Wellbeing in Psychological Therapy Trainees

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Thesis Abstract

Psychological Therapy Trainees (PTTs) experience a range of stressors and are vulnerable to high stress, and low wellbeing. The implications of poor wellbeing in this population are significant, with negative consequences for service delivery, workforce sustainability, and practitioner mental health. There is therefore a significant case for better understanding and supporting wellbeing in this population.

The purpose of this thesis was to explore wellbeing in PTTs, and to develop an intervention designed to support it. A mixed-methods approach was used, and findings were integrated in an attempt to provide a comprehensive answer to the questions of the PhD as a whole. Chapter 3 reports a systematic review of psychological interventions to support wellbeing in trainees. Chapter 4 reports a qualitative interview study designed to explore the experience of wellbeing during training in depth. In Chapter 6, the process and outcome of collaborating with stakeholders in the design of a tailored wellbeing intervention are reported. Finally, in Chapter 7, a mixed-methods acceptability and feasibility evaluation of the developed intervention is reported.

Together, findings indicate that interventions designed to support trainee wellbeing are valued by trainees, and can be effective. However, the centrality of connecting with personal values to how trainees described experiencing wellbeing suggests that earlier research focussing exclusively on reducing negative correlates of wellbeing (e.g. stress/anxiety) may have missed important parts of the picture.

Preliminary evidence indicates that the intervention developed here was well-received, and showed signals of efficacy. Next steps should involve a formal pilot study designed to trial the intervention at a larger scale, across multiple sites, and testing the acceptability and feasibility of randomising trainees ahead of a full-scale trial. To understand the potential of the developed intervention to

address core policy goals around staff wellbeing, economic evaluation of the cost-effectiveness of the intervention is also required.

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Lay Summary

Training to work in the psychological professions can be hard, and is often experienced as stressful. For this reason, strategies to support the wellbeing of trainees are needed. Research carried out across this thesis found that a large number of studies describing attempts to support wellbeing have already been published. However, it was often unclear how wellbeing was being thought about in these studies, or how and why the intervention that was being tested was expected to address the actual challenges that trainees commonly face.

A majority of prior studies in this area have focussed on interventions intended to reduce things like stress or anxiety. However, trainees who took part in the current research described wellbeing less as an absence or reduction of stress, and more as the presence of feelings of purpose, and connection to personal values. One important finding of this thesis then was that interventions for trainees should focus on supporting these feelings of connection with personal values, as well as techniques designed to eliminate or reduce 'unpleasant' feelings of stress or anxiety.

In an attempt to design an intervention that would support wellbeing in terms meaningful to trainees themselves, an intervention was developed in collaboration with current trainees and professional training staff. Trainees and staff helped to make decisions about the content of the intervention, when and where it would be delivered, and how it should be advertised. Following the delivery of the intervention, attempts were made to understand how trainees had experienced taking part. The findings of this were positive, and suggest that the intervention has the potential to be useful, and is likely to be welcomed by trainees.

Overall, findings from this research indicate that interventions to support trainee wellbeing can be effective, but that they should be designed in ways that capture how wellbeing is experienced and described by trainees themselves.

Publications and outputs associated with this thesis

Peer-reviewed publications arising from this PhD

- Owen, J., Biggart, L., Fisher, P., Figueredo, A., Al-Rousi, S., Colvin-Jarvis, J., Williamson, E., & Sanderson, K. (2025). What works for psychological interventions designed to increase wellbeing in psychological therapy trainees? A systematic review. *Journal of Mental Health Training, Education and Practice*, *20*(1), 45-60. https://doi.org/10.1108/JMHTEP-01-2024-0009 (This paper forms chapter 3 of this thesis).

- Owen, J., Biggart, L., Fisher, P., Kishita, N., & Sanderson, K. (accepted/in press) 'Developing a psychological wellbeing intervention for psychological therapy trainees: a collaborative and theory-informed intervention development process'. *the Cognitive Behaviour Therapist*. (This paper forms chapter 6 of this thesis).

- Owen, J., Biggart, L., Fisher, P., Kishita, N., & Sanderson, K. (under review – following a first round of review this has recently been invited for resubmission). 'Thriving in training: An acceptability and feasibility study of a tailored Acceptance and Commitment Therapy (ACT) intervention to support trainee psychological practitioner wellbeing'. *Behavioural and Cognitive Psychotherapy*. (This paper forms chapter 7 of this thesis).

Oral Presentations arising from this PhD

- Owen, J. (2023, January). *What works for wellbeing interventions for psychological therapy trainees?* Paper presented at ECR Presents: Projects in Progress, NIHR ARC East of England.

- Owen, J. (2024, July). *Wellbeing in psychological therapy trainees.* Paper presented at the British Association for Behavioural and Cognitive Psychotherapies (BABCP) Conference, Manchester, UK.

- Owen, J. (2024, October). *Supporting the wellbeing of psychological practitioners in training.* Paper presented at the Staff Wellbeing Summit, London. New Savoy Partnership and BPS Division of Clinical Psychology (Leadership and Management Faculty).

Glossary of abbreviations

Abbreviation	Full Term
ACT	Acceptance and Commitment Therapy
BABCP	British Association of Behavioural and Cognitive Psychotherapies
BPS	British Psychological Society
CAP	Clinical Associates in Psychology
CBT	Cognitive Behavioural Therapy
ClinPsyD	Clinical Psychology Doctorate
EMHP	Education Mental Health Practitioner
HIT	High Intensity Therapist
NHS	National Health Service
PWP	Psychological Wellbeing Practitioner
UEA	University of East Anglia

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I would also like to thank all the trainees and colleagues who took part in the research at the heart of this thesis. I'm grateful for what you have given to the research as participants, and for what I've learnt from your input. I hope that your input and the research presented here can go on to benefit those who train in these roles in years to come.

To my partner Karina, I am grateful beyond words for so many things about you. But a special thanks must be given here for the unwavering support and belief you've shown in me, and the willingness you've shown for helping me to complete this PhD. The many evenings and weekends that I have spent sat at my desk have been long, but your encouragement and belief have helped me keep going.

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Introduction

This thesis reports a series of studies and chapters designed to understand wellbeing in Psychological Therapy Trainees (PTTs), to review what is known about trainee wellbeing and interventions designed to improve it, and to test the acceptability and feasibility of a tailored wellbeing intervention for trainees. Below, a brief overview of the contents of each chapter is provided, to help set out the progression of the thesis as a whole, and to orientate the reader to the contents of each individual chapter.

Chapter 1: Background

Chapter 1 sets out the background to the research, providing an overview of the psychological professions in England. A discussion of the workforce, its demographic characteristics, and the ways in which it has evolved in recent years is provided, to give context to the population at the heart of this thesis. Subsequently, the field of Positive Psychology and the literature on the topic of wellbeing are critically reviewed, to situate the academic and research context of the thesis.

Chapter 2: Methods

Chapter 2 provides an overview of the methodological approach used across the PhD as a whole. Whilst each individual paper has its own distinct methodological sections, Chapter 2 aims to consider the PhD as a whole, setting out why particular decisions were taken for each study, and how the methodological approaches used sit together as a cohesive whole.

Chapter 3: Systematic Review

Chapter 3 reports a systematic review conducted to explore what works for wellbeing interventions designed to support trainee wellbeing. The review was undertaken early in the thesis timeline, and was designed to identify and synthesise all available literature on interventions or teaching strategies designed to support trainee wellbeing. Findings reviewed the effectiveness of interventions in the field and the perceived barriers and facilitators of successful interventions. Additionally, the methodological strengths and weaknesses of identified studies were considered. The findings of this review were used to support the planning and design of the intervention constructed later in the PhD. The review was published in *The Journal of Mental Health Training, Education and Practice* https://doi.org/10.1108/JMHTEP-01-2024-0009

Chapter 4: Qualitative interview study

Chapter 4 reports on a qualitative interview study conducted with current psychological therapy trainees across multiple psychological professions. The study was designed to explore the experience of wellbeing in the trainee role, and was intended to help address issues identified in the systematic review regarding how wellbeing should be conceptualised and supported in research in this field. The study used individual, semi-structured interviews to explore how trainees experience wellbeing in their roles. A reflexive form of thematic analysis was used to analyse the data, and findings were presented in relation to the literature on trainee wellbeing, and the wider wellbeing literature more generally.

Chapter 5: Acceptance and Commitment Therapy (ACT) and psychological flexibility

In Chapter 5, Acceptance and Commitment Therapy (ACT) is introduced in detail. The systematic review (reported in Chapter 3) had found tentative support for a range of interventions, but had also identified a lack of conceptual clarity regarding how many interventions in the field conceptualised

wellbeing or expected to address the specific challenges faced by trainees. The qualitative interview study (reported in Chapter 4) had identified that wellbeing was experienced by trainees primarily in terms of feeling connected through their roles to important personal values. Building on these two sets of findings, a decision was taken to base the intervention on principles of ACT, a therapeutic model which aligns closely with the account offered by trainees of wellbeing in their role. Given the importance of ACT then to the later stages of this thesis, Chapter 5 introduces ACT in depth, providing an account of its theoretical underpinnings and introducing the notion of psychological flexibility.

Chapter 6: Intervention development study

Chapter 6 reports an intervention development study in which core stakeholders (trainees and professional training staff) were invited to collaborate on the design of an ACT-based wellbeing intervention for trainees. Whilst building on the findings of the systematic review and qualitative study a decision had been made to base the intervention in the most general terms on principles of ACT, a wide range of questions regarding the way in which such an intervention should function remained. The systematic review had left open many questions regarding how a successful intervention should be implemented, and Chapter 6 reports on the efforts made to answer these questions in collaboration with intervention stakeholders. Two separate intervention development meetings were held with trainees and professional training staff, during which input was sought regarding all matters of the intervention design. The process was underpinned by an evidence-based model of behaviour change (COM-B) and completed in keeping with guidelines for intervention development research.

Chapter 7: Acceptability and feasibility study

Chapter 7 reports an acceptability and feasibility study of the intervention designed in collaboration with core stakeholders (as described in Chapter 6) and built on the foundations of the earlier research conducted in this PhD (as described in Chapters 3 and 4). A detailed account is provided of the intervention itself, and a mixed-methods design was used to explore intervention acceptability and feasibility. Data on recruitment, retention and data completion are reported and considered as indicators of intervention acceptability and feasibility. Interview data was also gathered from trainees post-intervention on the perceived acceptability and feasibility of the intervention. Findings across these multiple data sources were analysed independently and subsequently interpreted together to provide a comprehensive account of the perceived acceptability and feasibility of the intervention.

Chapter 8: Summary and discussion of findings

Chapter 8 provides an overall summary and discussion of findings across the PhD in its entirety. The chapter includes discussion of findings across each individual study, and integrates them, to provide a comprehensive overview of the core findings of the thesis. This chapter also includes discussion of the strengths and limitations of the thesis, and concludes with a number of recommendations made on the basis of core findings.

Chapter 1: Background

This chapter introduces the background, purpose and objectives of this PhD. It begins by setting out the background and context for training in the psychological professions in England, providing some contextual information regarding the demographics of the workforce, and its professional make-up. Some of the common challenges reported and experienced by those who train in the psychological professions are considered, and an introductory discussion to the literature on positive psychology and wellbeing is offered, to provide further context and rationale for this study.

Trainees in the psychological professions

The Psychological Professions in England

The psychological professions in England have undergone significant change and experienced a period of rapid growth in recent years, with the number of psychological professionals working in the NHS having increased by approximately 70% since 2016 (Kell & Self, 2024). At the time of writing, there are now over 20,000 psychological professionals working in the NHS in England (Whittington, 2024). The significantly expanded and diversified workforce has been classified into a taxonomy of 21 different psychological therapy and practitioner roles (Kell & Self, 2024). These roles include 4 psychologist roles (Clinical Psychologists, Counselling Psychologists, Forensic Psychologists and Health Psychologists), 2 associate and assistant roles (Clinical Associate in Psychology, and Assistant Psychologist), 7 psychological therapist roles (Cognitive Behavioural Therapists, Counsellors, Child and Adolescent Psychotherapists, Adult Psychotherapist, Family and Systemic Psychotherapists, Psychological Therapists, and Art, Drama and Music Therapists with AHP professional leadership), and 5 psychological practitioner roles (Psychological Wellbeing Practitioners, Education Mental Health Practitioners, Children's Wellbeing Practitioners, Mental Health and Wellbeing Practitioners, and Youth Intensive Psychological Practitioners). Collectively these roles are referred to in England as the psychological professions. The psychologist and therapist roles require individual professional

accreditation with bodies such as the Health and Care Professions Council (HCPC) or the British Association for Behavioural and Cognitive Psychotherapies (BABCP). Whilst the practitioner roles do not have the same level of professional registration requirements, in a recognition of their growing importance, there has been mandatory individual registration with the BABCP or British Psychological Society (BPS) since 2022. Notably therefore, the last decade has seen a dramatic shift in the psychological professional workforce. The number of professions and the number of professionals have significantly increased, and fundamental shifts have taken place in the type of work conducted in the field, with the creation of multiple new and often highly specialised practitioner roles being central to these changes (Clark, 2018; Kell & Self, 2024).

Central government strategy documents regarding NHS workforce planning indicate that a significant period of continued growth is also expected in the coming years (NHS England, 2023) though changes in government structures mean the continued roll-out of training provision has become somewhat unpredictable, with several regions failing to continue to expand. The current mental health workforce is being placed under enormous pressure, with evidence to suggest that the need for mental health services is growing faster than the mental health workforce (BMA, 2025). In this context, the psychological professions in England can be considered to remain in a period of significant change, growth and development. The mass roll-out of the NHS Talking Therapies programme (previously known as Improving Access to Psychological Therapies (IAPT)) has driven a large proportion of this workforce expansion, but expansion in traditional areas of the workforce such as Clinical Psychology, and the proliferation of additional new psychological practitioner roles is now also helping to drive this seismic shift of the workforce (Whittington, 2024). This context makes research into psychological professionals both timely and needed, as the success and stability of the workforce relies not only on increased training numbers, but also on concerted efforts to understand the career trajectories of psychological professionals, and the conditions that make work in the field sustainable and rewarding.

As the psychological professional workforce has expanded in England, a taxonomy has developed that conceptualises these new roles as all forming part of one integrated though varied workforce of psychological professionals. As noted above, this includes a range of different groupings (e.g. psychological therapists, psychological practitioners, psychologists etc.) with professionals across these groupings conducting highly varied work in a range of different settings. Psychological Practitioners for example are typically trained to conduct a relatively circumscribed set of practices, in specific settings. Psychological Wellbeing Practitioners (PWPs) for instance are trained to a national curriculum that prepares them to deliver guided self-help, based on principles of low-intensity cognitive behavioural therapy, in NHS Talking Therapies for Anxiety and Depression services (D. M. Clark, 2018). Similarly, Education Mental Health Practitioners work primarily in schools, are based within multi-disciplinary Mental Health Support Teams, and are also trained to deliver interventions based on low-intensity cognitive behavioural therapy (Health Education England, 2023). Psychologist roles such as Clinical Psychology on the other hand receive a broader training, designed to equip trainees with skills and knowledge in a range of different therapeutic techniques, as well as an advanced set of research and leadership competencies (The British Psychological Society, 2019). Reflecting their broader training, psychologists subsequently work in a wider range of settings including positions in primary care, secondary care and private practice (Rosairo et al., 2023). As such, whilst much is shared across these roles (e.g. a focus on supporting the wellbeing of others, an ability to form a therapeutic relationship with patients, a need to be able to think critically and flexibly etc.) it is important to note that the workforce comprises a range of roles which differ significantly from each other in multiple respects. Despite this, it is interesting to note that across a career, many of the same people will apply for and work in multiple different psychological professional roles. Indeed, it is common for people to undertake multiple training programmes at different times across their career, perhaps working as a Psychological Wellbeing Practitioner (PWP) early in their career, before training as a High Intensity Cognitive Behavioural Therapist, or moving from a Clinical Associate in Psychology (CAP) role to a Clinical Psychology course.

The Psychological Professional workforce census

Data on the demographic makeup of the psychological workforce in England indicates variability across professions. Recent data from NHS Talking Therapies for Anxiety and Depression services for example indicates that the demographics of the workforce is broadly representative of the general population in England, with regards to race and ethnicity (NHS England, 2023). However, in the field of Clinical Psychology, there is a longstanding recognition of a need to further diversify in this regard (Turpin & Coleman, 2010). Across the psychological professional workforce as a whole, Asian or Asian-British ethnicities are under-represented against the general population, but Black, Black British, Mixed and other ethnicities are all represented at or above the proportion within the general population (NHS England, 2023; Whittington, 2024).

Across the psychological professions, the psychological workforce is predominantly female (81%) (NHS England, 2023) and relatively young, with over half the workforce aged below 40, and only 5% aged above 60 (Whittington, 2024). In Clinical Psychology, where data on applications is available, data shows that more than half of all applications to the doctoral training nationally are made by people aged between 25 and 29 (Applicants & Acceptances, 2021).

A number of researchers have also enquired into the factors that influence decisions to train in applied psychology and mental health, with evidence to suggest that personal experience of mental health difficulties may be associated with greater likelihood of choosing a career in the field (Barnett et al., 2007; McKenzie et al., 2020).

Despite significant investment into training new professionals and an effort to continue to grow the workforce, a vacancy rate of 7.4% was identified for the psychological professions in the recent psychological professions survey (NHS England, 2023), a figure slightly above the average vacancy rate across the NHS as a whole from the same period (6.9%). Additionally, a turnover rate for the

psychological professions of 15.4% was also identified, indicating further challenges for growing the workforce to meet rising need. Whilst 33% of those for whom data was available were reported to have remained within the NHS, staff turnover within the psychological professions poses a significant problem for the sustainability of the workforce. In an effort to slow the movement of people from one role to another (most commonly, moving from one of the practitioner roles into a therapist or psychologist role) NHS England recently introduced what is known as the '2-year rule' (NHS England, 2022). The 2-year rule states that individuals cannot access funding to train in any of the psychological professions within 2 years of having completed another funded training in the field. This move was hoped to help stabilise the workforce, and ensure that people who were paid to train in one of the psychological professions subsequently worked for a sustained period of time in that role, before moving on. The high levels of turnover and the quick movement from practitioner to therapist or psychologist roles has several important implications for the workforce. Firstly, moving quickly out of roles that people have been paid to train in is costly, and creates a constant need to keep re-training in certain areas of the workforce, even to maintain the current size. Importantly however, it also has implications on service delivery, with highly experienced clinicians with extensive experience in the practitioner roles relatively few in number. Excluding NHS Talking Therapies services (where this data was unavailable) the most recent census identified that 65% of psychological professionals had been in their current post for less than 3 years, and 28% had been in post for less than a year (NHS England, 2023).

Psychological Professional Training

To support the expansion of the workforce and the new roles identified above, training curricula or accreditation standards and competencies have been developed (Kell & Self, 2023). These curricula detail the requirements of training, and provide guidance to education providers and accrediting bodies regarding what the training must include. Education providers must also attain programme accreditation with a professional body, typically the British Psychological Society (BPS) or the British

Association for Behavioural and Cognitive Psychotherapies (BABCP). Consequently, trainees across most psychological therapy or practitioner roles undertake a training that is guided by a standardised curriculum or set of competency standards, and overseen in a regulatory capacity by a professional body, promoting best-practice and consistency.

Trainees on psychological professional training programmes typically split their time across academic training and practical experience either on placement or in employment. Importantly, most training curricula recognise the centrality of practical competence, requiring training approaches designed to support the development not only of theoretical or abstract knowledge, but practical know-how and real-world competence (Health Education England, 2023; The British Psychological Society, 2019, 2023). In keeping with this requirement, and to support the effective development of clinical competence, training programmes typically involve a combination of traditional academic teaching and learning, and a significant amount of experiential learning (Bennett-Levy, 2006a). As such, trainees frequently spend large proportions of their time role-playing new skills, observing qualified peers, working under close supervision, and developing reflective competencies. Whilst few of the psychological professions in England currently mandate personal therapy during training, many training programmes do incorporate some form of self-experiential learning or Personal Practice (Bennett-Levy & Finlay-Jones, 2018) such as Self-Practice/Self-Reflection (SP/SR), an approach designed to place learners into the position of patient, by practising therapy techniques on themselves, and coming to understand these ideas 'from the inside-out' (Bennett-Levy, 2006a). These forms of personal practice have been described as a potential alternative to personal therapy during training (Bennett-Levy, 2019) with several of its proponents pointing towards evidence to suggest that it may fulfil many of the same functions (providing a deeper understanding of therapy techniques, supporting recognition of the importance of the therapeutic relationship, making positive contributions to personal wellbeing and so on) that personal therapy is reported to do (Bennett-Levy, 2019; Scott et al., 2021).

Training in one of the psychological professions therefore is a stretching, multi-faceted endeavour in which trainees develop a foundation of declarative knowledge, procedural competencies, and reflective capabilities. Training is designed to enhance practical, therapeutic competence, whilst also developing students into critically aware and reflective practitioners. In light of its strong reflective and experiential focus, training is also and often experienced as a period of personal as well as professional development. Whilst the experience of undertaking a training course in professional psychology has not been widely researched, evidence across a range of professions including therapist (Owen et al., 2021), psychologist (Pakenham & Stafford-Brown, 2012), and practitioner (Lloyd-Peck et al., 2024; Owen et al., 2022) roles suggests that it can frequently be experienced as a period of significant stress and challenge.

Psychological Professional Training: a summary

In summary, recent decades in England have seen significant changes in the provision of psychological services. Central to that has been significant investment in the creation of a considerably expanded psychological professional workforce, comprised largely of relatively young professionals. Much of the growth in this workforce has come from newly developed professional or practitioner roles, in which clinicians are trained to deliver a relatively circumscribed set of psychological techniques in specific contexts. Both the nature of the work being carried out, and the training received to deliver it have therefore changed significantly in recent years. A large proportion of the psychological professional workforce in England today is comprised of psychological practitioners (Kell & Self, 2024; Whittington, 2024), roles typically based on less intensive and more circumscribed training, carried out by people at an earlier stage in their career, and based on a service model in which practitioners receive more structured and regular supervision than is common in the psychologist and therapist roles (D. M. Clark, 2018). The consequence of this is that the composition and form of the psychological workforce has changed rapidly, and comparatively

little research has focussed on the experience of trainees, or the wellbeing of the emerging workforce.

