as a self-report scale. The MSAS scale was developed based on the Metacognitive Multi-Function Model (MMFM) (Faustino et al., 2019; Pedone et al, 2017 & Semerari et al. 2003). It was developed to assess five metacognitive functions, or abilities: 1) Monitoring; 2) Differentiation; 3) Integration; 4) Decentration and 5) Mastery. The scale is scored using a five-point Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = frequently, 5 = almost always), which produces a raw score range of 18 to 90. High scores on the scales indicate better evaluation of metacognitive abilities than low scores. Scores from the five subscales (all items) are summed to give a total score that represents the individual's overall level of metacognitive functioning. The MSAS showed strong internal consistency, Cronbach's alpha ranged between 0.72 and 0.87 for all MSAS subscales and for overall metacognitive function as measured by total MSAS score, exceeding the 0.70 criterion (Clark 1995, Kline 1998, Netemeyer et al. 2004, Ullman 1996). In this study, MSAS Global scores were used to measure overall meta-cognitive functioning of the participants.

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**Data Analysis.** The data were analysed using Statistical Package for Social Sciences (SPSS) version 29. Appropriate descriptive (mean, SD, range and frequency) and inferential (correlation and multiple regression) statistics were utilized to analyse the data. The significance level was set at a two-tailed 5%, and all p-values less than 0.05 were selected as the desired level of statistical significance. Multiple regression analysis was done among the variables to establish predictive relationships among them. Non-parametric statistics (Mann-Whitney U test) was carried out to find the mean difference between the two Gender groups (Females and Males).

### RESULTS

**Descriptive data.** Female clinical psychology trainees were significantly more, representing the majority of the sample (92.5 %), while Male clinical psychology trainees consisted of 7.5% of the sample. The mean age of male and female clinical psychology trainees combined was calculated to be 25.79 years. The age of the participants in this study ranged from 23 years to 29 years, with maximum number of participants were aged 26 years (22.9% of the sample). **Table 1** demonstrates the socio-demographic profile of the study sample.

*Table 1. Socio-demographic profile of the study sample (N=107)*

SAMPLE CHARACTERISTICS	N	%	Mean (SD)
<u>Age</u>			25.79 (1.68)
23	11	10.1	
24	15	13.8	
25	21	19.3	
26	25	22.9	
27	15	13.8	
28	14	12.8	
29	6	5.5	
<u>Gender</u>			
Female	99	92.5	
Male	8	7.5	
Others	0	0	
<u>RCI course currently pursuing</u>			
MPhil	85	79.4	
PsyD	11	10.3	
PDCP	11	10.3	

**Gender differences.** This study also aimed to explore whether there is a mean difference between the two genders of the sample (i.e., Male and Female) and passive-aggressive behaviour and its domains, as well as its domains: self-directed passive-aggressive behaviour (SDPA), and others-directed passive-aggressive behaviour (ODPA), using a two-tailed Mann-Whitney U rank-sum test. This non-parametric test was carried out because the gender of the participants were not normally distributed in this current study; there were 99 observations in Group A (Female) and 8 observations in Group B (Male). The results revealed a significant mean rank difference between Females and Males in Passive-aggressive behaviour, with mean rank of Female trainees being 51.81, and the mean rank of Male trainees 81.06,  $p = .010^{**}$ , significant at  $<0.01$  level. Similar findings were found for SDPA, where the mean rank of female trainees was 51.56; whereas for Male trainees the



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mean rank was 82.25,  $p = .004^{**}$  significant at  $<0.01$  level. However, the mean rank difference between both the genders (Male and female) trainees were not statistically significant for others-directed passive aggressive behaviour (ODPA), where the mean rank of Female trainees was 53.61; and the mean rank of Male trainees was 58.88. Hence it can be summarized from these above-mentioned findings that, in this current study, Male trainees reported engaging in passive aggressive behaviour and self-directed passive aggressive behaviour more significantly than female trainees.

**Relationship of childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with passive aggressive behaviour.** This relationship was studied using bivariate Pearson correlation analysis.

The findings (Table 2) suggested:

- Childhood traumatic experiences (CTE) is significantly positively correlated with passive-aggressive behaviour,  $p = .280^{**}$ , which signifies that increase in CTE led to a significant increase in Passive-aggressive behaviour among clinical psychology trainees.
- Benevolent childhood experiences (BCE) is significantly negatively correlated with passive-aggressive behaviour,  $p = -.235^*$ , which signifies that increase in BCE led to a significant decrease in Passive-aggressive behaviour among clinical psychology trainees.
- Recent traumatic experiences (RTE) is significantly positively correlated with passive-aggressive behaviour,  $p = .344^{**}$ , which signifies that increase in RTE led to a significant increase in Passive-aggressive behaviour among clinical psychology trainees.
- Meta-cognition is negatively correlated with passive-aggressive behaviour,  $p = -.117$ , however the  $p$  value is not statistically significant which signified that increase in Meta-cognition did lead to decrease in passive-aggressive behaviour, however, the amount of decrease is not statistically significant.