Positive psychology and the study of wellbeing

As a PhD focussed on understanding and supporting psychological wellbeing, this research falls within the growing field of Positive Psychology (Compton & Hoffman, 2023). As discussed above, understanding the wellbeing of psychological professionals and trainees is an important topic, with implications not only for practitioners themselves, but also the people they support and the services they work for (Posluns & Gall, 2020). In keeping with a positive psychology perspective, supporting the wellbeing of this population requires understanding not only how to reduce stress or minimise burnout, but also how to support thriving, enjoyment, and positive wellbeing in the role too. Positive psychology research aims to build explicitly on the positive aspects of human life, moving beyond a simple focus on the reduction or elimination of the negative features of human psychology, and towards understanding, and increasing what people value in life, what makes it enjoyable, rewarding, and meaningful (Seligman & Csikszentmihalyi, 2000). The goals and intentions of this PhD are neatly aligned with this positive psychology framework, and so to further situate the research within this field, a critical discussion of the fields of Positive Psychology and wellbeing research is set out below.

Positive Psychology

In their introductory article on positive psychology, Martin Seligman and Mihaly Csikszentmihalyi spoke of the need to look beyond what they took to be the existing focus in psychology on pathology, mental ill-health and dysfunction (Seligman & Csikszentmihalyi, 2000). They described a vision of a positive psychology that would shift the focus away from solely understanding how to remedy the worst and most troubling aspects of life, and towards understanding how to also build on what made life meaningful and fulfilling. Whilst acknowledging that others before them (notably

in the humanistic psychology tradition) had already called for greater focus on the positive, enriching, and meaning-giving features of life, they set out a vision for a scientific understanding of the good life that set the parameters for a new field of enquiry (Downey & Henderson, 2017; Seligman & Csikszentmihalyi, 2000).

The focus on positive emotions, and the efforts not simply to remedy pathology, but to better understand how to render ordinary lives more rewarding and fulfilling has led positive psychology to be occasionally dismissed as a frivolous and unserious topic of study, or a reserve for comfortable people already living well (Donaldson et al., 2015; van Zyl et al., 2024). Such criticisms however seem largely misplaced. Firstly, positive psychologists have always maintained the importance and value of continued study into understanding how to address mental ill-health and suffering. From the earliest movements in the field, exploration of the positive features of existence was always intended to accompany (rather than replace) such efforts (Seligman & Csikszentmihalyi, 2000). Secondly, a now well-established body of evidence indicates that the value of increased wellbeing in both clinical and non-clinical populations alike is substantial. Greater wellbeing has been associated with a range of positive outcomes such as improved physical health, better workplace productivity, and better relationships (Compton & Hoffman, 2020; Lyubomirsky et al., 2005), indicating that the subject matter of positive psychology is an important and urgent field for contemporary societies.

The work of positive psychologists has developed in part due to the recognition of the increasing evidence suggesting that mental health and mental illness are two related but ultimately distinct constructs (Keyes, 2005a; Westerhof & Keyes, 2010a). Findings from large scale population surveys have identified significant numbers of people who report both mental health difficulties *and* mental wellbeing for example (Keyes, 2005a). Similarly, others are found to report high levels of *neither* mental ill-health nor mental wellbeing. Contrary to what was once the received wisdom, mounting evidence also now indicates that positive and negative emotions can (and often do) co-occur, and

that the absence of one does not necessarily imply the presence of the other (Compton & Hoffman, 2020). Together, such findings indicate that understanding how to alleviate pain and suffering (important though such things remain) is not the same thing as understanding how to support flourishing or full and meaningful living (Compton & Hoffman, 2020).

In what has been termed the 'first wave' (Lomas et al., 2021) of positive psychology then, the focus was on the positive: positive traits, feelings and institutions. Researchers at this point focussed efforts on increasing positive emotions, and understanding the traits and behavioural characteristics associated with greater wellbeing. In the 'second wave' (Lomas et al., 2021) a more nuanced and refined vision of the good life emerged; one which began to more fully acknowledge the important place for 'negative' emotions and challenge in a well-lived life. Observations of how conventionally positive traits such as forgiveness or optimism can lead to negative outcomes in certain contexts were also important in directing this shift in focus away from an exclusive commitment to the positive. Researchers pointed towards how limitless forgiveness can lead someone to stay in an unhelpful and abusive relationship for example, or how excessive optimism about personal longevity is associated with unhealthy and risky behaviours such as smoking (Compton & Hoffman, 2020). Similarly, increasing recognition was given to the fact that most things considered to make life more meaningful, enjoyable or rewarding inevitably require an ability to delay gratification, to endure periods of hardship or stress for a future reward, or place the needs of others in front of one's own. Consequently, positive psychology researchers today are now insistent that a good life requires both positive and negative emotions (Compton & Hoffman, 2020; Lomas et al., 2021).

In the two and a half decades since its formal beginnings, the field of positive psychology has grown enormously (Donaldson et al., 2015), with a large and ever-increasing evidence-base developing around its value (Carr et al., 2021; van Agteren et al., 2021). Despite its enormous popularity both within and outside of academia, a growing body of critique has also emerged, in which positive

psychology has been criticised for being methodologically weak, theoretically under-developed, overly interested in the individual, and insufficiently concerned with context (Downey & Henderson, 2017; van Zyl et al., 2024). As a field still in its relative infancy, many of the criticisms levelled at positive psychology may follow from the fact that time is simply required and further work is needed to build on and expand the early ideas that initiated the movement. Alternatively however, there is a widespread recognition amongst many in the field that some of the criticisms aimed at positive psychology are significant, and that to advance further, a shift in emphasis in several regards may be required.

In what has been termed a nascent 'third wave' of positive psychology research (Lomas et al., 2021), positive psychologists today are increasingly concerned with addressing such criticisms, through further development and refinement of the theoretical and epistemological assumptions underpinning the field (van Zyl et al., 2024). Additionally, there has been a concerted call for researchers to both look out more beyond the individual (to further emphasise the importance of context and systems in influencing wellbeing) and to take a methodologically broader approach to the generation of new knowledge for the field. In Seligman and Csikszentmihalyi's founding article (Seligman & Csikszentmihalyi, 2000), a staunchly positivist and quantitative remit was set out for this new scientific discipline, and the boundaries for what might be considered as counting towards the generation of knowledge for the field were tightly delineated. Whilst such a perspective persists in some quarters of the field (Gallagher & Lopez, 2021), there has nonetheless been an increasing move towards the need for a broader array of methodologies and epistemologies, with researchers increasingly highlighting the need for qualitative and mixed-methods research to advance the field, and to provide a more nuanced and contextually-based understanding of wellbeing and how it is enhanced (Hamling et al., 2020; Lomas et al., 2021).

Wellbeing

Questions regarding the nature of wellbeing and the good life have been asked throughout history, and the research of contemporary psychology on the subject of wellbeing can be helpfully be framed in this historical and philosophical context (Owen, 2023; R. M. Ryan & Deci, 2001; Waterman, 1993). Advances in the scientific study of wellbeing in recent decades have led to significant advances in understanding regarding what wellbeing is comprised of and how it is facilitated. Despite this growing literature however, a universally accepted definition of wellbeing does not yet exist (Dodge et al., 2012; Simons & Baldwin, 2021). In recent years, multiple attempts to define wellbeing have been made, but without any one single definition gaining universal acceptance (cf. Dodge et al., 2012; Seligman, 2011; Simons & Baldwin, 2021). Whilst advances in the science and understanding of wellbeing have been made therefore, fundamental disagreements about its nature are still widespread in the scholarly literature, and such disagreements extend to even the most basic questions regarding the structure and form of wellbeing. Researchers continue to debate for example whether wellbeing is itself an actual phenomenon, or simply rather a construct, constituted by and measurable in terms of other phenomena (cf. Dodge et al., 2012; Seligman, 2011). Similarly, questions have been raised regarding whether the philosophical distinction between 'eudaimonic' and 'hedonic' conceptions of happiness tells us something meaningful and important about the nature and form of the good life, or whether the distinction between the two simply disintegrates and confuses matters under closer inspection (cf. Kashdan et al., 2008; Waterman, 2008). Many such questions remain, indicating that despite notable forward steps, continued research into the form, nature and experience of wellbeing across settings and contexts is needed. Such research is critical, since, as Julia Annas has argued, attempts to rush forward and measure or influence wellbeing without wellbeing itself being sufficiently well understood, can never be truly helpful or illuminating (Annas, 2004). The continued efforts of positive psychology researchers therefore to better understand wellbeing in context, and to design and implement interventions with an understanding of the needs and perspectives of those they are intended for are therefore important.

The nature of wellbeing

Notwithstanding the fact that some researchers have questioned the scientific utility of this philosophical heritage (Disabato et al., 2016; Kashdan et al., 2008), much of the contemporary literature regarding the nature of wellbeing and how it is achieved has been heavily informed by writings from Ancient Greek philosophers such as Aristotle, Socrates and the Stoics (Compton & Hoffman, 2020; Owen, 2023). Building on the distinction emphasised in ancient philosophical writings on the good life, contemporary thought on wellbeing continues to distinguish broadly between 'hedonic' and 'eudaimonic' conceptualisations of wellbeing (R. M. Ryan & Deci, 2001; Waterman, 1993, 2008). It is suggested by writers in this field that eudaimonia and hedonia describe two qualitatively different forms of happiness or wellbeing; phenomena that differ both in their means and ends (Waterman, 2008).

Hedonic wellbeing

The word hedonism is derived from the Ancient Greek word for pleasure, and in contemporary thought, it denotes the idea that pleasure is the (or a central) goal of life. In modern psychological research, hedonism is the term usually employed to describe a conception of happiness as pleasure (Joseph Sirgy & Wu, 2009; Kashdan et al., 2008).

Across the centuries, several highly influential and enduring philosophers have advocated various forms of hedonism. In the writings of the Ancient Greek Epicurus, or the 18th century Englishman Jeremy Bentham for example, pleasure is both what we *do* seek (in the sense that we are driven to do so by nature) and what we *should* seek (in the sense that pleasure and pain are seen to be the criterion according to which ethical motivations for action are considered) (Rist, 1972). Early development of a serious philosophical theory of hedonism is often described as having begun in the work of Aristippus, the 4th century BC Cyrenaic philosopher who argued that immediately available pleasures should be the guide for behaviour and the ultimate goal of our actions (Laertius, 2005).

In contemporary psychology, hedonic conceptions of happiness have become closely associated with the notion of subjective wellbeing (SWB), a highly influential and widely researched conception of wellbeing (Das et al., 2020). Here, wellbeing is understood to be comprised of a cognitive component (life satisfaction; how much we judge ourselves to be satisfied with our lives) and two affective components (the amount of positive affect experienced, relative to the amount of negative affect) (Diener et al., 2002). Hedonic conceptions of happiness place the individual at the centre of judgements regarding the happiness of a life, and reduce the importance of the *source* of pleasure. Happiness is primarily concerned with the experience of pleasure, with questions regarding where that pleasure comes from considered minor. Whilst it has been noted that this can leave hedonism in a vulnerable position (what of the person who feels pleasure when torturing puppies for example? (see Annas, 2004)) researchers in the field have nonetheless played down the importance of these concerns, arguing that very little in either everyday observation or the existing literature on wellbeing suggests that this is a meaningful problem (Kashdan et al., 2008).

Critically, subjective wellbeing (SWB) and hedonic conceptions of happiness have the important appeal of placing our subjective feelings (how we feel in particular moments and in regards to our life overall) at the centre of happiness, an idea which resonates with everyday language and also connects with aspects of previously reported lay conceptions of wellbeing (Fave et al., 2016). From this perspective, the individual has unique access to the information needed to make judgements about their wellbeing, and one's wellbeing is ultimately what one subjectively feels or experiences it to be.

Posing a potential problem for such conceptions of wellbeing however, a large body of evidence shows that current mood can be a forceful influence on all features of cognition (Oatley et al., 2013). Mood congruent biases in thinking having been demonstrated in relation to psychological states ranging from depression (Watkins et al., 1992) to positive mood (Fredrickson, 2003). Such findings leave subjective wellbeing in a potentially vulnerable position, with the possibility that judgements

about how happy an individual is or how satisfied they are with their lives overall may be sizeably influenced by their mood state at the time of being asked (Seligman, 2011). In a now famous example for instance, Schwarz and Clore found that asking people about how satisfied they were with their lives overall on sunny days led to significantly greater satisfaction being reported than when asking people on rainy days (Schwarz & Clore, 1983). Some authors in this field have argued that the large influence that current mood has on global life-satisfaction judgements fatally undermines life satisfaction as a meaningful measure for wellbeing (Schwarz & Clore, 1999; Seligman, 2011). However, in recent years, researchers have in turn questioned these results, suggesting that the influence of current mood on life satisfaction is in fact small and relatively inconsequential (Yap et al., 2017).

Eudaimonia

Eudaimonic perspectives on the other hand have drawn inspiration from the ideas of philosophers such as Aristotle and the Stoics, for whom happiness had to do with living a good human life, and fulfilling one's potential as a human being (Waterman, 1993). In contemporary thought, eudaimonic approaches to wellbeing have criticised what they consider to be the overly narrow view of the hedonic tradition, on the grounds that such perspectives neglect theoretically important components of a good life such as autonomy, positive relationships with others, or personal growth (Deci & Ryan, 2016; Ryff, 1989). Eudaimonic approaches build from the work of Aristotle, and his insistence that the highest good and ultimate aim for human beings was not simply feeling good, happy, or positive in an emotional sense, but rather it was fulfilling what is best in ourselves and embodying virtue (Aristotle, 2004).

A primary distinction between hedonic and eudaimonic conceptualisations of wellbeing as they were defined in early philosophical analyses rests on the place given to subjective experience. Whilst for Epicurus and other hedonic philosophers for example, wellbeing is distinctly subjective owing to the

primary place given to feelings of pleasure (Laertius, 2005), Aristotle's conceptualisation of eudaimonia is an objective state, to which subjective feelings do not contribute (Waterman, 2008). In other words, for Aristotle, eudaimonia is defined by a set of objective facts (such as realising one's inner potential) and not how one feels about doing so.

Eudaimonia then describes a sense of self-actualisation, living in accordance with what is best in us, and striving towards excellence (Waterman, 2008). This absence of subjective feeling from the notion of eudaimonia in early writings about the topic has led several contemporary researchers to critique eudaimonic conceptualisations of wellbeing on the grounds that they neglect what must be a central component of any meaningful notion of wellbeing; individual feeling (Disabato et al., 2016; Kashdan et al., 2008). Importantly however, such critiques take aim at eudaimonia as it is described in the work of ancient philosophers, whilst neglecting the more nuanced account of it given by contemporary researchers. Many researchers working on eudaimonic wellbeing today give an important place to subjective experience, recognising the centrality of feeling to any account of wellbeing. The prominent theorist Alan Waterman for example describes how positive subjective experience accompanies the self-realising fulfilment that seems to define eudaimonia, and notes that consequently eudaimonia 'is a highly positive affective condition' (Waterman, 2008, p.236). According to Waterman and others, eudaimonic wellbeing will always be accompanied by hedonic wellbeing; *it feels good* to realise our potentials and to fulfil what is best in ourselves.

Conversely however, for writers in the eudaimonistic trend, not every desire satisfied or pleasure experienced contributes to a person's wellbeing. The pleasure experienced whilst scrolling funny videos online for example might be considered enjoyable, but would hardly be taken to contribute to the realisation of what is best in oneself, or the fulfilment of one's potential. Whilst the exclusion of some sources of pleasure (such as those just mentioned, or those experienced through drugs or the satisfaction of morally reprehensible actions for example) from contributing to wellbeing perhaps makes intuitive sense, the normative nature of this perspective has led to it being criticised on the grounds that it attempts to define wellbeing according to terms that may not be recognised

by particular individuals (Diener et al., 2002). Proponents of subjective wellbeing therefore note that asking people to evaluate for themselves how satisfied they are with life, allows for individuals to determine their own wellbeing, rather than assessing it in terms of what others have determined constitute wellbeing (Diener et al., 2002).

A final and widely acknowledged challenge for the contemporary study of eudaimonia is the fact that psychological researchers have yet to converge on an agreed way of operationalising eudaimonia (Disabato et al., 2016; Waterman, 2008). In contrast to the widespread use of subjective-wellbeing as an indicator for hedonic wellbeing discussed above, eudaimonic researchers have advanced a wide array of ideas regarding how eudaimonia should be conceptualised. These include ideas associated with self-determination and autonomy (Deci & Ryan, 2008), personal expressiveness (Waterman, 1993) and multi-component descriptions of psychological wellbeing (Ryff, 1989). Indeed, in a recent study, it was noted that eudaimonia has been operationalised in at least 45 different ways across the current literature (Martela & Sheldon, 2019). Despite the fact that this leaves the literature on eudaimonic wellbeing somewhat heterogeneous, vague and loose (Martela & Ryan, 2023) it has been noted that in the contemporary psychological literature, the study of eudaimonia remains relatively young, and certainly sits several decades behind the body of work developed around hedonia and subjective wellbeing (Waterman, 2008). In recognition then of the widely acknowledged need for greater clarity, researchers in recent years have sought to drive the field towards greater consensus on the nature and form of the phenomenon (Huta & Waterman, 2014; Martela & Ryan, 2023; Martela & Sheldon, 2019).

The continued study of wellbeing then, and attempts to understand both how it is experienced and how it should be conceptualised, are important. Just as evidence indicates that interventions designed to increase mental health and those designed to decrease mental ill-health function differently (Compton & Hoffman, 2023), it might be expected that an intervention designed to increase positive emotions and one intended to support self-actualisation may also operate in

different ways. Such ideas indicate that attempts to understand how wellbeing is made sense of and experienced in particular settings may be important to the successful design of effective wellbeing interventions.

The importance of context in studying wellbeing

In recent years a growing trend has emerged for conceptualising wellbeing in contextually sensitive ways (e.g. Jarden et al., 2021). Researchers in this field draw attention to the fact that wellbeing appears to be conceptualised and experienced in different ways for different populations (e.g. different age groups, or employment types), an idea which has strengthened in recent years, but which has been evident in some research for several decades (King & Napa, 1998).

As noted above, as work in the field of Positive Psychology has advanced, researchers working in areas spanning from organisational to cross-cultural psychology have begun to dedicate increased attention to the ways in which wellbeing is contextually situated, and varied between different populations (Lomas et al., 2021). Researchers in this field have pointed to growing evidence that the way that specific populations experience wellbeing varies, with at least some variety in the features described as central to wellbeing, and its antecedents (Hamling et al., 2020; Jarden et al., 2021; Lomas et al., 2021).

As a significant life domain, and as an important contextual factor (Hamling et al., 2020) in many people's lives, a growing body of research has explored these issues from the perspective of workplace wellbeing. Evidence in this field has accrued to suggest that different professions experience wellbeing differently, and that wellbeing is differentially predicted across many job types (Hamling et al., 2015). In intensive care nurses for example, a significant emphasis on physical health was central to nurses' conceptualisations of wellbeing, despite being relatively absent from most contemporary models of wellbeing (Jarden et al., 2021). Similarly, research from Australia reported that teachers' conceptualisations of wellbeing placed an emphasis on feeling safe, valued and supported that has not featured heavily in understandings of wellbeing drawn from other contexts

(Vo et al., 2024). Elsewhere, job satisfaction was found to be more strongly predicted by factors such as resilience, feeling engaged, or feeling socially connected in some professions than others (Hamling et al., 2015). Such findings indicate that understanding the context within which people operate, and the ways in which context influences the antecedents and experience of wellbeing are important for understanding how to support or improve wellbeing. Notably, despite the growing literature in this field and the positive steps taken towards an enhanced understanding of contextual factors in the study of wellbeing, research in this area is vulnerable to several important criticisms. In several of the studies referenced above for example, antecedents and outcomes of wellbeing appear to be occasionally confounded with wellbeing itself, a concern that has been raised in relation to certain general models of wellbeing by others in the field (Kashdan et al., 2008). In the article exploring Australian teacher's conceptions of wellbeing for example, participants were asked to describe what wellbeing meant to them (Vo et al., 2024). In so doing, participants described a range of notions related to wellbeing, including antecedents and outcomes of wellbeing, as well as features of wellbeing itself. Whilst this highlights important features of lay conceptualisations of wellbeing and emphasises the ways in which the construct of wellbeing might be held broadly in people's minds, it nonetheless raises challenges for developing an understanding of what wellbeing for a specific populations *is.*

Wellbeing: a summary

The study of wellbeing has grown significantly in recent decades, and a now well-established body of research indicates that wellbeing is an important outcome, with consequences for individuals and the societies they live in. The study of wellbeing is complex and nuanced, and the literature in the field continues to grapple with a range of important questions, indicating a pressing need for carefully planned and contextually-based research into how wellbeing is experienced and supported. Given the complexity of defining wellbeing, and the indication that wellbeing may be at least partially context dependent, many authors have highlighted that there is a need for qualitative,

data-driven, and bottom-up research on wellbeing as it is experienced in context (Boniwell & Henry, 2007; Hamling et al., 2020). Such calls have come to take a central place in what has been termed the 'third-wave' of Positive Psychology research (Lomas et al., 2021), in which a broadened understanding of different ways of knowing and understanding wellbeing have been called for. From this perspective, it is suggested that attempts to improve wellbeing without first seeking to better understand the context in which an intervention is set to take place and the ways in which wellbeing is experienced in that context, are unlikely to realise their full potential (Hamling et al., 2015).

Wellbeing in the psychological professional workforce

In the following sections, a discussion of wellbeing in the psychological professional workforce is given, with particular focus paid to psychological professional trainees.

Psychological Professional Workforce Wellbeing Survey

In the UK, a series of workforce wellbeing surveys have been carried out across the psychological professions in recent years. In 2021, when the survey was last carried out, a total of 1,678 professionals took part, with psychological professions from 9 of the 21 recognised professions described above represented. As a whole, psychological professionals were found to have lower than average wellbeing (when comparing scores on the Short form Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) against UK population norms). The authors of this study drew attention to this, noting the way in which it aligns with the wider literature on mental health, wellbeing and burnout in psychological professionals, and suggesting it indicates a need to pay increased attention to the wellbeing of this section of the workforce (Summers et al., 2021). Interestingly, subgroup analyses revealed variation for both general wellbeing (as measured by the SWEMWBS) and workplace wellbeing (as measured by the Psychological Professional Workplace Wellbeing Measure (PPWWM)) across the psychological workforce. Psychological Wellbeing Practitioners (PWPs) for example were found to have higher than average general and workplace wellbeing. Whilst not addressed directly by the study authors, this interesting and perhaps unexpected finding appears at first to sit in contrast

with the wider literature on PWPs, in which PWPs have been consistently reported to experience high levels of stress and burnout (Steel et al., 2015; Westwood et al., 2017), often at levels which place them at the higher end of burnout for the mental health workforce more broadly (Owen et al., 2021). There are multiple ways in which this apparent contradiction could be accounted for, including the idea that the self-selecting nature of the workforce survey may have attracted those with higher wellbeing. However, the finding may also potentially be indicative that PWPs experience high levels of *both* positive and negative features of wellbeing; feeling purposeful and achieving for example, whilst also managing feelings of stress or anxiety.

In the survey published by Summers et al., (2021), the overwhelming majority of participants were qualified staff. However, the small number of trainee participants produced findings of potential interest to this thesis. Despite only making up 1% of the total sample (n=28), trainee Clinical Psychologists reported significantly lower than average scores on the SWEMWBS. This finding, along with the wider literature on trainee wellbeing, lent further support to the idea that the training period is a moment during which professionals may be especially vulnerable to poor wellbeing.

Wellbeing in Psychological Therapy Trainees

The wellbeing of psychological professional trainees has been identified as an area of concern for a number of years (Cushway, 1992). Whilst evidence in this field remains in its relative infancy, emerging evidence regarding the experience in some of the newer psychological practitioner roles suggests that certain professions within the psychological field may be especially at risk (Lloyd-Peck et al., 2024; Owen et al., 2021; Westwood et al., 2017). Trainees across a range of psychological professions have frequently been identified to experience high levels of stress and burnout (Owen et al., 2021b; Pakenham & Stafford-Brown, 2012), with concerns also raised about the implications of this for staff retention (Summers et al., 2021). As psychological professionals, trainees are exposed to a wide range of well-established stressors relating to personal, educational and occupational domains. These include those associated with managing a high workload and low-autonomy (Steel et

al., 2015; Westwood et al., 2017), emotionally challenging work (Johnson et al., 2018), vicarious trauma (Ball et al., 2022), organisational issues such as the quality of supervision (Westwood et al., 2017), and the strains that a busy training schedule places on wider work-life balance (Owen et al., 2021; Lloyd-Peck et al., 2023). Importantly, whilst training in one of the psychological professions, trainees are also university students, meaning that alongside their clinical role and responsibilities, trainees also encounter a range of stressors associated with university and academic work. These include stressors associated with examination, feedback, and learning large volumes of academic content (Owen et al., 2022, Richardson et al., 2020), findings in keeping with the wider literature on mental health in higher education, where an established body of research identifies elevated incidences of poor mental health in university students (Pascoe et al., 2020).

Significantly, emerging research suggests that PTTs not only manage two sets of competing demands and therefore two sets of potential stressors, but they also experience additional stressors which appear to result from the fact of holding these dual roles together (Owen et al., 2021, 2022). Trainees have described how the experience of being bound by two sets of expectations, managing two sets of demands, and embedding themselves into two social and organisational systems can contribute to a stress which emanates from neither role individually, but the challenge associated with holding the two positions concurrently (Owen et al., 2021, 2022). Additionally, it is notable that many of the commonly reported stressors found in the trainee literature (such as those associated with self-doubt, self-criticism, and perfectionism (Jones et al., 2017; Lloyd-Peck et al., 2024; Richardson et al., 2020)) may be fuelled by the circumstances in which trainees find themselves during training. By definition, trainees are frequently receiving high levels of feedback in both clinical and academic settings, learning new sets of skills, and applying those new skills in environments where comparison to others may be inevitable (such as when role-playing new clinical skills together with trainees).

Importantly however, whilst the wellbeing of the psychological trainee and professional workforce is frequently highlighted as a matter for concern, the issue is nonetheless a nuanced and potentially complex one. Training and work in this field have been frequently associated with high-stress, work-overload, emotional complexity and features of burnout (Owen et al., 2021; Simionato & Simpson, 2018). At the same time however, work in the field is also often described as being an important source of meaning, purpose, direction and enjoyment (Russo-Netzer et al., 2020; Toubassi et al., 2023). This nuanced relationship between 'positive' and 'negative' indicators of wellbeing potentially speaks to the complexities of work in this field, the inherent emotional investment required of the work, and the deep connection identified between helping others and personal wellbeing. It appears highly likely that it is also reflective of the systemic and organisational challenges placed on many working in the field. It is possible that despite the positive ways in which work in this field provides staff with a sense of meaning, purpose and enjoyment, the demands placed on staff within the modern healthcare workforce lead at the same time to a range of stressors that challenge and work in opposition to these more positive features. The co-existence of high negative and positive indicators of wellbeing appears to be supportive of the 'dual continua' model of mental health and wellbeing, in which positive and negative features are seen to co-exist on separate continua, rather than functioning as the two opposing poles of one continuum (Iasiello et al., 2020).

The context described here for trainees can also helpfully be considered in light of the well-known Job Demands-Resources Model (Bakker & Demerouti, 2007), in which an interaction between job demands and resources is proposed to account for job strain and work engagement across multiple different occupations. From the perspective of the Job Demands-Resources (JD-R) model, the reported combination of various job demands described above (e.g. a high workload and low-autonomy (Steel et al., 2015; Westwood et al., 2017)), alongside an identified paucity of important resources (such as high quality supervision (Westwood et al., 2017)) could account for many of the findings of high stress and poor wellbeing in this population. From the perspective of the Job Demands-Resources model, even high levels of job demands can be managed productively and

without negative consequences if sufficient job resources are in place. However, when demands are high but resources insufficient, then job strain and the associated negative outcomes for wellbeing are likely (Bakker & Demerouti, 2007). Recent developments in JD-R theory have also highlighted the importance of self-regulation and recovery processes (Bakker & de Vries, 2021). In keeping with findings from Fredrickson's broaden and build theory (Fredrickson, 2004), it has been observed how when individuals experience high levels of job demands and associated emotions (such as stress, anger or sadness), cognitive and attentional processes tend to become more narrow and coping processes become more inflexible (Bakker & de Vries, 2021). With increasing recognition of the way that the ability to adapt one's coping strategies to different needs and contexts is important, this narrowed and inflexible focus can be seen to be maladaptive. Similarly, contemporary work on the JD-R model highlights how processes and activities (such as exercise, socialising, or relaxation) that typically facilitate recovery from job strain and work-stress can become side-lined when job strain or work-stress are high, in turn then contributing to further strain. Trainees experiencing the high demands and low resources indicated in the literature therefore may find themselves increasingly less able over time to think and respond flexibly to the challenges they encounter. Further, in trying to manage the large volume of work and high levels of stress frequently reported during training, they may fail to engage in activities that provide distance from work/training and which facilitate recovery.

The presence of supports through both the university and employer that are available to trainees might be assumed to entail high levels of certain job resources (such as supervisory support or protected time for study). However, the literature in this field to date indicates that the high and varied demands placed on trainees (such as those related to the emotional nature of the work, the high demands from both university and work, and the relative absence of autonomy experienced) may exceed this, and account for many of the findings regarding trainee stress described above.

In summary, evidence suggests that trainees experience personal, educational and occupational stressors during training, indicating that the training period may put pressure on wellbeing across these domains. The work of this thesis focusses primarily at the level of the individual, supporting trainees to develop skills and behaviours relevant to wellbeing across these domains. As an example, whilst the psychological approaches used in this thesis will not alter core features of the role (e.g. the need to manage clinical complexity or submit assessed work to the university), they will seek to support trainees in approaching those and other features of their roles in ways that will be supportive of wellbeing.

The importance of supporting trainee wellbeing

The wellbeing of trainees is important on multiple fronts. Aside from the personal implications of poor wellbeing for individuals themselves, poor wellbeing in the healthcare workforce is costly (Daniels et al., 2022). In both psychological professionals specifically (Summers et al., 2021), and healthcare professionals more broadly (Martin et al., 2024), poor wellbeing has been associated with increased intention to leave the workforce, a major challenge given widespread healthcare staff shortages (Boniol et al., 2022). Poor wellbeing in psychological professionals has also been shown to impact negatively on clinical effectiveness (Delgadillo et al., 2018), meaning that poor staff wellbeing has societal, economic and clinical costs. In recognition of the importance of staff wellbeing for the effective and sustainable delivery of healthcare services, supporting staff wellbeing is highlighted in the *NHS Longterm Workforce Plan* (NHS England, 2023). Further, attempts to support positive wellbeing, and prevent issues from arising (rather than responding reactively to treat issues that have already developed) is central to one of the key 'shifts' ('from sickness to prevention') described in the NHS *Fit for the Future: 10 Year Health Plan for England* policy (DHSC, 2025). Given this, work in this area has the potential to be of significant policy and workforce-planning interest. An effective and feasible wellbeing intervention has the potential to positively influence core metrics at the heart of a sustainably delivered healthcare service, such as clinical effectiveness (Delgadillo et al., 2018),

quality of care (Hall et al., 2016) and staff retention (Martin et al, 2023; Summers et al., 2021). The expected economic case for improved staff wellbeing in the NHS overall is large (Daniels et al., 2022), and some evidence exists to suggest that psychological wellbeing interventions with university students can be cost-effective (Wagner et al., 2023). Taken together, this suggests that the focus of this thesis – to explore, understand, and support wellbeing in trainee psychological professionals – has the potential to be of significant policy and societal interest.

Purpose of the thesis

In recognition of the stresses frequently reported during training and the challenge this represents for the developing workforce, some training curricula encourage a focus on clinician self-care, and professional bodies and researchers have encouraged a requirement to embed this into all training programmes (Lorraway et al., 2024; Posluns & Gall, 2020). Despite this, minimal direction is provided to education providers regarding the form or duration that such support should take, and little is known about what exactly should be being aimed at, or what approaches are likely to be best suited for reaching the desired goal. As such, to better understand how to support, improve or facilitate wellbeing in this population, detailed work is needed to understand how wellbeing is experienced by PTTs, and how their specific context influences both wellbeing itself, and how an intervention designed to support it may work.

This thesis centres around the development of a body of work designed to understand, support and improve the wellbeing of psychological therapy trainees. To do so, in-depth exploration of the nature and experience of wellbeing in trainees is undertaken, and used to feed into the design of an intervention tailored to improving wellbeing for trainees. The intervention is intended specifically to promote skills that will support the wellbeing of trainees during a period (training) commonly experienced as challenging.

Despite the many advances made in recent years in the field of positive psychology, researchers have cautioned against rushing ahead to attempt to measure and influence wellbeing without first paying sufficient attention to what it is (Fave et al., 2016), arguing that attempts to first understand how wellbeing is experienced by particular populations, and what factors members of that population perceive to be important for shaping it should be an essential first step in all wellbeing initiatives (Hamling et al., 2015). Similarly, calls have been made for positive psychology researchers to pay more attention to context, and to consider how wellbeing and its antecedents – as well as interventions designed to improve it – will be experienced differently across various contexts (Hamling et al., 2020). The systematic progression of this PhD from an inquiry into the existing literature on trainee wellbeing interventions (Chapter 3), to an exploration of what wellbeing is, how it is experienced, and what influences it in the specific context of PTTs (Chapter 4), to a stakeholder-informed collaboration for the design of a PTT-specific intervention (Chapter 6), and to the acceptability and feasibility testing of a wellbeing intervention for PTTs (Chapter 7), is intended to reflect such concerns.

To provide an overview of the pathways through which the overarching objectives of this PhD are expected to be reached, a summary Theory of Change (TOC) is presented below. Following this, the specific research questions and study objectives addressed in the component studies are outlined.

Problem statement

Training in the psychological professions is frequently described as challenging, with many students reporting high stress, low wellbeing, and features of burnout during the training period. However, relatively little research to date has focussed on positive wellbeing in this population, and no known attempts have been made to understand in depth how trainees describe wellbeing in the role. Whilst systemic and organisational pressures exist, available evidence suggests that many of the challenges associated with training in the field function at the individual level, with self-criticism, self-doubt, and 'imposter syndrome' commonly reported and cited as challenges.

Inputs

- Skills, knowledge and time of staff
- Skills, knowledge and time of trainees and other stakeholders
- Data collection systems
- Knowledge of existing literature on wellbeing and the psychological professions
- Workshop resources
- Participants
- Funding
- Communication and collaboration with external partners
- Education provider buy-in

Activities

- Comprehensive review of challenges during training, and the current literature regarding interventions or strategies to improve trainee wellbeing
- In-depth exploration of how trainees experience wellbeing in their roles
- Collaboration with stakeholders in creation of an intervention to meet the challenges of training, that is feasible and acceptable to trainees.
- Trainees to attend a tailored wellbeing intervention, developed on the basis of existing literature, stakeholder perspectives, and researcher input.

Outcomes

- Increase in skills and behaviours associated with positive wellbeing
- Increase in psychological and behavioural antecedents to wellbeing in trainees
- Improvements in wellbeing in trainees
- New knowledge regarding how wellbeing is experienced and supported in trainees

Impact

- Better understanding of trainee wellbeing, leading to more effective support
- Better design of wellbeing interventions for this population, conducted in ways that incorporate trainee and stakeholder perspectives.
- Improved wellbeing during training, with downstream effects on important metrics such as retention, clinical effectiveness, and academic learning

Causal pathways

- By working closely with stakeholders, an in-depth understanding of trainee wellbeing and how an intervention to support it might function, will be reached – leading to better intervention design
- Working with trainees and stakeholders will support the development of an intervention that is acceptable and feasible to trainees, increasing the likelihood that it has its desired effects
- Attending adapted intervention will help to generate skills, knowledge, and behaviours that can support wellbeing during training

Moderating factors

- Trainees and stakeholders with necessary experience are recruited
- Organisational support allows for trainees to take part in meaningful ways at each stage
- Organisational or systematic issues not targeted through this thesis (e.g. job requirements in employing services) may influence both the ability of trainees to take part, and the extent to which any developed intervention is successful.

This Theory of Change highlights how working with trainees and stakeholders is expected to support the development of a novel and tailored intervention that is well-designed to meet the needs of trainees in the psychological professions. The anticipated pathways of change are identified, and consideration is given to potential modifying factors, such as the extent to which the right people contribute to the early stages of the thesis, and the extent to which external factors outside the scope of this thesis (such as workplace factors) influence wellbeing.

The specific research questions and study objective addressed over the duration of this thesis are as follows:

Study 1, Chapter 3: Systematic review

1. What are effective primary outcomes of psychological wellbeing interventions for psychological therapy trainees?
2. What are the perceived barriers and facilitators of successful psychological wellbeing interventions or teaching strategies designed to improve PTT wellbeing?

Study 2, Chapter 4: Qualitative interview study

1. How do trainee psychological therapists experience wellbeing in their roles?

Study 3, Chapter 6: Intervention development study

The objectives of this study were to design a psychological intervention intended to support wellbeing in psychological therapy and practitioner trainees.

Key questions addressed throughout the study process were:

1. How can an intervention be designed that builds on existing evidence and functions to support the wellbeing of PTTs specifically?
2. What do key stakeholders (current trainees, and clinical academics working on training programmes) consider most important in the design of such an intervention?
3. What would be the anticipated theory of change for an intervention designed to serve this purpose?

Study 4, Chapter 7: Acceptability and Feasibility study

Primary aims – acceptability and feasibility

1. To assess the acceptability and feasibility of a group ACT wellbeing intervention for psychological therapy trainees (PTTs)

Secondary aims – clinical outcomes

1. To explore preliminary estimates of clinical effectiveness

Chapter 2: Methods

A mixed-methods approach has been used across this PhD. As such, both quantitative and qualitative data have been generated and analysed, and the findings realised through this process have been integrated and combined in order to provide a more comprehensive account of wellbeing in PTTs and how it can be supported.

Mixed-methods research

In recent decades, interest in and use of mixed-methods research has grown significantly (Creswell & Plano Clarke, 2018)). Whilst some researchers have questioned the idea that mixing quantitative and qualitative data together is genuinely new in any meaningful sense (Maxwell, 2016), the modern field of mixed-methods research is typically described as beginning formally from the latter decades of the twentieth century (Creswell, 2024).

Positioned alongside quantitative and qualitative approaches, mixed-methods research has often been referred to as the 'third' methodological approach (Adu et al., 2022; Maxwell, 2016). It is guided by a set of philosophical assumptions regarding the collection, analysis and combining of quantitative and qualitative data, and it is built on the notion that working in this way can help provide deeper and more comprehensive answers to research questions than could either quantitative or qualitative approaches alone (Creswell & Plano Clarke, 2018). Importantly, mixed-methods research is not simply using both quantitative and qualitative research methods in parallel. A core characteristic of mixed-methods research is the idea of integration; the manner through which quantitative and qualitative data are generated, combined, contrasted, considered in light of one another, and used to provide an answer to key questions that extends beyond what could have been reached simply by having two distinct quantitative and qualitative streams of work (Creswell & Plano Clarke, 2011). In this sense, mixed-methods research has been likened to the equation 1 + 1 =

3, indicating that through integration (of quantitative and qualitative components), we arrive at a whole that is greater than the sum of its constituent parts (Fetters & Freshwater, 2015).

A further defining feature of mixed-methods research is the primary position given to the research question (Creswell & Plano Clarke, 2018). Understanding what you want to know, and then identifying the methods and methodology best suited to doing so is a key feature of mixed-methods research, and an important focus is also placed on real-world implications and a notion of doing 'what works' (Creswell & Plano Clarke, 2018). In this regard, mixed-methods researchers have sought to move away from what they consider to be the methodological constraints of firmly drawn dichotomies between competing worldviews (e.g. positivist and constructivist). Instead, mixed-methods researchers are increasingly adopting an attitude of doing 'what works', and embracing the possibility of worldviews that encompass both quantitative and qualitative approaches, or advocating for multiple worldviews underpinning different components of a research project, according to the questions being asked (Greene, 2012).

Proponents of mixed-methods research point to its ability to answer complex research questions (Shannon-Baker, 2016), provide more comprehensive answers to questions than can be reached by either quantitative or qualitative research alone (Greene, 2012), and provide an intuitive foundation upon which to undertake research (Creswell & Plano Clarke, 2018). Whilst mixed-methods research therefore is considered by some to have a number of important strengths, it is not suited to all research questions, and careful thought is required regarding the methods and methodologies best suited to answering any specific question or set of questions. For this reason, a clear justification and rationale is required for setting out why a mixed-methods approach is better suited than either a quantitative or qualitative approach alone (Creswell & Plano Clarke, 2018; Greene, 2012).

Relatedly, mixed-methods research also brings with it a range of practical and epistemological challenges (Adu et al., 2022). As an example, qualitative and quantitative research are typically considered to be founded on contrasting worldviews, with fundamentally different perspectives on

the nature of reality and the possibility of knowledge about it (Creswell & Plano Clarke, 2018). Quantitative approaches are typically founded on a positivist perspective. For quantitative research, the aim of research is to uncover details about a reality considered to be independent of human knowledge, and to do so in a way which reduces to the greatest possible extent the 'bias' of the researcher, or the limiting effects of context or confounding variables. Qualitative research on the other hand comes from an interpretivist ontology and typically considers reality as plural, and human beings (both researchers and participants) as foundational in the creation of and understanding about the world. Rather than see these differences as incommensurable issues rendering qualitative and quantitative approaches incompatible however, mixed-methods researchers seek ways to bring these contrasting perspectives into dialogue with each other, legitimising multiple ways of knowing, and generating deeper insights into phenomena through the way that findings from the two are interpreted in relation to the other (Greene, 2012).

Mixed-methods in this thesis

Taken as a whole, this thesis has adopted an exploratory sequential mixed-methods approach (Creswell & Plano Clark, 2018). In exploratory sequential mixed-methods designs, qualitative data is collected and analysed in early stages of the research, and is used to inform what follows. These later stages are analysed using a quantitative approach, and the findings across all stages are integrated and considered together in drawing conclusions for the project as a whole (Creswell & Plano Clark, 2018). In this PhD, a qualitative approach was used in the early stages of the research to explore the nature and experience of wellbeing in the trainee role. Findings from this study (along with those of the systematic review and the wider literature) were subsequently used to inform the design and development of an intervention. In the final stages of the PhD, both quantitative and qualitative methods were used to evaluate the acceptability and feasibility of this intervention. As such, whilst the design of this PhD as a whole broadly aligns with that described as an exploratory sequential approach, some flexibility to this was utilised (i.e. the use of both quantitative *and* qualitative

evaluation of the developed intervention) to ensure a comprehensive evaluation and answering of the questions asked at each stage of the intervention.

A decision to proceed using a mixed-methods approach is increasingly common practice for entire bodies of work, and within a single study (Creswell & Plano Clark, 2018) in recognition of the fact that a range of different types of knowledge on a topic can be of practical and applied significance (Gillespie, 2024). The decision to proceed using a mixed-methods approach in this thesis was taken for a number of reasons. Firstly, the thesis deals with a complex and multi-faceted issue: Trainee psychological therapists and practitioners function in complex and challenging contexts, and are embedded within multiple systems (through their work and study for example). The literature on practitioner wellbeing and burnout is complex and disparate, lacking a clear conceptualisation of what wellbeing in the role looks like or how it is best supported. Mixed-methods research offers ways of harnessing the strengths of both quantitative and qualitative research to address complexity (Creswell & Plano Clark, 2018). Importantly, the questions that this thesis has sought to answer are also best answered by a combination of qualitative and quantitative findings. Questions exploring the way that PTTs experience and make sense of wellbeing in their roles (as described in Chapter 4) are best answered through the employment of qualitative techniques: using open and explorative questions to develop a detailed and participant-led account of trainees' personal experience. Questions designed to assess acceptability and feasibility through recruitment and retention data, or to monitor changes in variables of interest to the study (such as those detailed in Chapter 7) require the collecting and analysis of quantitative data. By mixing and integrating the quantitative and qualitative findings generated across the studies comprising this thesis, attempts have been made to provide a comprehensive picture of wellbeing in psychological therapy trainees; offering an account of how wellbeing is experienced and made sense of, and how it can be supported, in ways that extend beyond what would have been possible employing only quantitative or qualitative approaches alone. This has required adopting different perspectives at different stages of the thesis, and being open to different ways of knowing. It has meant valuing different types of knowledge

regarding trainee wellbeing, and working to bring these different perspectives together. This has required acknowledging the limitations of different types of knowledge, and limiting the claims made or conclusions drawn from each stage of the research to what is consistent with the assumptions of the approach on which it is founded. In keeping however with the pragmatic underpinnings of the thesis, efforts have been made to keep the focus on doing what works to answer the research question being addressed, and drawing out the practical consequences of the knowledge generated (Gillespie, 2024).