**Table 2. Correlation matrix and descriptive statistics of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with passive aggressive behaviour.**

VARIABLE	M	SD	CTE	BCE	RTE	Meta-cognition	PA
CTE	8.44	7.41	1				
BCE	7.58	2.62	-	1			
RTE	8.19	7.43	-	-	1		
Meta-cognition	67.46	8.56	-	-	-	1	
PA	4.94	1.23	<b>.280**</b>	<b>-.235*</b>	<b>.344**</b>	-.117	1

\*Correlation is significant at the 0.05 level (2-tailed).

\*\*Correlation is significant at the 0.01 level (2-tailed).

CTE: Childhood traumatic experiences;

BCE: Benevolent Childhood Experiences;

RTE: Recent Traumatic Experiences;

PA: Passive-aggressive behaviour.

Note: Empty cells indicate values not relevant for this current study.

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**Relationship of CTE, BCE, RTE and meta-cognition, and domains of Passive-aggressive behaviour.** A relationship of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with the two domains of passive aggressive behaviour, Self-directed passive aggressive behaviour (SDPA); and Others-directed passive aggressive behaviour (ODPA) was studied using bivariate Pearson correlation analysis.

The findings (**Table 3**) suggested:

- Childhood traumatic experiences (CTE) is significantly positively correlated with self-directed passive-aggressive behaviour (SDPA),  $p = .399^{**}$ , which signifies that increase in CTE led to a significant increase in SDPA. Childhood traumatic experiences (CTE) is significantly positively correlated with others-directed passive-aggressive behaviour (ODPA),  $p = .225^*$ , which signifies that increase in CTE led to a significant increase in ODPa among clinical psychology trainees.
- Benevolent childhood experiences (BCE) is significantly negatively correlated with self-directed passive-aggressive behaviour (SDPA),  $p = -.210^{**}$ , which signifies that increase in BCE led to a significant decrease in SDPA. Benevolent childhood experiences (BCE) is significantly negatively correlated with others-directed passive-aggressive behaviour (ODPA),  $p = -.240^*$ , which signifies that increase in BCE led to a significant decrease in ODPa among clinical psychology trainees.
- Recent traumatic experiences (RTE) is significantly positively correlated with self-directed passive-aggressive behaviour (SDPA),  $p = .435^{**}$ , which signifies that increase in RTE led to a significant increase in SDPA. Recent traumatic experiences (RTE) is significantly positively correlated with others-directed passive-aggressive behaviour (ODPA),  $p = .312^{**}$ , which signifies that increase in RTE led to a significant increase in ODPa among clinical psychology trainees.
- Meta-cognition is positively correlated with self-directed passive-aggressive behaviour (SDPA),  $p = .060$ , however the p value is not statistically significant. Meta-cognition is negatively correlated with others-directed passive-aggressive behaviour (ODPA),  $p = -.107$ , however the p value is not statistically significant.

**Table 3. Correlation matrix and descriptive statistics of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with the two domains of passive aggressive behaviour: self-directed passive aggressive behaviour (SDPA) and others-directed passive aggressive behaviour (ODPA)**

VARIABLE	M	SD	CTE	BCE	RTE	Meta-cognition	SDPA	ODPA
CTE	8.44	7.41	1					
BCE	7.58	2.62	-	1				
RTE	8.19	7.43	-	-	1			
Meta-cognition	67.46	8.56	-	-	-	1		
SDPA	2.54	.697	<b>.399**</b>	<b>-.210**</b>	<b>.435**</b>	.060	1	
ODPA	2.41	.745	<b>.225*</b>	<b>-.240*</b>	<b>.312**</b>	-.107	-	1

\*Correlation is significant at the 0.05 level (2-tailed).

\*\*Correlation is significant at the 0.01 level (2-tailed).