Purpose of the thesis and methodological considerations of each study

Taken as a whole, the purpose and aims of this thesis were to understand how to support wellbeing in trainee psychological therapists and practitioners, and to feasibility and acceptability test an intervention designed to do this. To support this, a number of specific research aims and questions were outlined. In keeping with mixed-methods research approaches, these research questions and aims were considered key in informing the methodological approach taken in each of the distinct components of the thesis. Whilst each included chapter of this PhD contains a distinct methods section, the current chapter offers a more detailed account of the overall methodology informing the thesis as a whole.

Chapter 3: In order to arrive at a detailed understanding of the existing literature in the field, Chapter 3 reports a systematic review designed to explore what works for psychological interventions designed to support trainee wellbeing. The aims of this systematic review were twofold: to identify effective primary and secondary outcomes for psychological wellbeing interventions for this population, and to explore perceived barriers and facilitators of successful intervention. In keeping with these aims, a mixed-methods approach was adopted, with quantitative, qualitative and mixed-methods research included in the review. Critically, the quantitative and qualitative findings were

interpreted together, in a way that helped each one make better sense of the other (e.g. using qualitative findings regarding the ways that trainees described interventions as helpful, to make sense of the mixed quantitative findings regarding intervention effectiveness). The inclusion of both quantitative and qualitative findings in this review reflects the multiple aims, and the value of both quantitative and qualitative data in answering the specific questions of the review. A detailed account of the methods of this review are presented in Chapter 3.

Chapter 4: Chapter 4 reports a qualitative interview study designed to explore how psychological therapy trainees experience wellbeing in their roles. A key finding of the systematic review was that researchers working in the area and designing studies to support the wellbeing of trainees conceptualise wellbeing in myriad and often inconsistent ways. Across the existing literature, constructs such as wellbeing, mental health, stress, and burnout are often used interchangeably, and it was frequently unclear exactly what wellbeing interventions were aimed at supporting, or why it was supposed that the particular intervention trialled was likely to address the specific challenges faced by trainees. To support attempts at improving the wellbeing of trainees in ways in keeping with how trainees themselves describe experiencing wellbeing in their roles, Chapter 4 was designed to ask trainees in depth about their experience of wellbeing during training; exploring how they experience wellbeing in their roles, how they make sense of it, and what it means to them. The specific question addressed in this research was: How do psychological therapy trainees experience wellbeing in their roles?

In order to address this question, an explorative and qualitative study was designed, in which individual trainees took part in one-to-one, semi-structured interviews. In keeping with these aims, data were both collected and analysed through an interpretative and phenomenological lens, and a phenomenological perspective underpinned the entirety of the study. The focus was on working in an interpretive manner to understand the experience of trainees, and how they themselves

perceived the nature and experience of wellbeing during training. The research was framed within this worldview and the knowledge generated through this process was considered and reported in this context.

In planning the study, consideration was given to the recruitment strategy, the number of participants needed, and how to achieve a sample that would support attempts to comprehensively answer the question of the research. Matters regarding sample size in qualitative research have been discussed extensively, with authors offering broad guidance, 'rules of thumb' and considerations for how to determine an appropriate sample size. Despite this, the issue remains subject to debate and consequently, multiple sources in this regard were considered in the early stages of planning this study (e.g. Braun & Clarke, 2013; 2021b; Malterud et al., 2016). Decisions were made that sought to balance available guidance (e.g. Braun and Clarke's cautious and broad recommendation that – pending several contextual factors – a 'small' project may find 6-10 interviews to be appropriate, and a 'medium' project or one study within a larger project may be better served with a sample of approximately 10-20 (2013)), with theoretical considerations (such as Malterud et al.'s 2016 notion of 'information power'), and the practical and pragmatic constraints of the PhD scope.

The notion of 'data saturation', a concept initially linked closely to Grounded Theory and ideas of theoretical sampling and constant comparison, has become a widely used justification for determining sample size in qualitative research (Braun and Clarke, 2021b). Despite its prevalence and the fact that it features in widely-used qualitative quality appraisal tools such as COREQ (Tong et al., 2007) and CASP (2024), several authors have cautioned against its unconsidered application (see for e.g. Braun & Clarke, 2021b; Malterud et al., 2016). Despite its initial links with specific theoretical features of Grounded Theory, data saturation is now frequently evoked as the justification for a particular sample size across a wide range of qualitative approaches, including those purporting to proceed from epistemological and ontological positions which sit uneasily with the notion of

saturation, or the idea that nothing new remains to be discovered through further data collection or analysis (Braun & Clarke, 2021b).

In this study, I knew I would be trying to explore the experience of wellbeing in the trainee role in-depth and in open and explorative ways. I had devised a semi-structured interview guide, but intended to use it flexibly, to allow for following participants in unexpected directions where appropriate. The phenomenological and reflexive approach I was adopting was also one in which findings would be considered to be generated actively through my engagement with the data (Willig, 2013). As such, the notion of saturation, or of arriving at a point where more interviews or data would cease to add anything new was theoretically inconsistent (Braun & Clarke, 2021b). The notion of information power however, through which the number of participants needed can be guided by considerations relating to the study aims, participant characteristics, use of theory, quality of dialogue, and analysis strategy (Malterud et al., 2016) was a more useful construct. From an information power perspective, it could be suggested that the relatively specific focus of my research question on the experience of wellbeing *in training*, and the status of participants as purposefully selected current trainees all with highly relevant experience for my question, were perhaps indicative of requiring a smaller sample. The relative absence of theory however and my intentions to focus the analysis on looking for patterns of meaning across the data set would tend towards requiring a larger sample. Whilst a relatively novice researcher, several pilot interviews and in-depth conversations with supervisors to review a pilot transcript increased confidence that the quality of the dialogue was likely to be strong and that the questions and approach used were likely to yield deep and high-quality data; something again indicative of the idea that a smaller sample size may be required.

In summary, multiple considerations were held in mind when thinking about the sample size for which I should aim. As described here, these considerations combined theoretical guidance from the literature, practical guidance on typical sample sizes from the literature, the perspective of experienced supervisors, and pragmatic considerations relating to the scope and timeline of the PhD.

In light of these various considerations, the study was designed on the idea that a total of 15 participants would be sought.

Establishing the trustworthiness of the research

Throughout all stages of planning and conducting the work of this chapter, I sought to work in ways designed to increase the rigour and value of the research. In their seminal 1985 work *Naturalistic Inquiry* (Lincoln & Guba, 1985) Lincoln and Guba discuss the important concept of 'trustworthiness' in qualitative research. They note how conventional criteria used in research conducted from a positivist perspective (e.g. internal and external validity, reliability, and objectivity) are logically inconsistent with the ontological and epistemological assumptions of qualitative, 'naturalistic' research. However, given that naturalistic or qualitative researchers are 'at least as concerned with trustworthiness as the conventional inquirer' (Lincoln & Guba, 1985, p.294), they propose an alternative set of criteria for research of this kind. These criteria have subsequently been highly influential on qualitative writing, being termed as the four 'pillars' of trustworthiness in qualitative research (Ahmed, 2024).

In Lincoln and Guba's terms, the four criteria can be thought of in the following ways:

Credibility: Credibility has to do with the extent to which findings are plausible, convincing, and adequately represent the realities they have explored. In qualitative research, reality is typically considered as both plural and constructed, meaning there isn't a single objective truth against which findings can be compared, verified, or justified. Instead, the task is to generate findings that are *credible* – both to readers and indeed to those in the context that has been studied. Lincoln and Guba discuss a range of techniques they propose to enhance credibility, such as seeking to increase the probability that findings will be found to be credible via including detailed and lengthy

observation of participants, triangulation of different information sources, or member checking of findings with participants.

Transferability: Transferability has to do with the extent to which the findings generated in one context may be meaningful in another. According to Lincoln and Guba, the transferability of research findings is an empirical matter, depending on the degree of similarity between what they refer to as the 'sending' and 'receiving' contexts. Accordingly, the responsibility of the researcher 'ends in providing sufficient descriptive data' (Lincoln & Guba, 1985, p.298) for others to make judgements about the extent to which the researched context and any other context they might seek to transfer findings into are similar. From this perspective then, providing rich and 'thick' descriptions of the phenomena that has been studied can help to increase the transferability of findings, by providing more of the information required by readers to make decisions regarding the extent to which generated findings transfer credibly to another context.

Dependability: Dependability has to do with the transparency and consistency of the research process, meaning for example that the process through which findings were generated is clearly documented and shown. Lincoln and Guba discuss ideas such as an 'audit' through which the findings of a research project, and the notes, data, and process through which such findings were generated, are 'audited' or explored. Whilst from an interpretivist position there is no single truth that the research can be demonstrated to represent, a clear and open audit trail which enables readers of the research to understand the methodological processes followed in arriving at the findings presented, is an important feature of 'trustworthy' research.

Confirmability: Confirmability has to do with the extent to which findings are grounded in the data, and the extent to which findings authentically represent the data from which they are generated. Rather than focussing on the objectivity or subjectivity of the researcher, Lincoln and Guba propose emphasising the data themselves; 'are they or are they not confirmable?' (Lincoln & Guba, 1985, p.300). Techniques such as reflexive journals and documenting audit trails are again highlighted as

important here, enabling readers to determine the extent to which findings relate to and reflect the data generated, collected and analysed through the process of the research.

In this chapter, efforts were undertaken at all stages to enhance the trustworthiness of the research. To enhance the credibility of findings, a reflective journal was kept at all stages of the project, providing a space to think out and work through thoughts about the research topic, why I was interested in it, how my thoughts and feelings about the topic were evolving as I planned and conducted the research, and what I attributed this to. Extensive notes were made after each interview, and supervisory discussions provided a platform for me to talk through my interpretations, and have my ideas prodded and questioned in productive ways. I found it useful to have the opportunity to respond to questions, to explain my thought processes, and to reflect on the logic and rigour of my own thinking. During interviews themselves, I used opportunities to informally check with participants that I was understanding them as intended, using summaries and reflections for example as a way of checking that the sense I was making of what they told me related to what they had intended. All participants were also offered the opportunity to review their transcripts, though none chose to do so. Due to pragmatic constraints regarding timelines of the PhD, it was not feasible to member check the write-up of the paper, something which could have provided a useful opportunity to hear from participants about whether they felt the sense I had made of data captured something important in what they had contributed. As such, the extent to which generated findings were credible to the research participants themselves remained unclear. Whilst not intended as a direct replacement for member-checking in the sense intended by Lincoln and Guba, Meeting 1 of the intervention development study began with a brief overview of the findings of the qualitative study (and systematic review) and an opportunity to discuss the extent to which these findings did or did not resonate with participants experience. This had been deliberately planned in order to provide

an opportunity to discuss with additional trainees and stakeholders whether the findings I had generated captured something credible and meaningful that resonated with the trainee experience.

To enhance the transferability of my findings, I sought to provide detailed descriptive accounts of the participants and the context in which the work was carried out, as well as the ontological and epistemological assumptions underpinning how data was generated and analysed. Whilst pointing to the need for comprehensive and 'thick' descriptions for enhancing transferability, Lincoln and Guba noted the absence of clear criteria for what such 'thickness' entailed (Lincoln & Guba, 1985, p.316). In recent writings on this topic (e.g. Younas et al., 2023), practical guidelines for providing thick descriptions in qualitative research have been developed in which 'thick' descriptions relate not only to descriptions of the context and participants of the research, but also the way in which data are interpreted and the manner in which the narrative of the findings is set out. In the work described in this chapter, I attempted to provide a detailed, meaningful, and contextualised account of trainees' experience, so that findings could be understood contextually, and so that readers had the information needed to make judgements about whether these findings were resonant with their own contexts.

In an effort to support the dependability of the research conducted in this chapter, I kept a detailed and extensive audit trail, documenting the decisions I made, the reasons behind these, and how I ultimately arrived at the conclusions that I did about the data. Raw data (i.e. transcribed interviews) was kept in an anonymised fashion, coded transcripts were saved, and accounts of how I was developing my analysis were saved repeatedly throughout. In so doing, I sought to keep a clear trail of the process I was following. In my original submission of this thesis, I accidentally left out examples of this trail, meaning readers had limited information on which to establish the dependability of my work. This important limitation meant that it would have been unclear to readers what process I followed, what paths I navigated in coding data or developing themes, or what data I was drawing on in generating the themes that I generated. In this re-submission, I have

been able to address this, by including multiple examples from my audit trail. I have included extract examples of a coded transcript for instance, demonstrating how data extracts were coded. I have also included examples from different stages of how I began to shape themes, grouping related codes and subsequently refining these to capture what I believed to be important in the data. Doing so has enabled me to increase the dependability, and therefore the trustworthiness, of this chapter.

In an effort to enhance the confirmability of the research findings presented in this chapter, I sought to ensure that findings were deeply grounded in the data, and that sufficient examples of quotes were provided for the reader to understand both what participants had described, and how the interpretative narrative I provided was built up from the data. Again, the initial omission of features of my reflective diary or audit trail from my submission impacted negatively on the confirmability of my work, though I hope that the chance to provide further information (extracts from my reflective diary, evidence of my analytic process, coding and efforts to develop themes etc.) with this re-submission helps to address this, by providing readers with the information required to understand how the interpretation I offer in the chapter can be traced back to the data from which they were developed.

In summary, I sought to ensure that the work of this chapter fulfilled the requirements of trustworthiness in qualitative research. In several regards (such as the absence of attempts to establish the credibility of my findings with research participants) the work presented in this chapter did not comprehensively fulfil all such requirements. However, despite these identified limitations, the work presented (especially as now evidenced in this re-submission) represents methodologically coherent, strong, and transparent work, evidencing strong levels of rigour and trustworthiness. The full details of the methods for this study are reported in Chapter 4.

Chapter 6: Chapter 6 reports a theory and stakeholder-informed intervention development study, guided by the MRC framework for developing and evaluating complex interventions (Skivington et

al., 2021). The 2021 MRC framework places significant emphasis on the need to evaluate complex interventions in ways that go beyond effectiveness or efficacy perspectives, and towards understanding how interventions interact with the contexts in which they are implemented, what wider changes will occur as a result of the intervention, how features of the intervention setting may mediate effects, and whether interventions are cost-effective (Skivington et al., 2021). Whilst acknowledging the important place that efficacy and effectiveness research continues to have for answering certain research questions, the central ethos of the updated framework emphasises the need to generate evidence that is useful in the real-world, and helpful for decision-makers in understanding which research to progress and what policies to implement in contexts that are dynamic, and in which resources are finite. For each stage of the intervention development process outlined in the framework (development or identification of the intervention, feasibility, evaluation, and implementation), a set of core elements are outlined. These core elements span considering context, developing and refining programme theory, engaging stakeholders, identifying key uncertainties, refining the intervention, and economic considerations. Efforts were made in the conceptualisation and delivery of the research presented in this chapter to adhere to multiple tenets of the MRC guidance. Key stakeholders (trainees and professional training staff) were involved at two separate points in the intervention development process for example, and stakeholder perspectives were central to supporting the development and refinement of a theory of change for the intervention, the development and refinement of the intervention itself, and for considering the complexity of the context for which the intervention was being designed. Reflections on the extent to which the research succeeded in aligning fully with the MRC framework are provided in the *Strengths and Limitations* section of the Thesis Discussion (Chapter 8).

The research of chapter 6 was underpinned by a worldview of pragmatism (Gillespie, 2024), with an emphasis on 'doing what works' to answer the questions of the research in a practically useful manner (Creswell & Plano Clark, 2018). Stakeholders (current trainees and professional training staff) were invited to take part in a series of two intervention development meetings during which their

views and perspectives were sought on the developing ideas for a wellbeing intervention designed for trainees. Feedback was sought from stakeholders through these structured intervention development meetings, scheduled to take place at two separate points across the intervention development process in an effort to ensure that stakeholder perspectives informed the process at multiple stages. Meetings were not recorded or transcribed, but notes were kept during and after meetings, and reflections were subsequently written up immediately after each meeting. In this way, whilst the accounts given by stakeholders were considered to offer a genuine insight into their thoughts and perspectives, my own position and values as a researcher were also considered central to the way that stakeholder perspectives were made sense of and interpreted.

The COM-B model (Michie et al., 2011) was used to provide an overarching theory of behaviour change for the study. The COM-B model was developed by Susan Michie and colleagues as a comprehensive model of the conditions required for behaviour change. From a COM-B perspective, behaviour occurs through a combination of capability, opportunity, and motivation. In the model, each of these components can be further sub-divided into two. Capability encapsulates both *psychological* capability (e.g. knowledge regarding how or why to undertake a particular behaviour) and *physical* capability (e.g. the physical capacity for undertaking a particular behaviour). Opportunity is considered both in terms of *physical* opportunity (e.g. the environment in which a behaviour is undertaken) and *social* opportunity (e.g. the way in which constructs such as culture, social norms, or language influence behaviour). Finally, motivation is considered in terms of *reflective* motivation (e.g. considered action, reflective planning, or conscious decision-making) and *automatic* motivation (e.g. factors related to how things such as emotions, dispositions, and moods might prompt or impede a behaviour).

To support the intervention development process, target behaviours were identified in collaboration with stakeholders. Two target behaviours were agreed: (1) Attend the intervention sessions and (2) Engage with between-session tasks. Consideration was subsequently given to how to encourage and

promote these behaviours through focussed discussion designed to uncover stakeholder perspectives on this point.

The COM-B model was applied in this study primarily as an underpinning theory of behaviour change, and an organising framework through which the primary researcher made sense of stakeholder contributions. As an example, researcher notes capturing key features of stakeholder input were organised according to relevance to capability, opportunity, and motivation. Stakeholder perspectives that mandating attendance may lead to trainees feeling negatively towards the intervention for example was framed as relevant to Motivation. Similarly, stakeholder feedback that attending sessions around the requirements of a busy training schedule would be facilitated by keeping session numbers and length to the minimum considered likely to have a beneficial effect, was framed in terms of Opportunity.

Whilst stakeholders were not expected to be familiar with COM-B in order to participate and the model was not used explicitly to direct the discussions in the meetings, it underpinned the way that the study was conducted (framing how the target behaviours were thought about, and informing the questions asked in meetings by seeking to uncover stakeholder perspectives on what might facilitate or impede such behaviour) and the manner in which stakeholder perspectives were made sense of. In this way, the model provided a robust and transparent framework through which the findings could be interpreted, and research decisions made sense of. Notably however, COM-B is only one feature of the larger Behaviour Change Wheel (BCW) (Michie et al., 2011; Michie et al., 2016), and in this way, the use of COM-B in the current study was focussed and contained. The BCW consists of three layers (Michie et al., 2011), with COM-B conceptualised centrally, as a simple model of behaviour: behaviour occurs when there is an adequate combination of capability, opportunity, and motivation. Outside this central hub in the BCW sit nine 'intervention functions'; functions of an intervention (such as 'education', 'persuasion' or 'coercion') that can aid in increasing capability, opportunity or motivation. In the outer layer of the BCW, seven different policy types (such as

'Guidelines', 'Legislation', or 'Service Provision') through which intervention functions can be implemented are described. When designing behaviour change interventions, the BCW can therefore be used to identify target behaviours for a particular individual or group, consider the effect of capability, opportunity, and motivation on that behaviour, identify functions of an intervention which might increase capability, opportunity or motivation, and finally to align such functions with an appropriate policy type. Whilst the BCW is used widely in intervention development research (Michie et al., 2016), it has occasionally been criticised for extensive resource implications and a level of complexity which risks rendering it impractical in some settings (e.g. Webb et al., 2016; Whittal et al., 2021). In the current study therefore, a decision was made to use COM-B in the more focussed and contained way described here. Target behaviours were identified, and a COM-B analysis through which stakeholder perspectives of what might facilitate or impede the performance of these behaviours was undertaken by the primary researcher, on the basis of stakeholder input. As discussed in the strengths and limitations section of this chapter, this decision was seen both to strengthen the research (by encouraging stakeholder involvement through minimising requirements to take part, and providing a transparent framework to underpin the research that was conducive to the resources and timeline available to the project) but also to pose a limitation. The process undertaken here for example (driven primarily as it was by myself as the primary researcher) was comparatively informal, and required subjective decision-making at times. Decisions regarding how to categorise stakeholder input (e.g. as relevant to capability or motivation) were led by myself as the primary researcher. Similarly, whilst decisions about the implications of stakeholder views were discussed in detail with stakeholders at both the first and the second intervention development meetings, final decisions were nonetheless led by myself. As an example, in the COM-B analysis developed following Meeting 1 and shared with stakeholders in Meeting 2, the implications of trainee schedules having been described as busy were presented as meaning that sessions should be kept to a minimum and delivered online (as this was my interpretation of what stakeholders had fedback). As such, whilst the full BCW itself has also occasionally been criticised for requiring high-

levels of subjective judgement (Whittal et al., 2021), it is important to note that its use in the current study may have supported higher levels of transparency and rigour than were achieved through the use of COM-B in this more contained form. This places important limitations on the research, and is an issue which should be borne in mind when making sense of the results presented in this chapter. Further details of the methods employed are detailed in Chapter 6.

Chapter 7 reports a mixed-methods acceptability and feasibility study of the intervention developed as a result of the earlier processes described above. Acceptability and feasibility are complex constructs that are considered important implementation outcomes (Proctor et al., 2011). In the Implementation Outcomes Framework of Proctor and colleagues, acceptability is described as a perception amongst stakeholders that an intervention or service is 'agreeable, palatable, or satisfactory' (Proctor et al., 2011, p.67). Feasibility is described by the same authors as the extent to which a treatment or intervention 'can be successfully used or carried out within a given agency or setting' (Proctor et al., 2011, p.69). Whilst implementation outcomes such as acceptability and feasibility have occasionally been assessed using similar items and are acknowledged to be related (Weiner et al., 2017), consideration of these outcomes as distinct constructs is important, with each contributing differently to implementation success (Proctor et al., 2011).