CTE: Childhood traumatic experiences;



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*BCE: Benevolent Childhood Experiences;*

*RTE: Recent Traumatic Experiences;*

*SDPA: Self-directed passive-aggressive behaviour*

*ODPA: Others-directed passive-aggressive behaviour.*

*Note: Empty cells indicate values not relevant for this current study.*

**Prediction of Passive-aggressive behaviour.** This study also explored a predictive relationship between of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with passive aggressive behaviour was studied using multivariate regression analysis. In **Table 4**, The overall regression model fit was found to be significant ( $p = .001^{**}$ ) with an overall  $R^2$  change of .157, which signifies that the predictor variables (CTE, RTE, BCE and meta-cognition) amounted for 15.7% change in the dependent variable, i.e., passive-aggressive behaviour. Individually, all the predictor variables, i.e., childhood traumatic experiences (CTE); benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition amounted for significant changes in the dependent variable, i.e., Passive-aggressive behaviour. CTE significantly predicted 7.8% change in passive-aggressive behaviour; RTE significantly predicted 11.8% change in passive-aggressive behaviour; BCE amounted for a total of .055, i.e., 5.5% change in passive-aggressive behaviour; and Meta-cognition amounted for a total of .014, i.e., 1.4% change in passive-aggressive behaviour. The regression coefficients presented in Table 4 suggests that, CTE predicted a statistically significant change in the effect size of the dependent variable, i.e., passive-aggressive behaviour ( $p = .003^{**}$ ), RTE predicted a statistically significant change in the effect size of the dependent variable, i.e., passive-aggressive behaviour ( $p = 0.02^*$ ). The other predictor variables (BCE and Meta-cognition) did predict a change in PA, however, it is not statistically significant.

**Table 4. Regression Coefficients of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with passive aggressive behaviour.**

VARIABLES	R <sup>2</sup>	B	95% CI	b	t	p
CTE - PA	.078	.047	[.016, .077]	.280	2.99	.003**
RTE - PA	.118	.040	[.006, .073]	.239	2.32	.022*
BCE - PA	.055	-.051	[-.143, .041]	-.108	-1.10	.274
Metacognition - PA	.014	-.008	[-.035, .019]	-.005	-.588	.558

$df = 4$ ;  $R^2 = .157$ ;  $F = 4.76$

\*p value is significant at 0.05 level.

CTE: Childhood Traumatic Experiences;

RTE: Recent Traumatic Experiences;

BCE: Benevolent Childhood Experiences;

PA: Passive-aggressive behaviour.

**Prediction of Self-directed passive-aggressive behaviour (SDPA).** A predictive relationship between of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with a domain of passive aggressive behaviour, i.e., Self-directed passive-aggressive behaviour (SDPA) was studied using multiple regression analysis. In **Table 5**, overall regression model fit was found to be significant ( $p < .001^{**}$ ) with an overall  $R^2$  change of .266, which signifies that the predictor variables (CTE, RTE, BCE and meta-cognition) amounted for 26.6% change in the domain of passive-aggressive behaviour,

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i.e., self-directed passive-aggressive behaviour (SDPA). Individually, all the predictor variables, i.e., childhood traumatic experiences (CTE); benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition amounted for significant changes in Self-directed passive-aggressive behaviour (SDPA). CTE significantly predicted 15.9% change in Self-directed passive-aggressive behaviour; RTE significantly predicted 18.9% change in self-directed passive-aggressive behaviour; BCE amounted for a total of .044, i.e., 4.4% negative change in self-directed passive-aggressive behaviour; and Meta-cognition predicted a change of .006, i.e., 0.6% change in self-directed passive-aggressive behaviour. The regression coefficients presented in Table 5 suggests that, both CTE and RTE predicted a statistically significant change in the effect size of the SDPA; CTE predicted a statistically significant change in the effect size of the SDPA ( $p = .007^{**}$ ). RTE predicted a statistically significant change in the effect size of the SDPA ( $p = .001^{**}$ ). The other predictor variables (BCE and Meta-cognition) did predict a change in SDPA, however, it is not statistically significant.

**Table 5. Regression Coefficients of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with domain of passive-aggressive behaviour: self-directed passive-aggressive behaviour (SDPA)**

VARIABLES	R <sup>2</sup>	B	95% CI	b	t	p
CTE - SDPA	.159	.024	[.007, .041]	.256	2.73	.007**
RTE - SDPA	.189	.030	[.013, .048]	.325	3.38	.001**
BCE - SDPA	.044	-.019	[-.068, .029]	-.073	-0.78	.432
Metacognition SDPA	– .006	.011	[-.003, .025]	.130	1.49	.139

$dF = 4$ ;  $R^2 = .266$ ;  $F = 9.26$

\*\* $p$  value is significant at 0.01 level.

CTE: Childhood Traumatic Experiences;

RTE: Recent Traumatic Experiences;

BCE: Benevolent Childhood Experiences;

SDPA: self-directed passive-aggressive behaviour.

**Prediction of Others-directed passive-aggressive behaviour (ODPA).** A predictive relationship between of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with another domain of passive aggressive behaviour, i.e., Others-directed passive-aggressive behaviour (ODPA) was studied using multiple regression analysis. In **Table 6**, overall regression model fit was found to be significant ( $p = .007^{**}$ ) with an overall  $R^2$  change of .129, which signifies that the predictor variables (CTE, RTE, BCE and meta-cognition) amounted for 12.9% change in the domain of passive-aggressive behaviour, i.e., others-directed passive-aggressive behaviour (ODPA). Individually, all the predictor variables, i.e., childhood traumatic experiences (CTE); benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition amounted for significant changes in Others-directed passive-aggressive behaviour (ODPA). CTE significantly predicted 5.1% change in others-directed passive-aggressive behaviour; RTE significantly predicted 9.7% change in others-directed passive-aggressive behaviour; BCE amounted for a total of .058, i.e., 5.8% negative change in others-directed passive-aggressive behaviour; and Meta-cognition predicted a negative change of .011, i.e., 1.1% change in others-directed passive-aggressive behaviour. The regression coefficients presented in Table 6 suggests that, CTE predicted a statistically significant change in the effect size of others-

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directed passive aggressive behaviour ( $p= 0.020^*$ ). RTE predicted a statistically significant change in the effect size of others-directed passive aggressive behaviour ( $p= 0.037^*$ ). The other predictor variables (BCE and Meta-cognition) did predict a change in ODPa, however, it is not statistically significant.

**Table 6. Regression Coefficients of Childhood Experiences, both childhood traumatic experiences (CTE), and benevolent childhood experiences (BCE); recent traumatic experiences (RTE); and meta-cognition, with domain of passive-aggressive behaviour: others-directed passive-aggressive behaviour (ODPA)**

VARIABLES	R <sup>2</sup>	B	95% CI	b	t	p
CTE - ODPa	.051	.023	[.004, .042]	.225	2.36	<b>.020*</b>
RTE - ODPa	.097	.022	[.001, .043]	.222	2.11	<b>.037*</b>
BCE - ODPa	.058	-.038	[-.095, .018]	-.134	-1.33	.183
Metacognition	.011	-.004	[-.020, .013]	-.044	-.462	.645

$dF= 4; R^2= .129; F= 3.77$

\*p value is significant at 0.05 level.

CTE: Childhood Traumatic Experiences;

RTE: Recent Traumatic Experiences;

BCE: Benevolent Childhood Experiences;

ODPA: others-directed passive-aggressive behaviour.

## DISCUSSION

The role of childhood experiences has been widely researched in the context of aggression, however, very few studies have focused on its role on passive-aggressive behaviour. Our study focused on both traumatic experiences (CTE) and benevolent experiences (BCE) faced during childhood and it correlates with and predicts passive aggressive behaviour, as well as its two domains: self-directed (SDPA) and others directed passive aggressive behaviour (ODPA). It was revealed in our results that, increase in CTE led to a significant increase in PA, as well as SDPA and ODPa. CTE also significantly predicted PA, SDPA and ODPa. Increase in BCE led to a significant decrease in PA, SDPA and ODPa. This signified that, individuals with higher traumatic experiences in childhood engaged in higher use of PA; individuals with higher levels of benevolent/positive childhood experiences reported lower levels of PA. Passive-aggressive behaviour has often been categorized as an immature defense mechanism and has often been associated with childhood trauma and neglect (Nickel and Egle, 2006). Authoritarian and dominating style of parenting has often been associated with indirect and passive expressions of anger. As a result, their children repeatedly went through negative early life experiences and thus tend to develop an ingrained passive way of conflict resolution and anger expression, leading to such behaviour patterns in their adulthood (Long & Whitson, 2017; Meyers, 2022; Webb, 2016). Along with parenting, various other childhood traumatic experiences, such as, physical or sexual assault, separation or divorce of parents, death of a close friend or family member, or being a victim of violence was often linked with the development of maladaptive defense styles, in the absence of any positive or benevolent childhood experiences, which is corroborating with the findings of this study where participants who reported such kind of traumatic experiences in childhood had increased levels of passive aggressive behaviour. This particular finding can be explained by a study conducted by Lovejoy (2020) where he suggested that, when children go through traumatic experiences regularly, it impairs their ability to process emotions accurately, ultimately leading to frequent use of maladaptive ways of coping and defense style when dealing with uncomfortable emotions. The role of