A worldview of pragmatism underpinned the study conducted in Chapter 7, meaning that the consequences of the research were held firmly in mind throughout, and a focus was retained on doing 'what works' to answer the questions of the research in practical and useful ways (Creswell & Plano Clark, 2018). Pragmatism has become increasingly popular as a worldview to underpin mixed methods research in recent years, with its emergence coinciding with a calming of paradigm debates regarding the supposedly opposing lenses of quantitative and qualitative research (Creswell & Plano Clark, 2018). Instead, when working from a pragmatic perspective, researchers can draw on multiple methods of data collection and multiple ways of knowing, in an effort to create applicable and

translatable knowledge. Instead of seeking absolute truths supposed to be timeliness and independent of human beings, researchers working from a perspective of pragmatism are interested in generating knowledge and ideas that can be impactful in the real world (Gillespie, 2024). In keeping with such ideas, this acceptability and feasibility study used quantitative analysis of relevant psychometric measures and qualitative analysis of interview transcripts to answer questions regarding the perceived acceptability and feasibility of the intervention. The quantitative and qualitative data were analysed independently using methods appropriate for that data and the specific questions being asked. These findings were then integrated to provide a more comprehensive answer to the questions of the research, and to inform the design of future larger trials of a similar intervention in a similar context.

Despite the growing recognition of the importance of implementation outcomes such as acceptability and feasibility, researchers have noted a paucity of validated, reliable and pragmatic measures of these constructs, and drawn attention to the fact that the constructs themselves are often insufficiently defined in research (Weiner et al., 2017). In an overview review of systematic reviews exploring the acceptability of healthcare interventions for example, Sekhon and colleagues noted how acceptability was rarely defined, and was often inferred instead via measurement of other constructs such as satisfaction, or behavioural indicators such as dropping out from an intervention (Sekhon et al., 2017).

In the Acceptability and Feasibility study of Chapter 7, acceptability and feasibility were conceptualised in terms aligned with their presentation in the Implementation Outcomes Framework (Proctor et al., 2017). Whilst considered together, efforts were made to distinguish between the two outcomes, both through independent psychometric measurement of each construct, and the use of qualitative interview data to differentiate between when observed behavioural outcomes (such as dropping out of the study) reflected acceptability or feasibility concerns.

Acceptability and feasibility were measured directly using validated measures (the Acceptability of Intervention measure (AIM) and the Feasibility of Intervention Measure (FIM)) (Weiner et al., 2017). The AIM and FIM drew on the Implementation Outcomes Framework of Proctor and colleagues, and were designed to provide pragmatic, reliable, and easy-to-use measures of acceptability and feasibility, given the central place these outcomes are frequently afforded in evaluating implementation success (Weiner et al., 2017). In recognition of the fact that supplementing direct measurement of these constructs with measures of observed behaviour can provide a more comprehensive evaluation (Sekhon et al., 2017), acceptability and feasibility were also assessed via quantitative assessment of recruitment and retention. Finally, in keeping with the mixed-methods approach of the study and reflecting the fact that integrating quantitative and qualitative data can provide a richer and more nuanced account than either data alone (Creswell & Plano Clark, 2018), acceptability and feasibility were also evaluated qualitatively, via semi-structured interviews with participants (both intervention completers and drop-outs) designed to explore matters relating to the extent to which the intervention was perceived as acceptable and feasible. The integration of quantitative and qualitative data in this way enabled a more nuanced understanding of the intervention acceptability and feasibility. Whilst measurable behaviours relating to recruitment and retention have frequently been used alone as indicators of intervention acceptability for example, they do in fact provide only limited value in this regard since the reasons that an individual ceases to continue with an intervention may be many and varied (Sekhon et al., 2017). In Chapter 7 of this thesis therefore, qualitative interview data regarding the reasons participants had not completed the intervention were used to understand the extent to which retention figures reflected acceptability or feasibility concerns. Further methodological considerations for this study are described in Chapter 7.

Summary

As can be seen therefore, different worldviews have been used to underpin different components of this thesis, and these worldviews have been adopted in relation to the context and questions of each

individual study (Creswell & Plano Clark, 2018). In this sense, the research has proceeded in keeping with Maxwell's account of paradigms and philosophical assumptions as useful but fallible lenses through which we can view phenomena and generate knowledge (Maxwell, 2023). Rather than seeking to identify one single and internally coherent worldview to underpin the entirety of the research project, care has been taken to proceed in ways consistent with the questions being asked at each stage of the thesis. By acknowledging the inherent complexity of human phenomena and experience, this approach has sought to address and work with this complexity in multiple ways. Instead of searching for one single, legitimate approach or worldview, this has meant acknowledging, legitimising and valuing multiple ways of knowing (Greene, 2012). Importantly, this has not meant doing away with philosophical argument, ignoring the significance of philosophical assumptions, or proceeding as though these complexities did not exist. Rather, it has meant paying careful attention to these assumptions at each stage of the project, and designing each study in a way that gives careful and considered thought to the requirements of the research question, the best way to answer it, and the assumptions underpinning any attempt to do so. In this regard, the research has followed Maxwell's suggestion that the 'coherence' that mixed-methods research should aim at is best understood not in terms of consistency and singularity, but in terms of practical and pragmatic compatibility (Maxwell, 2023).

In practical terms, this meant valuing different types of knowledge (such as that generated through the qualitative interview study, and the quantitative findings of the acceptability and feasibility study) whilst also acknowledging their limitations and carefully considering the types of practical claims that can be developed from the positions from which they were developed. It also meant seeking to use these different types of knowledge to work together in the effort to provide a more comprehensive answer to the overall aims of the thesis. As examples of this, in the final discussion chapter, qualitative findings from Chapter 4 are used to unpack possible reasons for some of the unexplained features of effectiveness findings identified in the systematic review, and further, these findings are considered in dialogue with each other to generate additional insights into the nature

and experience of wellbeing in the trainee role. Similarly, quantitative and qualitative findings regarding the value and acceptability of the ACT intervention reported in Chapter 7 are used in dialogue with each other, in an effort to provide a more comprehensive account of the intervention's acceptability, feasibility, and potential wellbeing value.

By consistently keeping the primacy of the research question in mind, and adopting perspectives and approaches seen to best fit the particular research question or aim being addressed, I have sought to make flexible use of a variety of worldviews in a way that has supported a comprehensive answering of the research questions. By drawing together both qualitative and quantitative data, and by seeking to dialogue between these different findings I have sought to generate deeper and more comprehensive knowledge on the topic, whilst always respecting and paying careful attention to the epistemological and ontological assumptions underpinning each facet of the research (Greene, 2012). In so doing, my focus has been on pragmatic and real-world implications and practical consistency.

Reflexivity

As a researcher working in the field of psychological practitioner wellbeing, an educator delivering training to applied psychological professionals, and the intervention lead for the intervention that was delivered as part of this thesis, I have held several different roles regarding the subject matter, over the duration of this PhD. This has required careful thought and planning, and a determination to consider how my position has influenced the research at all stages. My interest in the topic, the questions I have asked, the ways I have made sense of the data, and my hopes for what I can do with the findings have all been influenced by my own personal and professional history. Conducting the research then in a way that seeks to embrace and build on that, whilst keeping firmly in mind the ways that it might impact on my approach, has been important. It has also been necessary to keep in

mind the ways that my position (as Programme Director for an applied psychology programme in the department I have recruited participants from, and as PhD student and researcher) may have influenced who amongst the trainees advertised to may have been willing to take part, and what they may have felt able to discuss with me at each stage of the research. Consideration of these points, and the wider issues of power imbalances in the research have been reflected on and discussed in detail throughout the PhD, especially in relevant sections of empirical chapters. Regular discussion with supervisors, frequent journalling, and the maintenance of strong and clear audit trails at all stages have been imperative in this regard, and have helped me to maintain methodological rigour across the thesis as a whole.

Chapter 3: What works for psychological interventions designed to increase wellbeing in psychological therapy trainees: A systematic review

This systematic review was accepted for publication in *the Journal of Mental Health Education, Training & Practice* in October 2024. The accepted version is presented below.

Owen, J., Biggart, L., Fisher, P., Figueredo, A., Al-Rousi, S., Colvin-Jarvis, J., Williamson, E., & Sanderson, K. (2025). What works for psychological interventions designed to increase wellbeing in psychological therapy trainees? A systematic review. *Journal of Mental Health Training, Education and Practice*, *20*(1), 45-60. https://doi.org/10.1108/JMHTEP-01-2024-0009

Abstract

Purpose: This systematic review sought to identify what works for psychological interventions or teaching strategies designed to improve wellbeing in Psychological Therapy Trainees (PTTs).

Design: A Systematic Review was conducted in keeping with best-practice guidelines. The protocol for the review was registered prospectively on PROSPERO.

Findings: 70 studies were included in the review. The balance of evidence across quantitative, qualitative and mixed-methods studies cautiously suggests that interventions designed to improve PTT wellbeing may be of value. Novel findings regarding barriers and facilitators of successful intervention were identified. Particularly notable in this regard was the finding that providing trainees with a degree of choice or control over elements of the intervention appeared to be an important facilitator of success. Importantly however, the review identified a number of

methodological weaknesses in the literature, undermining the certainty of findings. More high-quality research is needed in order to answer the questions of the review decisively.

Originality: This is the first review to systematically identify and synthesise findings on this important topic.

Practical implications: Evidence tentatively suggests that interventions to support trainee wellbeing are often received well by trainees and are frequently perceived by trainees as beneficial. Providing trainees with some degree of choice or control regarding how to engage with wellbeing interventions during training may be important.

Introduction

The wellbeing of the psychological therapist workforce has been identified as an area of concern (Simionato & Simpson, 2018), with increasing evidence to suggest the issue is even greater during training (Owen et al., 2021; Pakenham & Stafford-Brown, 2012). Poor wellbeing has been shown to impact negatively on a range of outcomes relevant to this population, including reduced clinical effectiveness (Delgadillo et al., 2018), poorer academic outcomes (Pascoe et al., 2020), greater intention to leave the workforce (Summers et al., 2021) and higher incidences of professional misconduct (Barnett et al., 2007a). Poor wellbeing in this population can therefore be costly, meaning that the implementation of interventions designed to support trainee wellbeing may offer a cost-effective investment (Wagner et al., 2023).

Research regarding interventions designed to improve psychological therapy trainee (PTT) wellbeing has increased in recent years, but as yet no systematic attempt has been made to identify and synthesise findings on the topic. In complex intervention research, there is an increasing awareness of the need to understand the ways in which an intervention interacts with the context in which it is delivered, and the nature of the underlying programme theory (Skivington et al., 2021). This review

therefore seeks to synthesise findings regarding what works for wellbeing interventions for PTTs in a way that will support future researchers in the design of effective interventions in this population; collating findings regarding effectiveness, and the factors associated with successful intervention. The review will synthesise findings regarding 'barriers' and 'facilitators' of successful intervention, an approach that remains a common and influential way of positively informing evidence-based policy and practice (Bach-Mortensen & Verboom, 2020). To support this, the review will also utilise the implementation outcome framework of Proctor and colleagues (Proctor et al., 2011) as a useful framework from which implementation success can be evaluated.

Objectives

The purpose of this systematic review is to establish what is known about psychological well-being interventions for PTTs. The specific questions are:

1. What are effective primary outcomes of psychological wellbeing interventions for psychological therapy trainees?
2. What are the perceived barriers and facilitators of successful psychological wellbeing interventions or teaching strategies designed to improve PTT wellbeing?

Method

A protocol for this review was registered prospectively on PROSPERO (CRD42022319638). The review protocol was informed by PRISMA and SWiM guidance (Campbell et al., 2020; Page et al., 2021).

Eligibility criteria

Eligibility criteria were: (a) written in English, (b) report original empirical findings on psychological interventions or teaching strategies for which improving wellbeing is one of the research aims or

hypotheses, or for which at least one wellbeing related outcome measure is used, (c) delivered in a formal psychological therapy training program, (d) have psychological therapy trainee participants.

PTTs were defined as anyone enrolled in a formal training program leading to qualification as any type of psychological therapy practitioner. Trainees across multiple therapeutic modalities (e.g. CBT, counselling, clinical psychology) and academic levels (e.g. undergraduate, masters and doctoral-level) were included. Wellbeing outcomes were conceptualised broadly and from a psychological perspective, to include measures of wellbeing, stress, mental health, burnout, and psychological distress, as well as qualitative data on wellbeing. Qualitative, quantitative and mixed-methods studies were eligible, and no constraints on study design were applied. Both published and unpublished work were eligible.

Search strategy

A systematic search was carried out on 18/10/2023 on APA PsychINFO, CINAHL Complete, MEDLINE Complete, Academic Search Complete, SCOPUS, and the authors' Library Catalogue (EBSCO). MeSH terms, wildcards (the '*' symbol) and Boolean Operators (AND or OR) were used with the following keywords: wellbeing *OR* well-being *OR* stress *OR* burnout *OR* burn-out *OR* psychological distress *AND* psychology* *OR* counsel* *OR* therap* *OR* psychotherapy* *AND* trainee *OR* student *OR* training *OR* education. A full search strategy for PsychINFO is provided in Supplementary Material 1.

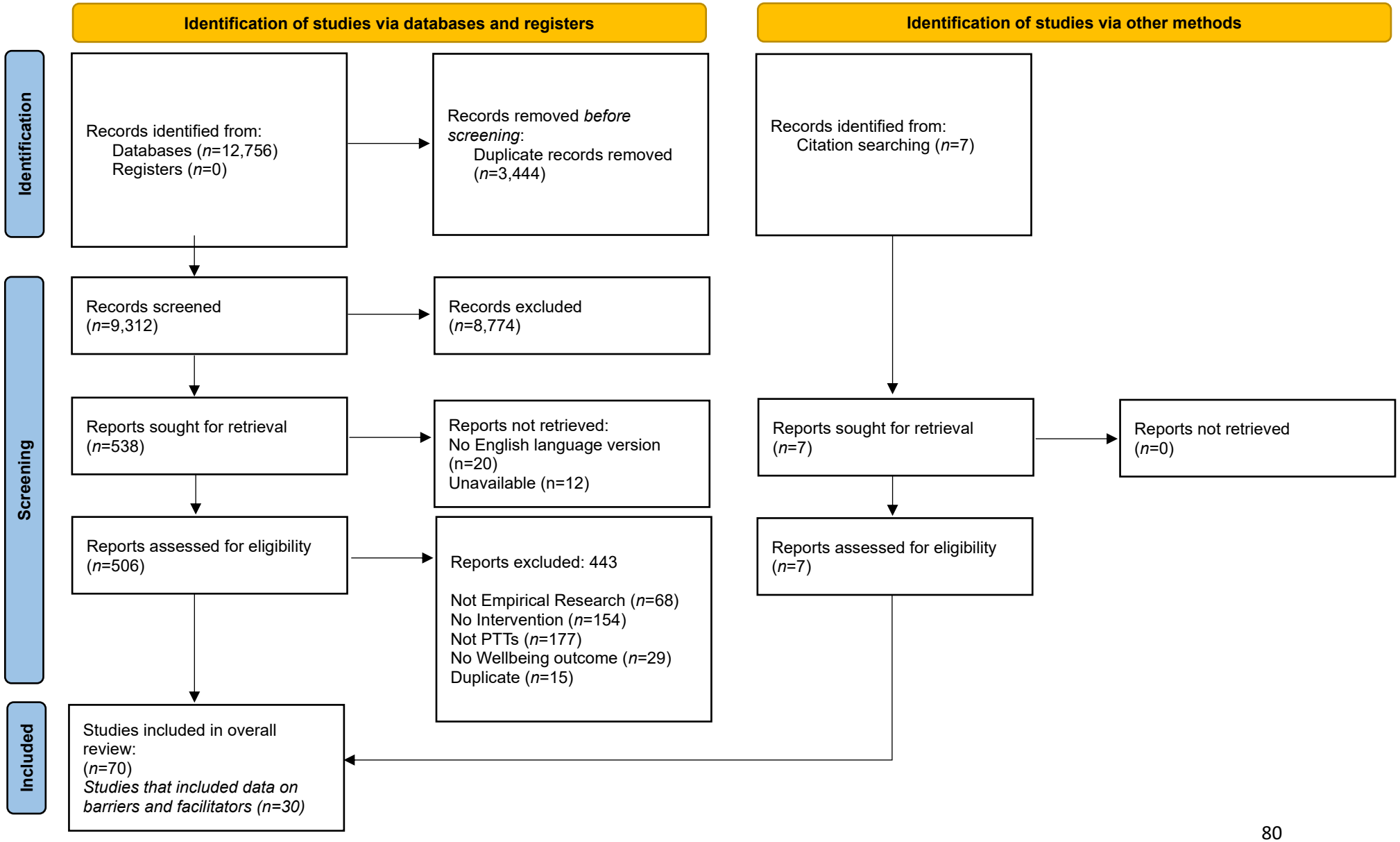
Study selection

The first author screened all texts at title/abstract (*n*=9,312) and full-text (*n*=538) stages. Members of the research team double-screened 25% of articles at both stages, with agreement exceeding 97% at both stages. Disagreements were resolved through discussion. A subset of included studies (n=28) contained data relevant to barriers and facilitators. The research team met frequently throughout this process, to discuss and promote consistency.

Data collection process

Data was extracted using a purpose-designed table in Microsoft Excel. The first author performed data extraction for all included studies. This process was repeated on 30% of studies by research team members. Data extraction was highly consistent across researchers, with only minor and infrequent discrepancies identified (e.g. phrasing used to describe details). Extracted data included author and date; article type; Research questions or aims; Participant (n=); Participant characteristics; Attrition; Compulsory (Y/N); Design; Intervention; Duration; mode of delivery; outcomes measured; summary of key findings. A basic overview of characteristics for each study is presented in Table 1. Extended study characteristic details can be found in Supplementary Material 2.

Figure 1: PRISMA flow diagram showing identification of final results. (Source: Page et al., (2021))



Risk of bias

Risk of bias was assessed at study level using the Mixed-Methods Appraisal Tool (MMAT) (Hong et al., 2018), an efficient and reliable tool for appraising quantitative, qualitative and mixed-methods designs (Souto et al., 2015). All studies were assessed by the primary author, and a randomly selected 30% were double screened by three members of the research team. Consistency was high, with over 98% of all rating items agreed upon. Discrepancies were resolved through discussion. In keeping with MMAT guidelines, consideration of the quality issues identified through the Quality Appraisal are reported in the narrative presentation of results (Hong et al., 2018), meaning that findings regarding study quality informed the presentation of results, and are considered explicitly when drawing conclusions. Full details of the Quality Appraisal outcome for each study are available in Supplementary Material 3.

Synthesis Method

SWiM guidance has been drawn upon for the synthesis and presentation of results (Campbell et al., 2020). After being extracted into tables, data was grouped by intervention type (e.g. Mindfulness, ACT etc.) and analysed by comparing significance of quantitative outcomes, as heterogeneity of included studies precluded meta-analysis. Qualitative findings were carefully read and compared, with shared findings being combined, before a narrative synthesis was produced that captured both quantitative and qualitative findings. In keeping with SWiM guidance, the certainty of outcomes was considered and presented in a manner which accounted for heterogeneity in findings and study quality. Despite having been analysed by intervention, results are presented below as a whole to reflect the key finding that outcomes and perceived effects did not vary consistently between intervention groups. Findings regarding barriers and facilitators were identified and synthesised in keeping with methodological recommendations for Systematic Reviews of barriers and facilitators (Bach-Mortensen & Verboom, 2020). All data relating to barriers and facilitators were extracted, before being categorised, coded and grouped as barriers or facilitators. Related codes were grouped

systematically to facilitate clear and structured organisation of the data. In keeping with relevant guidance, themes were then created to capture salient perceived barriers and facilitators as experienced by PTTs, by considering both the frequency with which they were mentioned and the extent to which such barriers and facilitators were perceived by participants to impede or promote success or engagement. In the absence of established guidelines for testing the robustness of such groupings (Bach-Mortensen & Verboom, 2020), their rigour and usefulness were examined through discussion with the research team. To further contextualise the findings, and to support their organisation, Proctor et al.'s Implementation Framework (Proctor et al., 2011) has been drawn upon to provide a conceptual framework to underpin the presentation of results.

Results

A total of 70 studies were identified, from locations across the UK, USA, Australia, and continental Europe. Participants included trainees from a variety of therapy training programmes (e.g. clinical psychology, cognitive behavioural therapy, and counselling). Trainees spanned the working age-group, though most were aged in their mid-twenties to mid-thirties, and predominantly female. All data relating to barriers and facilitators in all included papers was from the perspective of intervention participants.

Included studies were based on a wide-range of therapeutic approaches (including those based on Mindfulness (n=31), Wellness Plans (n=8), Compassion-based interventions (n=3), Stress-Management (n=4), Acceptance & Commitment Therapy (n=4), and a theoretically diverse mixed/other category (n=20)). Significant diversity was also identified in terms of intervention duration and intensity, with interventions based on 10-minute mindfulness practices, through to interventions taking place over several months and involving extensive home-practice. (Comprehensive information regarding the design, nature and findings of each included study is available in Supplementary Material 2).

A total of 44 studies reported quantitative data on wellbeing, with 27 (61%) reporting a significant improvement on at least one measure of wellbeing (see Table 1). Wellbeing was measured and conceptualised broadly, including measures of stress, burnout, satisfaction with life, psychological wellbeing, anxiety and depression. A majority of studies relied on 'negative' indicators of wellbeing (e.g. anxiety, stress or burnout) and few studies included measures of both positive and negative indicators of wellbeing. Every study reporting qualitative data relevant to wellbeing (*n*=36) indicated that a majority of participants reported positive gains in respect to wellbeing, with trainees frequently describing themselves as experiencing increases in positive emotion and purpose, and decreases in stress, anxiety or burnout. Whilst the strong trend across quantitative and qualitative data combined therefore was towards supporting the usefulness of interventions, the quality-appraisal process identified a number of methodological weaknesses in studies across all intervention types, suggesting a need for caution in interpreting these results. Quality issues were especially pronounced in studies employing quantitative methodologies, where incomplete outcome data, lack of clarity regarding whether training practices had been adhered to, and the presence of uncontrolled-for confounding factors were common. Similarly, few studies used any form of control group (*n*=17), raising questions about the extent to which the positive findings identified can be reliably attributed to the interventions undertaken. An important finding of this review therefore is that whilst the volume of studies in this field has expanded significantly, more high-quality and well-designed studies (including those using a control-group, reporting follow-up effects and measuring outcomes to capture both positive and negative features of wellbeing) are needed before definitive conclusions can be drawn about intervention effectiveness with this population.

Table 1. Study details and significance of quantitative outcomes

Author & Date	**Quant/Qual/MMR**	**Intervention Type**	**Significant effect on one or more wellbeing measures**
(Abel et al., 2012)	Quant	Stress-Management	Y
(Bauman, 2017)	Quant	Mindfulness-based	N
(Bell et al., 2017)*	Qual	Compassion-Based	n/a
(Biberstein, 2006)	Quant	Stress-Management	Y
(Boellinghaus et al., 2013)*	Qual	Mindfulness-based	n/a
(Bohecker & Doughty Horn, 2016)	Quant	Mindfulness-based	N
(Bohecker et al., 2014)*	Qual	Mindfulness-based	n/a
(Bohecker et al., 2016)*	Qual	Mindfulness-based	n/a
(Brat, 2017)	Quant	Mindfulness-based	Y

(Burkhart, 2014)	MMR	Mixed/Other - Integral Life Practice (ILP).	N
(Chan et al., 2021a)	Quant	Mindfulness-based	Y
(Chandler et al., 2001)	Quant	Mixed/Other - Relaxation therapy with biofeedback.	Y
(Chlebak et al., 2013)*	Qual	Mindfulness-based	n/a
(Chrisman et al., 2009)*	Qual	Mindfulness-based	n/a
(Christopher et al., 2006)	Qual	Mindfulness-based	n/a
(Christopher et al., 2011)	Qual	Mindfulness-based	n/a
(J. S. Cohen & Miller, 2009)	Quant	Mindfulness-based	Y
(Collard et al., 2008)*	Quant	Mindfulness-based	Y
(Costello, 2016)	MMR	Mindfulness-based	N
(Dorian & Killebrew, 2014)*	Qual	Mindfulness-based	n/a

(Dye et al., 2020)	MMR	Mindfulness-based	N
(Felton et al., 2015)	Qual	Mindfulness-based	n/a
(Finlay-Jones et al., 2017)*	Quant	Compassion-Based	Y
(Fiorentino, 2009)	Quant	Stress-Management	N
(Golwurm et al., 2003)	Quant	Mixed/Other - Subjective Wellbeing Intervention	Y
(Guler & Ceyhan, 2021)	MMR	Mixed/Other - Purpose designed 'Self-Care for Counsellors' course	Y
(Guse, 2010)*	Qual	Mixed/Other - Positive Psychology	n/a
(Gutierrez et al., 2016)	Quant	Mindfulness-based	Y
(Gutierrez et al., 2019)*	Qual	Mindfulness-based	n/a
(Harris, 2010)	Quant	Mindfulness-based	N

(Hopkins & Proeve, 2013)*	MMR	Mindfulness-based	N
(Jones-Trabatoski, 2009)	Quant	Mixed/Other - Hypnosis for Stress Management	Y
(Katzenmeier, 2015)	Quant	Stress-Management	N
(Kissil & Niño, 2017)	Qual	Mixed/Other - Person of the Therapist Training	n/a
(Kumari, 2011)*	Qual	Mixed/Other - Personal Therapy	n/a
(Lau, 2012)*	Qual	Mindfulness-based	n/a
(Leppma & Young, 2016)	Quant	Mindfulness-based	n/a
(Lindo et al., 2015)*	Qual	Wellness-Plans	n/a
(McMahon, 2016)*	Quant	Mixed/Other – Combined DBT/ACT	Y
(Meany-Walen et al., 2016)	Quant	Wellness-Plans	Y

(Moore, 2008)*	MMR	Mindfulness-based	N
(Moyer et al., 2017)*	MMR	ACT-Based	Y
(Mumbauer-Pisano & Kim, 2021)*	Quant	Wellness-Plans	Y
(Nelson et al., 2023)*	MMR	Mixed-Other – Resilience Training	N
(Newsome et al., 2006)*	Qual	Mindfulness-based	n/a
(Norris, 2016)*	Qual	Compassion-Based	n/a
(Ohrt et al., 2015)	Quant	Wellness-Plans	N
(Pakenham & Stafford-Brown, 2013)*	MMR	ACT-Based	n/a
(Pakenham, 2015)	Quant	ACT-Based	N
(Pintado, 2019)	Qual	Mindfulness-based	n/a
(Pirtle et al., 2019)	MMR	Mixed/Other – Logotherapy Group	Y

(Primavera, 2022)*	Qual	Mixed/Other – Eclectic self-care	n/a
(Quigley et al., 2022)	Quant	Mixed/Other - Text-message-based mHealth intervention	Y
(Rimes & Wingrove, 2011)	MMR	Mindfulness-based	N
(Robins et al., 2019a)*	Quant	Mixed/Other – Manualised DBT for BPD	Y
(Roby, 2007)	Quant	Mixed/Other – Psycho-ed about burnout, its causes, and consequences	N
(Rockwell, 2019)	Qual	Mindfulness-based	n/a
(Roembke, 2015)	Quant	Mixed/Other – Purpose-designed Burnout-Prevention Seminar	Y
(Sartor et al., 2023)	Quant	Mixed/Other – Grace Intervention	N
(Schanche et al., 2020)	Quant	Mindfulness-based	Y

(Schure et al., 2008)*	Qual	Mindfulness-based	n/a
(Scott et al., 2021)	Quant	Mixed/Other – CBT-based Self-Practice/Self-Reflection	Y
(Shapiro et al., 2007)	Quant	Mindfulness-based	Y
(Simon, 2021)*	Qual	Mixed/Other – Eclectic approaches to self-care and wellbeing psycho-education	n/a
(Spendelow & Butler, 2016)*	MMR	Mixed/Other – CBT-based Self-Practice/Self-Reflection	n/a
(Stafford-Brown & Pakenham, 2012)*	Quant	ACT-Based	Y
(Stalnaker-Shofner, 2014), 2014)	Quant	Wellness-Plans	Y
(Storlie & Smith, 2012)	Quant	Wellness-Plans	Y
(Wolf et al., 2014)	MMR	Wellness-Plans	Y
(Young et al., 2013)*	Quant	Wellness-Plans	N

	Total: Quant = 34 Qual = 23 MMR = 13	**Total**: Mindfulness = 31 Wellness Plans = 8 ACT-based = 4 Compassion-based = 3 Stress Management = 4 Mixed/other = 20	**Total**: Y = 27 N = 17

Note: studies identified with asterisk (*) included data on barriers and facilitators.

Barriers and Facilitators

The extent to which participants engage with interventions is of paramount importance for their success. Therefore, assessing barriers and facilitators to intervention implementation is as important as evaluating results of the intervention itself. In keeping with relevant recommendations (Bach-Mortensen & Verboom, 2020), we note here an explicit definition of how barriers and facilitators were conceptualised in this review. 'Facilitators' were conceptualised as factors that were perceived to promote or enable success with, or engagement in, an intervention, under the conditions in which it was delivered. 'Barriers' were conceptualised as factors that were perceived to impede success with, or engagement in, an intervention, under the conditions in which it was delivered. In total, 28 of the 70 studies included in the review also included data regarding barriers and facilitators (for information regarding which studies included this data, see Table 1).

Facilitators

Facilitators identified across the review related to the Implementation Outcomes of 'Acceptability', 'Appropriateness' and 'Feasibility' (Proctor et al., 2011). Salient perceived facilitators of engagement and success were a group format (Bohecker et al., 2016; Chrisman et al., 2009; Guse, 2010; Lindo et al., 2015; Robins et al., 2019a; Young et al., 2013), having some degree of choice over intervention content (Chlebak et al., 2013; Dorian & Killebrew, 2014; Hopkins & Proeve, 2013; Mumbauer-Pisano & Kim, 2021; Schure et al., 2008), the experiential nature of interventions (McMahon, 2016; Moyer et al., 2017; Robins et al., 2019b), and interventions being brief in nature (Chlebak et al., 2013; Moore, 2008). Five studies indicated that providing choice or autonomy over the techniques practiced was an important facilitator of engagement and success. In two of these studies, providing participants with choice over the techniques practised was reported to counter challenges associated with finding time to practice, or engaging successfully with mindfulness practice (Dorian & Killebrew, 2014; Hopkins & Proeve, 2013). Results in the further three studies (Chlebak et al., 2013; Mumbauer-Pisano & Kim, 2021; Schure et al., 2008) indicated that participants valued different aspects of a

multi-component intervention differently, suggesting that offering choice engaged individuals with the intervention, where a more fixed – or single-strand – intervention may have failed. This represents a novel and important finding, with the potential to support educators in the successful design of wellbeing interventions across multiple different intervention types.

Barriers

Barriers identified across the review related to the Implementation Outcomes of 'Acceptability', 'Appropriateness' and 'Feasibility' (Proctor et al., 2011). Salient barriers related to the challenge of time constraints (Bell et al., 2017; Finlay-Jones et al., 2017; Gutierrez et al., 2019; Hopkins & Proeve, 2013; Kumari, 2011; Lau, 2012; Primavera, 2022), challenges with technical content (Bell et al., 2017; Dorian & Killebrew, 2014; Guse, 2010; Gutierrez et al., 2019; Pakenham, 2015; Stafford-Brown & Pakenham, 2012), concerns about potential negative effects of interventions (Boellinghaus et al., 2013; Kumari, 2011; Spendelow & Butler, 2016), insufficient choice and variety in techniques (Primavera, 2022), and feeling that interventions were not tailored specifically enough to psychology trainees, already familiar with key psychological concepts (Nelson et al., 2023). PTTs taking part in self-practice/self-reflection of CBT techniques, personal therapy, and mindfulness, described concerns about possible adverse effects such as uncovering previously unacknowledged difficulties or aggravating negative emotional states (Boellinghaus et al., 2013; Kumari, 2011; Spendelow & Butler, 2016). These findings highlight that paradoxically, interventions designed to improve wellbeing have the potential to do the opposite. This important finding emphasises how facilitating and delivering interventions in a way that manages and contains unintended negative consequences of interventions is critical.

Discussion

In recent years, a growing evidence base has explored the effectiveness of interventions designed to improve healthcare professional wellbeing (Kletter et al., 2021; Lomas et al., 2018). With

psychological-therapy workforces operating in stretched services and expanding to meet constantly rising need, the issue of trainee wellbeing is of ever-increasing importance. Wellbeing interventions with this population may help to mitigate against costs of staff turnover and attrition. In this context, understanding how to use initiatives to support the wellbeing of clinicians from the very beginning of their careers is critical. As employers and education providers seek better understanding regarding how to support the health and sustainability of the emerging workforce, the findings of this review offer a number of important messages. The findings of our review cautiously suggest that wellbeing interventions may be effective for PTTs, and the results indicate that trainees themselves frequently valued these interventions and experienced them as beneficial. Despite this, a central finding of this review relates to the quality of the literature in this field. Whilst the quality of included studies was generally acceptable, limitations and weaknesses were identified in many studies, an important point which precludes definitive answers to the central questions of this review. Despite the large number of papers identified, more high-quality studies, including those employing control groups, are needed to help better understand what works for wellbeing interventions with this population.

Studies across a wide-range of intervention types were identified, though studies based on Mindfulness were by far the most-widely researched (*n*=31). In general, neither study quality nor effectiveness varied consistently between intervention types. As such, there was insufficient evidence to indicate superiority of one intervention approach over others with this population, a finding which mirrors that of a recent, large systematic review of wellbeing interventions with clinical and non-clinical populations (van Agteren et al., 2021).

In this light, findings regarding perceived barriers and facilitators of success across intervention types are critical. By identifying a range of perceived barriers and facilitators that may apply across any intervention designed to support PTT wellbeing, the findings of this review make a significant contribution to the evidence-base; supporting educators and researchers in making evidence-informed decisions about supporting PTT wellbeing. Whilst a number of questions remain open

regarding what intervention type performs best for example, educators in the field can use the findings regarding barriers and facilitators identified here to support the design of effective interventions across a range of different intervention-types. For intervention 'appropriateness' and 'acceptability' (Proctor et al., 2011) a group format, experiential nature of interventions, and some degree of choice or autonomy over aspects of the intervention were important. For many trainees, choice enhanced engagement, enabled participants to develop and pursue interests, and encouraged continued engagement in the face of perceived challenges. This important finding highlights the need for educators and researchers to find ways of providing trainees with elements of autonomy over central features of interventions; something which many interventions in the field currently do not routinely do. Notably, these findings resonate with the well-established body of literature on Self-Determination Theory (Deci & Ryan, 2008), in which the provision of choice and autonomy have consistently been shown to be associated with positive outcomes such as deeper understanding, greater persistence with tasks, and increased wellbeing (Deci & Ryan, 2008; Niemiec & Ryan, 2009).

Whilst the busy schedules of trainees have led some (Dye et al., 2020; Moore, 2008; Norris, 2016) to focus efforts on scaling back content and minimising the time-investment required to take part in an effort to increase intervention 'acceptability' (Proctor et al., 2011), the findings of this review indicate instead that a primary focus of researchers and educators in the field should be on designing interventions which have been tailored specifically to psychology trainees, which are perceived as beneficial, and which provide for some choice and autonomy over intervention content. These are important and novel findings which can provide direction to future research and practice in the area. Educators and researchers designing wellbeing initiatives across any intervention type are encouraged to think about how to design content that provides some degree of choice or autonomy to participants, that provides for group interaction and learning, that is heavily focussed on experiential practice of practical techniques, and relatedly, which has been designed specifically for this population (who may be familiar with key psychological principles already).

Notably, some participants had concerns about potentially negative (Boellinghaus et al., 2013; Kumari, 2011; Spendelow & Butler, 2016). This concern negatively affected intervention 'acceptability' (Proctor et al., 2011). Negative effects of therapeutic interventions remain a poorly understood phenomenon, though some evidence suggests that patients who receive little information in advance about the nature of treatment, and who do not routinely discuss progress with their therapists appear particularly at risk for negative consequences (McQuaid et al., 2021). Researchers are advised to ensure that in addressing PTT wellbeing, participants are provided with sufficient information about the intervention content and purpose, and also provided with frequent opportunity to reflect on progress. Such steps may also help address concerns raised about the technically demanding nature of some interventions. Given the high number of mindfulness-based studies being conducted with this population, particular consideration should perhaps also be given to minimising potential risks associated with mindfulness-based practices (e.g. by providing adequate psychoeducation regarding how specific practices work, and ensuring facilitators are suitably trained to be able to recognise appropriate levels of discomfort in participants, and support them with how to draw maximum benefit from the practices) (Baer et al., 2019).

In light of growing evidence to suggest that mental-health and mental-illness represent two distinct continua, rather than opposing poles of one continuum (Iasiello et al., 2020), calls have been made recently for researchers to assess for mental health and wellbeing outcome change broadly, including both positive and negative indicators in their assessment (Iasiello et al., 2020; Summers et al., 2020). Recent evidence has also supported the partial independence of both positive and negative aspects of wellbeing, as well as workplace and general wellbeing, in psychological therapy professionals specifically (Summers et al., 2020, 2021). As noted above, in this current review, more studies relied on 'negative' indicators of wellbeing (e.g. stress, anxiety, depression or burnout) than 'positive' indicators (such as satisfaction with life, or positive emotion), with few studies reporting data on both positive and negative wellbeing outcomes. Similarly, few studies included a specific measure of workplace wellbeing. This suggests that the full impact of interventions on PTT wellbeing may not

have been well captured. Future researchers should address this by including measures for both 'positive' and 'negative' indicators of wellbeing, as well as workplace wellbeing specifically.

Limitations

Only 25% of papers were double-screened. However, agreement ratings were high, and the research-team met frequently to discuss each stage. Only English-language studies were included, meaning relevant findings produced elsewhere may not have been included. Despite best efforts, a small number of studies identified at title/abstract stage could not be accessed, meaning potentially relevant work was excluded. Whilst efforts were made to search-out and include unpublished data, there is nonetheless a risk that publication bias will have influenced results, potentially leading to an over-estimation of the value of wellbeing interventions. Finally, whilst no studies indicated this to be the case, the requirement in some forms of therapeutic training to undergo personal therapy may potentially have meant that some trainees were also concurrently engaged in personal therapy at the time of the intervention.

Conclusion

The findings of our review tentatively indicate that wellbeing interventions for PTTs may be effective and are often valued by trainees, though the mixed quality of included studies means further high-quality research is needed. In the context of the challenged financial position in which many university and public sector employers are currently placed, such research appears critical for building on the important findings generated here, and further supporting educators in making evidence-informed decisions regarding how and when to invest in timely and effective wellbeing interventions. Key barriers identified in the review included time constraints, concerns about potentially negative consequences of interventions, and challenges engaging with content that was viewed as either too technically demanding, or too familiar. The provision of choice within interventions designed for PTTs may be important for overcoming such challenges. Trainees who

have a degree of autonomy may better find the time to engage in interventions, stay with interventions in the face of challenges, and develop a lasting motivation to implement the exercises. Future researchers are encouraged to measure wellbeing broadly, including measurements of positive and negative indicators of wellbeing, and to consider differential impact of interventions on general and workplace wellbeing. Qualitative and mixed-methods research may be important in helping to capture these nuances. Given the important identification of concerns about negative effects in some studies, findings suggest that reporting negative effects should become routine practice, to support more comprehensive understanding regarding the impact of wellbeing interventions. Finally, future researchers in the area should routinely use control groups and report follow-up data, to help better understand the effectiveness of interventions, and the durability of effects.

Supplementary Material 1. PsychINFO Search Strategy

S1	DE "Well Being" OR DE "Employee Well Being" OR DE "Spiritual Well Being"
S2	TI wellbeing OR AB wellbeing
S3	TI "well-being" OR AB "well-being"
S4	TI stress OR AB stress
S5	TI burnout OR AB burnout
S6	TI "burn-out" OR AB "burn-out"
S7	TI "psychological distress" OR AB "psychological distress"
S8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7
S9	DE "Psychotherapists"
S10	DE "Counselors"
S11	DE "Clinical Psychologists"
S12	S9 OR S10 OR S11
S13	DE "Students"
S14	DE "Counselor Trainees"
S15	DE "Therapist Trainees"
S16	S13 OR S14 OR S15
S17	S12 AND S16
S18	TI Psycholog* OR AB Psycholog*
S19	TI counsel* OR AB counsel*
S20	TI therap* OR AB therap*
S21	TI psychotherap* OR AB psychotherap*
S22	S18 OR S19 OR S20 OR S21
S23	TI Trainee* OR AB Trainee*
S24	TI student* OR AB student*
S25	TI training OR AB training
S26	TI education OR AB education
S27	S23 OR S24 OR S25 OR S26
S28	S22 N1 S27
S29	S17 OR S28

S30	TI intervention* OR AB intervention*
S31	TI course* OR AB course*
S32	TI therap* OR AB therap*
S33	TI strateg* OR AB strateg*
S34	TI prevent* OR AB prevent*
S35	TI program* OR AB program*
S36	TI training OR AB training
S37	S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36
S38	S8 AND S29 AND S37

Supplementary Material 2. Extended Study Characteristics

Supplementary Table 1. Extended Study Characteristics

Author & Date	Participants (n=)	Participant characteristics	Quant/Qual/MMR	Design	Intervention
Abel, Abel & Smith (2011)	Masters level counselling trainees (n=101)	The treatment group (n=55) had a mean age of 32 years, were unmarried (55%), women (76%), with children (49%), and employed full time (85%). Hispanic/Latino (44%), Caucasian (38%), African American (9%), other (6%), and multiracial (3%).	Quant	Pre-post control group design.	Stress Management Course covering stress theory, nutrition and exercise, breathing and body awareness, relaxation response and progressive muscle relaxation, visualization/imagery, meditation, worry control, thought stopping, refuting irrational thoughts, goal setting and time management, and assertiveness training. Delivered over 14 weeks.
Bauman (2017)	Clinical Psychology trainees (n=8)	7 females and 1 male, aged 22-28. All participants described themselves as Caucasian and had high levels of prior academic achievement (4.0 GPA).	Quant	Multiple-baseline-across-subjects design	Brief Mindfulness Intervention (Breath Counting) (Levinson et al., 2014). Delivered over 4 weeks.
Bell et al., (2017)	Trainee CBT therapists (n=7)	4 males and 3 females, aged between 27 and 61 (mean age 40). White British (n=6), and British Bangladeshi (n=1).	Qual	Post-intervention Semi-structured interviews to explore participant experience. Interpretive Phenomenological Analysis (IPA) used to analyse data.	Compassion Focussed Therapy (CFT)-based intervention, with experiential and reflective exercises adapted for a trainee therapist population.

					Delivered over 4 weeks.
Biberstein (2006)	Masters level Counselling trainees (n=62)	Treatment group: 11 males and 20 females. 16 were White, 14 Hispanic and 1 Native American. 15 were single, 11 married, and 5 divorced.	Quant	Pre-post quasi experimental design with non-randomised treatment and control groups.	Stress Management Course covering: Stress theory, Nutrition and exercise, Biofeedback, Meditation, Worry Control, Thought stopping, Refuting irrational thoughts, Goal setting and time management, Assertiveness training, Breathing techniques, Body awareness, Progressive muscle relaxation, Autogenics, Visualization and guided imagery, Behavioural self-management. Delivered over 12 weeks.
Boellinghaus, Jones & Hutton (2013)	Trainee Clinical Psychologists (n=5) and Trainee CBT therapist (n=7)	10 females and 2 males, aged 26-54. 11 participants identified as White British, and one Identified as Any Other.	Qual	Data from semi-structured interviews analysed using Interpretive Phenomenological Analysis (IPA)	Loving Kindness Meditation (LKM) Delivered over 8 weeks.
Bohecker & Horn, 2016	Counsellors in training (CITs) (n = 22).	16 females. Mean age 28.7. White/Caucasian n=20; bi-racial Black/African American-White/Caucasian n=1; Hawaiian/Pacific Islander n=1.	Quant	Solomon 4-group design.	Mindfulness Experiential Small Group (MESG) curriculum. Delivered over 8 weeks.
Bohecker et al., (2014)	Masters level counselling trainees. (n=unclear)	No info provided.	Qual	Interpretive dialogue to explore participant experience of group. Data analysed using Grounded Theory approach.	Mindfulness Education Small Group (MESG) curriculum.