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Recent traumatic experiences (RTE) on passive aggressive behaviour and its domains was also explored in this study. RTE was found to be significantly positively correlated with PA and its domains: SDPA and ODPA. RTE was also found to be a significant predictor of PA, SDPA and ODPA. This signifies that increased level of recent events in life which has been perceived as traumatic, is leading to an increased use of passive-aggressive behaviour as a way of coping with these situations in this particular sample. Researches till now, have extensively focused on the amount of stress that a clinical psychology trainee goes through on a regular basis (Adam & Riggs, 2008; Cushway, 1992; Hannigan, 2009; Pankenhams & Brown, 2012; Pica, 1998). Jenaro, Flores & Arias (2007) suggested that, the extent to which a training event (such as the trainee's first interview with a client or even the process of admission into such courses) is often a stressful event for a trainee, and is determined by the characteristics of that particular situation, and three specific cognitive, behavioural and interpersonal processes, i.e., appraisal of the event, available coping resources and coping strategies. Other stressors such as, ambiguity, which includes dealing with complicated clinical presentations, various ethical dilemmas, etc. (Pica, 1998); along with this, the reality of clinical training and conducting therapy sessions which often lacks 'glamorised expectations' (Skovholt & Ronnestad, 2003); general fear of evaluation (Schwartz-Mette, 2009; Skovholt, Ronnestad & Jennings, 1997); time constraints, long training hours, and having to constantly switch between roles, for example, attending lectures, to doing researches, and also being a therapist (Cahir & Morris, 1991; Schwartz-Mette, 2009) often leads to professional self-doubt (Cushway, 1992; Cushway & Tyler, 1994) and has negative effects on the trainee's personal as well as, professional functioning (Kumary & Baker, 2008; Szymanska, 2002). Various researches have focused on the impact of trainees engaging in work with various individuals dealing with mental health issues and illnesses regularly during their training period. Certain studies (Chrestman, 1999; Pearlman & Mac Ian, 1995). Pearlman & Saakvitne (1995) examined the possible risk factors for secondary trauma among clinicians and related it to having a history of trauma in the past, as well as, experience level of the clinician and suggested the lack of formal trauma coursework and the presence of maladaptive defense styles among therapists might create a vulnerability to trauma-related symptomatology. In a study, Adams & Riggs (2008) explored vicarious trauma among therapist trainees and related it to history of trauma, experience level and defense styles of such trainees. Immature defense systems, when they are unconscious in nature, often influence coping strategies and might lead to the therapist feeling uncomfortable in the presence of powerful emotions and might feel inept to deal with such emotions of their clients (Schauben & Frazier, 1995; Weeks, 2000).

We also explored the relationship between meta-cognition and passive-aggressive behaviour and its domains. The findings suggested that meta-cognition led to a decrease in passive-aggressive behaviour and one of its domains: others-directed passive aggressive behaviour (ODPA), however, these values were not statistically significant. This finding is corroborated with a study conducted by Candini et. al., (2020) where they studied the relationship of meta-cognition with aggressive and violent behaviour and found that meta-cognition did not emerge as having a significant relationship with aggression, although increase in meta-cognition did lead to a decrease in the latter, however not significantly. Thus, this study aimed at exploring a relationship between meta-cognition with passive-aggressive behaviour, and found similar results. Researches conducted by Carcione & Pedone, et. al., (2011); Hengartner et. al., (2013); and Taubner, (2013) suggested that, higher levels of adaptive meta-cognitive abilities that had been developed and influenced by

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childhood experiences and led to adaptation and use of more adaptive and helpful ways of coping with stressful situations throughout life.

However, Meta-cognition was found to be positively correlated with self-directed passive-aggressive behaviour, i.e., increase in meta-cognitive abilities led to an increase in self-directed passive aggressive behaviour; signifying that this relationship might not be linear and various factors that were not revealed in this current study, might be influencing this relationship, in this particular sample. Future studies might focus on this specific relationship in depth and detail for more substantial findings.

### **Limitations**

The gender distribution in this study was not uniform; out of 107 participants, only 8 participants were Male (i.e., 7.5%) of the sample, while 99 participants were female; therefore, non-parametric test (Mann Whitney U Rank-sum test) was used to assess the gender difference in this study. Poor representation of male trainees is pan-India phenomena.

### **Implications**

This study was conducted keeping in mind the mental health of clinical psychology trainees who primarily engage in dealing with individuals having mental health issues and illnesses on a regular basis. It is important to understand past history of trauma in trainees who are experiencing overwhelming levels of daily stressors. Therefore, regular supervision is required to resolve their personal conflicts and dissonances Training seminars might help the students learn about their typical defense style.

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***Conflict of Interest***

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