					Delivered over 9 weeks.
Bohecker et al., (2016)	Masters level counselling trainees (n=20)	No info provided.	Qual	Semi-structured interviews used to gather data following group participation. Grounded Theory used for analysis.	Mindfulness Education Small Group (MESG) curriculum. Delivered over 9 weeks.
Brat (2017)	Counselling trainees (n=17) at masters and doctoral level.	9 females and 2 males completed. 1 aged 18-21, 4 aged 22-25, 5 aged 26-30 and 1 aged 41 or over. Christian (n=6), No religious or spiritual affiliation (n=3), Muslim (n=1), Jewish (n=1). White/European American (n=7), Africa-American/Black (n=3) Turkish (n = 1).	Quant	One group, pre-test - post-test design.	Zen Mindfulness Meditation. Delivered over 6 weeks.
Burkhart (2014)	Trainee graduate level clinical psychologists. (n=5)	4 females and 1 male. All aged between 23 and 41. Average age, 29. Participants identified as Caucasian, Hispanic, Native American or Alaskan native.	MMR	Mixed-methods, quasi-experimental research design using pre-, post- and weekly-measures.	Integral Life Practice (ILP). Delivered over 10 weeks.
Chan et al., (2021)	UG Counselling trainees (n=50)	11 males and 14 females. Aged between 18 and 23.	Quant	Randomised controlled crossover design with repeated measures.	Mindfulness Based Cognitive Therapy (MBCT). Delivered over 8 weeks.
Chandler et al., (2001)	Masters level counselling trainees (n=24)	Ages ranged from 25 to 45 years. 18 participants were Caucasian, and 1 participant was Asian. Treatment group: 6 females and 2 males.	Quant	Randomised controlled design with repeated measures.	Relaxation therapy with biofeedback. Delivered over 10 weeks.
Chlebak et al., (2013)	Graduate students in Counsellling Psychology (n=9)	8 female and 1 male, aged between 25-46 years. Mean age = 32. 6 participants identified as	Qual	Data from semi-structured interviews and student diaries	Mindfulness Meditation and Gratitude Journalling

		Caucasian (n=6), Latin American (n=1), Caucasian-Armenian (n=1), Asian (n=1).		analysed using Thematic Analysis.	Delivered over 11 weeks.
Chrisman et al., (2009)	Masters level Counselling trainees (n=31)	Participants described as being of mixed gender and ranging in age from mid-twenties to mid-thirties.	Qual	Content analysis of qualitative data taken from participant journal entries.	Qigong meditation. Delivered over 15 weeks.
Christopher et al., (2006)	Counselling trainees (n=11)	8 females and 3 males aged between their early 20s and mid 50s.	Qual	Content analysis of focus groups exploring the impact of taking the course.	Mindfulness based on MBSR programme. Delivered over 15 weeks.
Christopher et al., (2011)	Former counselling trainees (n=16)	13 female and 3 male. Ages ranged from mid-twenties to mid-fifties. All participants European American.	Qual	Content analysis of focus groups exploring the longitudinal impact of taking the course on former trainees, several years on.	Mindfulness based on MBSR programme. Delivered over 15 weeks.
Cohen & Miller (2009)	Masters and doctoral level clinical psychology trainees (n=21)	20 females. Median age 24, ranging from 22-46. 66.7% (n=14) White-non-Latino. 4.8% (n=1) African American; Asian; Mixed Indian/Caucasian; Mixed White/Latino; Other Spanish/Mexican; Other Indian American.	Quant	Single group pre-test post-test design.	Interpersonal Mindfulness Training (IMT), based on MBSR. Delivered over 6 weeks.
Collard et al., (2008)	Trainees in integrative counselling and psychotherapy (n=16)	14 women and 2 men, aged between 24 and 56.	Quant	Repeated measures (test-retest), within participants design.	Mindfulness Based Cognitive Therapy (MBCT) Delivered over 8 weeks
Costello (2015)	Masters level counselling trainees (n=5)	4 females and 1 male. Ages ranged from mid-twenties to late forties. 4 participants identified as White, and one as African American.	MMR	Single case study design.	Creative Mindfulness Training (CMT).

					Delivered over 5 weeks.
Dorian & Evers Killebrew (2014)	Graduate students in psychotherapy (n=21)	19 females and 2 males, aged 22 to 41 years. Caucasian (n=14), Latino (n=2), African American (n=1), Asian (n=2), or of mixed ethnicity (n=2). Christian (n=7), Buddhist (n=2), Jewish (n=1), and other/none (n=11).	Qual	Exploratory and emergent design, using qualitative data and The Constant Comparison Method of analysis.	Experiential Mindfulness Course. Delivered over 10 weeks.
Dye et al., (2020)	Graduate Counsellors in training (n=32)	24 females and 8 males, aged between 23 and 41.	MMR	Mixed-methods triangulation design. Quantitative Repeated measures design. Qualitative data analysed using a phenomenological approach.	Mindfulness-based practices based on The Heart, Mind, & Body Curriculum (Dye, 2018). Delivered over 13 weeks.
Felton et al., (2015)	Masters level counselling trainees (n=41)	38 females and 3 males, aged between mid-20s to mid-50s.	Qual	Qualitative Content Analysis of reflective journals, both before and after the intervention period.	Mindfulness programme based on MBSR and titled Mind–Body Medicine and the Art of Self-Care. Delivered over 15 weeks.
Finlay-Jones et al., (2017)	Trainees in Counselling Psychology (n=8) and Clinical Psychology (n=29).	89% of participants were female and the mean age was 32.61 years.	Quant	Pre-experimental, pre-post repeated measures design without comparison group.	Online Self-Compassion training developed by one of the study authors. Programme draws on psycho-ed about self-compassion and stress, as well as experiential exercises informed by self-compassion exercises, mindfulness and acceptance. Delivered over 6 weeks.
Fiorentino (2009)	Counselors-in-training (n=26)	4 males and 22 females. Participants were aged between 24 and 69. 19 identified as White (not of Hispanic origin) and 7 as Black.	Quant	The study was a quasi-experimental pre-test-post-test design.	Stress Management workshop (with and without verbal email reminders) including information on stress, as well as didactic

					information and experiential activities based on relaxation, cognitive restructuring, problem solving and time management techniques. Delivered over 12 weeks.
Goldwurm, Baruffi & Colombo (2003)	Psychotherapy trainees (n=112).	Intervention group participants were 88% female, 39% married and with a mean age of 31.53.	Quant	Non-randomised, controlled trial with repeated measures.	Subjective Wellbeing Intervention based on Fordyce's model of the 14 Fundamentals of Happiness. Delivered over 6 months.
Guler & Ceyhan (2021)	Counsellors-in-training (n=20)	Participants included 4 males and 16 females, aged between 21 and 26.	MMR	Action Research Design.	Purpose designed 'Self-Care for Counsellors' course, drawing on techniques from Cognitive Behavioural Therapy, Reality Therapy and Mindfulness Based Cognitive Therapy. Delivered over 12 weeks.
Guse (2010)	Masters level trainees in Clinical or Counselling psychology (n=10)	4 male and 6 females, aged 22 to 43. Eig8ht participants were White, 1 was Black and 1 was Indian.	Qual	Exploratory design using Thematic Analysis.	Positive Psychology Course. (Course content included a focus on identification and use of signature strengths/values in action). 20-hour workshop.

Gutierrez et al. (2016)	Masters level counselling trainees (n=60)	53 female and 7 male. Mean age 24 years. White (n=38), Latino (n=7), Black (n=9), and Asian(n=5), one participant declined to report race. Christian (n=31), Muslim (n=3), Jewish (n=2), Hindu (n=1), atheist (n=8).	Quant	Randomised Controlled Trial, using growth curve analysis to measure the impact of the intervention on stress.	Jyoti Meditation (JM). Delivered over 6 weeks.
Gutierrez et al. (2019)	Masters level Counselling trainees (n=60)	53 female and 7 male. Mean age 24 years. Seventy three percent identified as "spiritual," and 56.7% identified as religious.	Qual	Qualitative Content Analysis of reflective journals.	Jyoti Meditation (JM). Delivered over 6 weeks.
Harris (2010)	Doctoral trainees in Clinical Psychology (n=8)	3 males and 5 females, aged between 24 and 32. 7 participants identified as Caucasian and 1 as Middle Eastern.	Quant	A single subject, multiple baseline, across subjects design.	Values Enhanced Mindfulness Based Stress Reduction (VEMBSR). Delivered over 8 weeks.
Hopkins & Proeve (2013)	Clinical Psychology Trainees (n=12)	11 females and 1 males, aged between 24 and 55 (mean age 33.6).	MMR	Repeated measures design. Psychometric measures and semi-structured interviews at pre-test, post-test and 2-month follow up.	Mindfulness-Based Cognitive Therapy (MBCT). Delivered over 8 weeks.
Jones-Trabatoski (2009)	11 graduate counselling trainees.	4 males and 7 females aged 23 to 60 (mean age = 38). 6 participants were single and 5 were married. 6 did not have children and 5 had children. 6 Caucasian and 5 Hispanic.	Quant	Single group multiple baseline time series design.	Hypnosis for Stress Management. Delivered over 10 weeks.
Katzenmeier (2014)	Graduate trainees in clinical psychology (n=20) across various years/stages of training.	3 participants were male and 17 were female. Ages ranged from 25-50 with a mean age of 34.35.	Quant	Switching replication design with two groups.	Structured Stress Reduction training consisting of psycho-ed about stress, and experiential techniques for breathing exercises, Applied Relaxation training, challenging negative thoughts in the stress process and

					teaching skills of time management and goal setting. Delivered over 4 weeks.
Kissil & Nino (2017)	Masters level counselling trainees (n=70)	66 women and 4 men aged 22 to 50. 35 White/Caucasian; 23 Black/African American; 4 Asian, and 8 identified themselves in another racial category including mixed-race, Mexican American, and Native American.	Qual	Thematic Analysis of Reflective Journals	Person of the Therapist Training. Delivered over 9 months.
Kumari (2011)	Counselling Psychology trainees (n=8)	7 females and 1 male. 7 participants described their ethnic origin as White British and 1 participant said they were of Indian origin.	Qual	Semi-structured interviews, with data analysed using Interpretive Phenomenological Analysis.	Personal Therapy. 40 hours.
Lau (2012)	Doctoral trainees in Clinical Psychology (n=5)	3 females and 2 males, aged between 30 and 45. Asian (n=2), mixed Asian/Caucasian (n=1), Caucasian (n=2).	Qual	Interpretative Phenomenological Analysis (IPA). Use of initial and follow-up interviews.	Mindfulness and Psychotherapy taught module. Delivered over 10 weeks.
Leppma & Young (2016)	Masters level counselling trainees (n=107)	94 women and 13 men. Mean age 27.5 years. Caucasian (n=80), Hispanic (n=12), Black (n=4), Asian (n=2), and other or biracial (n=9). Fifty-six participants reported having tried meditating in the past.	Quant	Quasi-experimental pre-post design with control group.	Loving Kindness Meditation (LKM) and psychoeducation on counsellor wellness. Delivered over 6 weeks.
Lindo et al., 2015	Counselling trainees (n=10)	All participants were female. Participants included one Iranian-American, two African-American, and seven white American students.	Qual	Data from semi-structured interviews analysed using An inductive-deductive phenomenological approach.	Wellness Intervention comprising psycho-ed and the creation of and work towards individualised wellness plans.

					Delivered over 15 weeks.
McMahon (2015)	Doctoral level clinical psychology trainees (n=45)	Completing participants were 90% female and 80% Caucasian.	Quant	Pre-post-follow up design.	Experiential teaching of mindfulness and acceptance techniques drawn from DBT and ACT skills training. Duration information unavailable.
Meany-Walen et al., (2016)	Mental Health Counselling trainees (n=4)	3 women and 1 man, 2 aged above 30 and 2 aged below 30. Participants were European American (n=3) and Latino (n=1)	Quant	Single Case Design	Group format Wellness Model of Supervision, including wellness psycho-ed and the creation of and work towards individualised wellness plans. Delivered over 12 weeks.
Moore (2008)	Clinical Psychology trainees (n=17)	Of the 10 participants included in the evaluation, 9 were female and 1, male.	MMR	A repeated-measures pre-post intervention without a control group. Qualitative feedback gathered post-intervention.	Brief Mindfulness Intervention. Based on skills of Vipassana Insight Meditation Delivered over 4 weeks.
Moyer et al., (2017)	Clinical (n=3) and Counselling (n=7) Psychology doctorate trainees.	'Demographic information was not collected to protect confidentiality among students in these small, intimate programs. [However], most students were in their third year of training and in their mid-20s to mid-30s. There were slightly more female students than male students, and approximately 25–30% of students would identify as a minority in at least one way.'	MMR	Pre-post measures design without comparison group. + 4 month follow-up.	Acceptance and Commitment Therapy (ACT) Experiential training module. Delivered over 14 weeks.

Mumbauer-Pisano & Kim (2021)	Masters level counselling trainees (n=62)	49 women, 12 men and 1 nonbinary. Caucasian/White (n = 39), African American/Black (n = 8), Hispanic Latino (n = 11), Asian (n = 2), American Indian (n = 1), and multiracial (n = 1).	Quant	Pre-experimental, pre-post repeated measures design without comparison group.	Purpose designed Wellness Curriculum consisting of psycho-education about wellness, encouragement of 'career sustaining behaviours', and working towards SMART wellness goals. Delivered over 5 weeks.
Nelson et al., (2023)	Trainee Psychological Wellbeing Practitioners (n=56)	Mean age 28.75 years with a range of 22–54 years. Majority of participants were female (87.7%), who reported their highest previous educational level as BA or BSc (60%). The average years of experience working in mental health fields was 2.58 years.	MMR	Pre-post-follow up design.	Resilience Training based on Baker et al., (2021). One day workshop.
Newsome et al., (2006)	Masters level counselling trainees (n=33)	27 females and 6 males aged between mid-twenties and early-fifties. 30 were White, 2 were Japanese, and 1 was Native American. 11 of these participants also participated in the Focus Groups.	Qual	Focus groups and qualitative reports gathered following participation. Data analysed using Inductive Content Analysis.	Mindfulness loosely based on MBSR. Delivered over 15 weeks.
Norris (2018)	Masters level Counselors-in-training (CITs) (n=11).	2 males and 9 females, aged between 18 and 54. Six participants identified as Caucasian, one as African American, and four as Hispanic.	Qual	Qualitative design using a phenomenological approach. Data from journals, individual interviews and focus groups were analysed.	Psycho-education on Self-Compassion, and the teaching and practice of 5 distinct Self-Compassion Interventions (SCIs). Delivered over 5 sessions.
Ohrt et al., (2015)	Masters level Counsellors-in-training (CITs) (n=95)	Treatment group: 43 women and 4 men. White (n = 32), Black/African American (n = 4), Hispanic/Latino (n = 3), Asian/Pacific Islander (n = 4), multiracial (n = 3), and other (n = 1). Ages ranged from 23 to 53 years (mean = 31.2).	Quant	Quasi-experimental design. Pre- and post-test measures using treatment and control groups.	Wellness Intervention incorporating psycho-education on burnout and wellness, and the creation of individual wellness

					goals. Progress towards the goals subsequently reviewed. Delivered over 1 semester.
Pakenham & Stafford-Brown (2013)	Clinical psychology trainees (n=56)	49 females. Mean age of participants 28.45 years (SD=8.26, range=21–52years). 70% (n=39) were single.	MMR	Analysis of post-treatment data on satisfaction with the intervention.	Acceptance and Commitment Therapy (ACT) Stress Management Intervention. Delivered over 4 weeks.
Pakenham (2015)	Clinical Psychology Trainees (n=51)	Mean age 27.66 years (standard deviation (SD) = 6.62, range = 21–50 years). 88% (n= 28) were women and 69% (n = 22) were single.	Quant	Repeated measures pre-post design. Measures taken before the workshop and 4 weeks after its completion.	Acceptance and Commitment Therapy (ACT) Experiential training module. Delivered over 12 weeks.
Pintado (2019)	Clinical Psychology trainees (UG) (n=8)	7 females and 1 male.	Qual	Thematic Analysis of reflective journals, written after each session.	Mindfulness Based Stress Reduction (MBSR). Delivered over 8 weeks.
Pirtle et al., (2019)	Masters level counselling trainees (n=10)	9 females and 1 male, aged 27 to 41 (mean age = 32.4 (SD = 4.01). All participants grew up in the United States and identified as Hispanic.	MMR	Pre-post repeated measures design without control group. Qualitative reports also provided post intervention.	Wellness Group based on the principles of Logotherapy. Delivered over ‘multiple’ weeks.
Primavera (2022)	Clinical Psychology Trainees (n=6)	Ages ranged from 26 to 40 years. Participants identified as White / Caucasian (n=5) and Asian (n=1), and female (n=1), male (n=1), nonbinary	Qual	Interpretive Phenomenological Analysis (IPA).	Eclectic self-care and burnout prevention strategies.

		(n=1), cisgender woman (n=1), female and genderfluid (n=1), and queer (n=1).			Duration information unavailable.
Quigley, Schmuldt, Todd & Bender (2021)	Masters level graduate counselling students (n=123).	Treatment group: 87% female and 13% male, aged 19 to 58. Participants identified as White (85%), Black (12%), Hispanic (2%).	Quant	Non-randomised pre-post study design.	Do Something Different (DSD) text-message-based mHealth intervention. Delivered over 3 weeks.
Rimes & Wingrove (2011)	Clinical Psychology trainees (n=20)	All 20 participants were female.	MMR	Pre-post repeated measures design without control group. Content analysis used to analyse qualitative data.	Mindfulness-Based Cognitive Therapy (MBCT) modified for stress, not depression. Delivered over 8 weeks.
Robins et al., (2019)	Trainee psychologists (n=74).	Experimental condition: 16 participants were females and the mean age was 31.53 (SD= 6.60), ranging from 23 to 51 years old.	Quant	Non-randomised controlled trial with pre-post-follow-up repeated measures.	The intervention closely followed the “Skills training manual for treating Borderline Personality Disorder” (Linehan, 1993). Delivered over 8 sessions.
Roby (2007)	Clinical Psychology trainees (n=24)	33% male, 83% Caucasian, and aged between 23 and 53 years (Mean age of 40 (SD=10.84). 71% reported having a significant other. 87% reported being religious.	Quant	A within-subjects pre, post, and follow-up design.	Burnout Prevention Intervention based on psycho-educational information about burnout, its causes, symptoms and consequences. Delivered over 3 weeks.
Rockwell (2019)	Clinical Psychology Trainees (n=57)	No info provided.	Qual	Pre and post-test qualitative questionnaires.	'Mindfulness & Psychotherapy' taught module.

					Delivered over 10 weeks.
Roembke (1995)	Graduate Trainees in Clinical Psychology (n=21)	14 females and 7 males. Mean age of 35.7 (range 23-56). 95% of participants were White and 5% were African-American. 67% were single, 24% married and 9% divorced. 76% had no children and 14% had children.	Quant	Pre-post single trial, without control group.	Purpose designed Burnout Prevention Seminar. Single-session workshop.
Sartor et al., (2023)	Counsellors in Training (n=36)	Mean age of the participants was 31.36 (SD = 10.18). Females (n=30) and males (n=6). Participants identified as Caucasian (83%), African American 14%, and Hispanic (3%). All participants self-identified as having a Christian affiliation.	Quant	Pre-post single trial, without control group.	Group-Based Grace Intervention. Delivered over 10 months.
Schanche et al., (2020)	Clinical psychology trainees (n=28)	15 females and 10 males, aged between 19 and 28 years. Mean age 23.12 years.	Quant	Repeated measures, pre-post design without comparison group.	Mindfulness, based on Mindfulness Based Cognitive Therapy (MBCT). Delivered over 2 weeks.
Schure et al., (2008)	Masters levels counselling trainees (n=33)	27 females and 6 males, aged between their early 20s and mid-50s. 30 were White, 2 were Japanese, and 1 was Native American.	Qual	Written journals analysed using well established qualitative approaches and cross case analysis.	Mindfulness 'loosely based' on MBSR. Delivered over 15 weeks.
Scott et al., (2021)	Clinical Psychology Trainees. Study 1 (n=30) Study 2 (n=24)	Study 1: Participants were predominantly female and aged in their mid-late twenties. Study 2: All participants were female. The average age was (M= 31.92,SD= 10.41).	Quant	Repeated measures pre-post designs using non-randomised control groups.	Self-Practice/Self-Reflection (SP/SR). Based on the 'Experiencing CBT From the Inside-Out' manual.

					Study 1: Delivered over 12 weeks. Study 2: Delivered over 7 weeks.
Shapiro et al., (2007)	Masters level counselling trainees (n=64)	88.9% female, with an average age of 29.2 years (SD= 9.07). 76.9% Caucasian. Latina/Latino (7.7%), Asian (5.8%), Filipino (3.8%), African American (1.9%), Portuguese, and Persian (each 1.9%); two (3.8%) declined to indicate their race or ethnicity.	Quant	Prospective, nonrandomised, cohort-controlled design.	Mindfulness-Based Stress Reduction (MBSR). Delivered over 10 weeks.
Simon (2021)	Entry-level counsellors (n=5) reflecting retrospectively on their experience whilst in training.	Participants include three white cisgender women, one white non-binary individual, and one white cisgender male.	Qual	Interpretive Phenomenological Analysis (IPA).	Eclectic approaches to self-care and wellbeing psycho-education. Duration information not provided.
Spendelow & Butler (2016)	Clinical Psychology Trainees (n=58)	91% female, aged 23 to 31 years (average age of 25.9 years). 60% had less than 1-years' experience of CBT and 40% had 1-3 years.	MMR	Single-group, post-test design.	CBT-based Self-Practice/Self-Reflection (SP/SR). Delivered over 8 weeks.
Stafford-Brown & Pakenham (2012)	Clinical psychology trainees (n=56) across masters, PsyD and PhD levels.	7 males and 49 females, with average age of 28.45 years (SD=8.26). 39 were single, 13 were married and 4 were divorced or separated. 53 participants were studying full-time and 3 were studying part-time.	Quant	Non-randomised controlled trial with repeated measures, with experimental condition compared to control group.	Acceptance & Commitment Therapy (ACT) informed Stress Management Intervention. Delivered over 4 weeks.
Stalnaker-Shofner & Manyam (2014)	Masters level counselling trainees (n=73)	Final sample (n=30) 24 females and 6 males, aged 20 to 60 (mean range 35-39). Caucasian (27.3%), African American (63.6%), Hispanic/Latino (3%), and Asian (3%) ethnicities.	Quant	A quasi-experimental, single-group pre-test-post-test design.	Workshop based on the Five Factor Wellness and Habit Change Workbook (Myers & Sweeney, 2005). Creation and work towards individualised wellness plans.

		All participants held at least a bachelors degree and were enrolled in the training full-time.			Delivered over 6 weeks.
Storlie & Smith (2012)	Masters level counsellor trainees (n=42)	Treatment group: 20 women and 1 man, with a mean age of 29 years (SD= 6.34). Caucasian (N= 19), Asian (N= 1) and African-American (N= 1).	Quant	Quasi-experimental between groups, repeated measures design.	Wellness Intervention based on the Wheel of Wellness (Myers et al., 2000). Included the identification of an area of wellness to address, individual wellness plan to do this, and subsequent review of progress towards this. Delivered over 16 weeks.
Wolf et al., (2014)	Counselling trainees (n=41) at masters and doctoral level.	15% male and 85% female. 13% Asian or Pacific Islander, 3% African American, 68% Caucasian, 11% Hispanic or Latino, and 5% preferred not to answer.	MMR	Mixed-Methods design using repeated measures pre-post surveys and follow up interviews.	Wellness Workshops based on the Indivisible Self Model of Wellness (Myers & Sweeney, 2005). Including introductory info on the wellness model, and the identification of one personalised wellness goal, with subsequent reviews of progress. Delivered over 4 months.
Young et al., (2014)	Graduate level counselling trainees (n=43)	30 females and 13 males aged between 22 and 53 years, (Mean = 30.73). African American (n=14), Asian (n=1), Caucasian (n=28).	Quant	Repeated measures design without comparison or control group.	Personal Growth Groups based on information regarding personal wellness and self-care. Participants were supported to identify and work on one personal wellness goal. Delivered over one semester.

Supplementary Material 3. Quality Appraisal ratings using the MMAT (Hong et al., 2018)

Supplementary table 2. Study appraisal using the MMAT (2018) for qualitative studies

Article author & date	**Screening questions**		**Qualitative studies**				
	Are there clear research questions?	**Do the collected data allow to address the research questions?**	**Is the qualitative approach appropriate to answer the research question?**	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
Bell et al., (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Boellinghaus, Jones & Hutton (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bohecker et al., (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bohecker et al., (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chlebak et al., (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Chrisman et al., (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Christopher et al., (2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Christopher et al., (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dorian & Evers-Killebrew (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Felton et al., (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Guse (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gutierrez et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kissil & Nino (2017)	Yes	Yes	Yes	Yes	No	Yes	Yes
Kumari (2011)	Yes	Yes	Yes	Yes	Can’t tell	Yes	Yes
Lau (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lindo et al., (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Norris (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pintado (2019)	Yes	Yes	Yes	Yes	Can’t tell	Yes	No
Primavera (2022)	Yes	Yes	Yes	Yes	No	Yes	No
Rockwell (2019)	Yes	Yes	Yes	Yes	Can’t tell	Yes	Can’t tell
Schure et al., (2008)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Simon (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Supplementary table 3. Study appraisal using the MMAT (2018) for Quantitative non-randomised studies

Article author & date	**Screening questions**		**Quantitative non-randomised studies**				
	Are there clear research questions?	**Do the collected data allow to address the research questions?**	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
Abel, Abel & Smith (2011)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Bauman (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes
Biberstein (2006)	Yes	Yes	Yes	Yes	Can't tell	No	Can't tell
Cohen & Miller (2009)	Yes	Yes	Yes	Yes	No	No	Yes
Collard et al., (2008)	Yes	Yes	Yes	Yes	No	No	No
Finlay-Jones et al., (2017)	Yes	Yes	Yes	Yes	No	No	Can't tell
Fiorentino (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Goldwurm et al., (2003)	Yes	Yes	Yes	Yes	Can't tell	No	Can't tell
Harris	Yes	Yes	Yes	Yes	No	No	Can't tell
Jones-Trabatoski (2009)	Yes	Yes	Yes	No	Yes	No	Can't tell
Katzenmeir (2014)	Yes	Yes	Yes	Yes	Yes	No	Can't tell

Leppma & Young (2016)	Yes	Yes	Yes	No	Yes	Yes	No
McMahon (2015)	Yes	Yes	Yes	Yes	No	No	Can't tell
Meany-Walen et al., (2016)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Mumbauer-Pisano & Kim (2021)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Nelson et al., (2023)	Yes	Yes	Yes	Yes	No	No	No
Ohrt et al., (2015)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Pakenham (2015)	Yes	Yes	Yes	Yes	No	No	Can't tell
Quigley et al., (2021)	Yes	Yes	Yes	Yes	No	No	Can't tell
Robins et al., (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes
Roby (2007)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Roembke (1995)	Yes	Yes	Yes	No	Yes	Yes	Yes
Sartor et al. (2023)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Schanche et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Scott et al., (2021)	Yes	Yes	Yes	Yes	No	No	Can't tell
Shapiro et al., (2007)	Yes	Yes	Yes	Yes	No	Yes	Can't tell
Stafford-Brown & Pakenham (2012)	Yes	Yes	Yes	Yes	Yes	No	Can't tell

Stalnaker-Shofner & Manyam (2014)	Yes	Yes	Yes	Yes	No	No	Can't tell
Storlie & Smith (2012)	Yes	Yes	Yes	Yes	Can't tell	No	Can't tell
Young et al., (2014)	Yes	Yes	Yes	Yes	Yes	No	Yes

Supplementary table 4. Study appraisal using the MMAT (2018) for Quantitative randomised studies

Article author & date	**Screening questions**		**Quantitative randomised studies**				
	Are there clear research questions?	**Do the collected data allow to address the research questions?**	**2.1 Is randomisation appropriately performed?**	**2.2 Are the groups comparable at baseline?**	**Are there complete outcome data?**	**2.4 Are outcome assessors blinded to the intervention provided?**	**2.5 Did the participants adhere to the assigned intervention?**
Bohecker & Horn (2016)	Yes	Yes	Yes	Yes	Yes	No	Can't tell
Brat (2017)	Yes	Yes	Yes	Yes	No	No	Can't tell
Chan et al., (2021)	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell
Chandler et al., (2001)	Yes	Yes	Can't tell	Can't tell	No	No	Can't tell
Gutierrez et al., (2016)	Yes	Yes	Yes	Can't tell	Yes	No	No

Supplementary table 5. Study appraisal using the MMAT (2018) for mixed-methods studies

Article author & date	Screening questions		Mixed Methods				
	Are there clear research questions?	Do the collected data allow to address the research questions?					
Burkhart (2014)	Yes	Yes	**Quantitative non-randomised studies**				
			Are the participants representative of the target population?	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Yes
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	No	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**

			Yes	No	No	No	Yes
Costello (2015)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Yes
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	No	No	Can't tell
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	No	No	No	No
Dye et al., (2020)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Can't tell	No	Yes
			Is the qualitative approach appropriate to	**Are the qualitative data collection methods**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently**	**Is there coherence between qualitative data**

			answer the research question?	**adequate to address the research question?**		**substantiated by data?**	**sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	Yes	Yes	Yes	Yes
Guler & Ceyhan (2021)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	Yes	Yes	Yes	Yes

Hopkins & Proeve (2013)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	Yes	Yes
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	Yes	Yes	Yes	Yes
Moore (2008)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	No	No	Yes
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a	**Are the different components of the study**	**Are the outputs of the integration of qualitative**	**Are divergences and inconsistencies**	**Do the different components of the**

			mixed methods design to address the research question?	**effectively integrated to answer the research question?**	**and quantitative components adequately interpreted?**	**between quantitative and qualitative results adequately addressed?**	**study adhere to the quality criteria of each tradition of the methods involved?**
			No	Yes	Yes	Yes	No
Moyer et al., (2017)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Can't tell	No	Can't tell
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			No	No	No	Yes	No
Newsome et al., (2006)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or**

							exposure occurred) as intended?
			Yes	No	Can't tell	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	Yes	Yes	Yes	No
Pakenham & Stafford-Brown (2013)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	No	No	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results**	**Do the different components of the study adhere to the quality criteria of each tradition of**

						adequately addressed?	**the methods involved?**
			No	Yes	Yes	No	No
Pirtle et al., (2019)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			No	Yes	Yes	Yes	Yes
Rimes & Wingrove (2011)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	Yes
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**

			Yes	Yes	No	No	No
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			No	Yes	Yes	Yes	No
Spendelow & Butler (2016)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	No	No	No	Can't tell
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Can't tell	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			No	No	No	Yes	No

Wolf et al., (2014)	Yes	Yes	**Are the participants representative of the target population?**	**Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**Are there complete outcome data?**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered (or exposure occurred) as intended?**
			Yes	Yes	Yes	No	No
			Is the qualitative approach appropriate to answer the research question?	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
			Yes	Yes	Yes	Yes	Yes
			Is there an adequate rationale for using a mixed methods design to address the research question?	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
			Yes	No	No	Yes	Yes

Appendix - Addendum

Addendum to What works for psychological interventions designed to increase wellbeing in psychological therapy trainees: a systematic review

This addendum includes the following:

1. Detailed overview of SWiM and how categories were addressed in the review
2. Data quality table, GRADE and GRADE-CERQual considerations and statement, and consideration of the implications of the quality and certainty of the reviewed evidence for the conclusions of the review
3. Strengthened quantitative data presentation with critical reflection
4. Clarification of process and supporting information regarding qualitative data
5. Clear statement of remaining uncertainties

1. Detailed overview of SWiM and how categories were addressed in the review

SWiM Item	Considerations regarding presence in my review
Item 1: grouping studies for synthesis. 1a) Provide a description of, and rationale for, the groups used in the synthesis (for example, groupings of interventions, population, outcomes, study design).	In the original version of this review, findings were grouped by intervention type (e.g. mindfulness, wellness plans, etc.). In this original, lengthier version of the review, the rationale for that decision was stated as follows: 'To facilitate the practical interpretation of findings, and to support clinicians and researchers in identifying interventions of use, studies were grouped by intervention type.'
1b) Detail and provide rationale for any changes made subsequent to the protocol in the groups used in the synthesis.	In the protocol for this review, I stated that I had intended to group by outcome (e.g. stress, life satisfaction, burnout etc.). However, following data extraction it was felt that grouping in this way would be less practically useful for clinicians, researchers, or educators interested in applying the results. As such, the original version of the review grouped results by intervention type as stated above. Following peer-review, the original and lengthier version of this paper was re-written into the paper that went on to be published and which was included in my thesis. In making decisions about how to re-frame the paper in a much-shortened manner, I thought carefully about what key findings were and how to present them in a way that was most useful. In light of the finding to suggest there were not systematic and sustained differences between intervention types, I decided to present all interventions together. The following sentence was written into the published version of the paper: 'Despite having been analysed by intervention, results are presented below as a whole to reflect the key finding that outcomes and perceived effects did not vary consistently between intervention groups'

Item 2: describe the standardised metric and transformation method used: Describe the standardised metric for each outcome. Explain why the metric(s) was chosen, and describe any methods used to transform the intervention effects, as reported in the study, to the standardised metric, citing any methodological guidance used.	Statistically significant direction of effect was used as the standardised metric in the published paper. The limitations of this approach and the implications it poses for the conclusions of the review are considered in this *Addendum*.
Item 3: describe the synthesis methods Describe and justify the methods used to synthesise the effects for each outcome when it was not possible to undertake a meta-analysis of effect estimates.	In my review I state that heterogeneity of outcomes precluded meta-analysis and that consequently a narrative form of synthesis combining quantitative and qualitative data was used. I consider the limitations to and implications of the synthesis method used in this *Addendum*.
Item 4: criteria used to prioritise results for summary and synthesis: Where applicable, provide the criteria used, with supporting justification, to select	The synthesis was only restricted to a sub-set of studies with regards to the barriers and facilitators findings. This is because only a subset of reviewed studies included data relevant to barriers and facilitators. This was determined in advance and stated in the 'Study Selection' section. It was also outlined in the PRISMA flow diagram. The studies contributing data to the barriers and facilitators results were also explicitly noted in Table 1.

particular studies, or a particular study, for the main synthesis or to draw conclusions from the synthesis (for example, based on study design, risk of bias assessments, directness in relation to the review question).	Regarding the synthesis of data relating to trainee wellbeing, I did not pre-define particular criteria for prioritising certain studies in the synthesis and did not restrict the synthesis to a sub-set of studies. Due to the large number of studies being synthesised, specific discussion of findings from individual studies was rare, with the focus of the synthesis at a higher level, looking across the body of studies as a whole. Whilst individual studies were not prioritised or removed for reasons relating to risk of bias or sample size, I tried to ensure that throughout the paper, all results were presented in a way that acknowledged the limitations of the literature. The need to interpret findings cautiously, the methodological weaknesses across many of the included studies, and the specific shortcomings of papers where they had been identified, were all stated explicitly multiple times throughout the paper.
Item 5: investigation of heterogeneity in reported effects: State the method(s) used to examine heterogeneity in reported effects when it is not possible to do a metaanalysis of effect estimates and its extensions to investigate heterogeneity.	In the original, lengthier version of the review, consideration of heterogeneity was considered explicitly. In keeping with SWiM's suggestion that such investigations be limited owing to the fact that they are rarely definitive, this was done in a contained way that acknowledged the potential for multiple explanations for the identified heterogeneity. In that earlier version of the review, I had stated: "Across all intervention types, some degree of heterogeneity in results was identified. This heterogeneity may be partially explained by the fact that the quality of included studies was mixed, that many studies were underpowered or reported high-levels of attrition, or that the intensity of interventions varied significantly. Similarly, data regarding extent of engagement with home practice was frequently unavailable, and studies also frequently drew on a wide range of different measures for the same construct". Following discussion of the literature on the nature and measurement of wellbeing, I also wrote: "It is possible therefore that the sometimes-mixed findings of this review may be at least in part a product of the tools chosen for measurement. Similarly, the more consistently positive findings reported here in the qualitative data may be explained by the fact that qualitative exploration allowed for participants to identify and articulate ways in which their

	wellbeing had been improved, in ways that the more restricted focus of a quantitative measure could not account for. Alternatively, findings may point towards the idea that particular interventions are more successful at addressing some indicators of wellbeing than others, a finding also reported in a recent review of mindfulness interventions for healthcare professionals (Lomas et al., 2018)." In the shortened, published version of the review that featured in this thesis, these considerations were removed in the process of re-shaping the paper to be more focussed on the core, practically applicable findings.
Item 6: certainty of evidence: Describe the methods used to assess the certainty of the synthesis findings.	In describing how the review aligned with key features of the SWiM guidance (in the *Synthesis Method* section) I stated explicitly that the certainty of findings would be considered in relation to the quality of the literature reviewed. Throughout the *Results* and *Discussion*, I sought to make clear that the findings of the paper should be interpreted cautiously and with the limitations of a mixed-quality literature borne in mind. Explicit note was given to the fact that methodological weaknesses were identified across studies from all intervention types, and that these weaknesses required that findings be interpreted with caution. I noted that the quality appraisal process had identified quantitative studies in particular to be have methodological weaknesses, signalling less confidence in these findings. Tabulated reports of how each individual paper had been rated using the Mixed-Methods Appraisal Tool (MMAT) were included with the published paper (erroneously missed from my original thesis submission, but now included as Supplementary Material 3 for this chapter). Importantly however, I did not provide a GRADE rating. GRADE and GRADE-CERQual ratings have now however been added to this Addendum and used to inform the *Study Conclusions*.
Item 7: data presentation methods: Describe the graphical and tabular methods used to present the effects (for example, tables, forest plots,	The results and study characteristics are presented in the review in alphabetical order and as a single group. In the earlier, lengthier version of this review in which results had been grouped by intervention type, tables were also presented in the same way (e.g. study characteristic tables for all mindfulness interventions, then separately for all compassion-based interventions etc.), and both the narrative synthesis of results for interventions and the relevant tables followed the same order.

harvest plots). Specify key study characteristics (for example, study design, risk of bias) used to order the studies, in the text and any tables or graphs, clearly referencing the studies included	
Item 8: reporting results: For each comparison and outcome, provide a description of the synthesised findings and the certainty of the findings. Describe the result in language that is consistent with the question the synthesis addresses and indicate which studies contribute to the synthesis.	A narrative description of the synthesis of findings relating to the effect or influence of interventions on wellbeing was provided, and it was stated that all 70 included studies contributed to this section. Frequent reference was made to the certainty of findings, suggesting that results were tentative owing to the nature of the literature reviewed. A narrative synthesis for barriers and facilitators was provided, with clear indication that the findings of that section were based on only the sub-section of studies contributing data to answering that question.
Item 9: limitations of the synthesis: Report the limitations of the synthesis methods used and/or the groupings used in the synthesis and how these affect the conclusions that can be	This is an important omission that was missing from my review. A comprehensive and critical reflection on this point has now been added to my reviewer response and in the included *Addendum*.

drawn in relation to the original review question.	

2. Data quality table, GRADE statement, and consideration of the implications of the quality and certainty of the reviewed evidence, for the conclusions of the review

For the full data quality table, please see Supplementary Material 3 for this Chapter (Supplementary Material 3 – MMAT). This table shows how each reviewed study was appraised using the Mixed-Methods Appraisal Tool (MMAT).

In the published version of this review, I had sought to ensure that matters relating to evidence quality and the certainty of findings were presented consistently throughout the paper. A comprehensive quality assessment process was undertaken to assess the quality of each included study using the Mixed-Methods Appraisal Tool (MMAT). The findings from this process were presented in tables to support readers in understanding the quality, strengths and weaknesses of each reviewed study. In keeping with MMAT guidance, no total score was given to individual studies, but the assessment of studies was held consistently in mind when I was considering how to make sense of and present the findings in a way that was transparent and balanced. Given the overall mixed quality of included studies, there is frequent reference throughout the *Results* and *Discussion* sections to the need to interpret findings with caution, and the tentative nature of the conclusions that can be drawn on the basis of the reviewed evidence is frequently emphasised. Specific methodological weaknesses are noted explicitly in the *Results* section, and the study types that generally performed weakest in the MMAT appraisal are highlighted.

This review did not previously however include GRADE or GRADE-CERQual statements. In order to address this, below I provide a detailed discussion of GRADE and GRADE-CERQual, and use them to produce overarching statements on the quality and certainty of the evidence in this review.

GRADE

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach is a widely used, structured and systematic approach for assessing the quality or certainty of evidence, and the strength of the recommendations that can be made in relation to it (Guyatt et al., 2008a; Prasad, 2024). GRADE provides researchers, decisions-makers, and clinicians with a transparent and replicable process through which to make these judgements, helping therefore to make the decisions underlying this process explicit.

Having been outlined in a series of 2008 articles (see Guyatt et al., 2008a) GRADE has continued to evolve and be updated in the years since (Schünemann et al., 2023). The GRADE approach involves classifying the quality or certainty of evidence into one of four categories: high, moderate, low, and very low. It also involves classifying the strength of recommendations to be made about the evidence as 'strong' or 'weak' (Guyatt et al., 2008a). In so doing, it provides the research and policy communities with readily interpretable standards for understanding the quality of evidence and strength of recommendations. Whilst the somewhat arbitrary nature of any categories imposed on a continuum – such as quality – has been acknowledged, advocates of GRADE note how the simplicity and transparency of such categories are sufficient gains to outweigh such concerns (Guyatt et al., 2008b).

The quality or certainty of evidence categories have been defined in the following way (Guyatt et al., 2008a):

High: Where the certainty of evidence is high, further research is considered very unlikely to change confidence in the estimate

Moderate: Where the certainty of evidence is moderate, it is considered likely that further research will have an important impact on the estimate, and that this may change the estimate

Low: Where the certainty of evidence is low, it is considered very likely that further research will have an important impact on the estimate, and that this may change the estimate

Very Low: Where the certainty of evidence is very low, the estimate of the effect is considered to be very uncertain

In keeping with the acknowledgement of the somewhat arbitrary nature of such classifications, GRADE does not claim to remove the need for judgement or interpretation. Rather, it provides a systematic structure for guiding judgements that can be readily understood by others (GRADE).

A key feature of GRADE is the distinction between the assessment of the quality or certainty of evidence, and the strength of recommendations that can be made on it. This is important, since despite connection, the two ideas are fundamentally different. Whilst the certainty of evidence can be expected to have an influence on the strength of recommendations to be made for example, it is not the only relevant feature. Judgements about the strength of recommendations must take into account the certainty of the evidence, the degree of uncertainty regarding the balance between positive and negative effects of an intervention, the degree of uncertainty in the values and preferences of those for whom the intervention is intended, and the degree of uncertainty about the extent to which investing in a particular intervention represents a good use of resources (Guyatt et al., 2008a). Even where the quality of evidence regarding the effectiveness of a particular intervention is judged to be high for instance, weaker recommendations about it would likely be warranted if the intervention was also known to have a range of impactful side-effects, to be inconvenient and costly, or if it was unclear to what extent the intervention would align with the preferences and values of those for whom it was intended (Guyatt et al., 2008b; Guyatt et al., 2008c).

In the GRADE approach, just two categories for strength of recommendation are outlined (typically referred to as ‘strong’ vs ‘weak’) (Guyatt et al., 2008c):

Strong: Strong recommendations indicate that provided with the necessary information to make an informed decision, most people would choose this treatment, and therefore clinicians and policy-makers can proceed in offering or implementing it routinely.

Weak: Weak recommendations indicate that provided with the necessary information to make an informed decision, many people would choose this treatment, but that will vary with preference and values, and many people would also choose not to have it. Clinicians should therefore support patients to make decisions that are consistent with their preferences, and policy makers should recognise that substantial discussion with multiple stakeholders will be required in order to make decisions about whether and to what extent to implement an intervention.

Assessing the quality or certainty of evidence

The starting point for rating of the quality of evidence via GRADE is the study design used in contributing studies. In recognition of their greater rigour, randomised controlled trials without important flaws are typically considered high-quality evidence, and observational studies without notable strengths or obvious flaws typically begin as low-quality evidence (Guyatt et al., 2008b).

Following from this initial start point, a series of judgements are then made regarding a number of factors considered to reduce or increase the quality of the evidence. The five factors considered to downgrade the quality of evidence are:

1. **Study limitations**: Major limitations in how studies are designed or conducted can reduce confidence in the findings produced.
2. **Inconsistent results**: Where substantial heterogeneity and variation in results is identified without plausible explanation, this is considered to reduce the certainty or quality of the evidence.

3. **Indirectness of evidence**: The indirectness of evidence can relate to questions regarding differences between the populations studied, interventions used or outcomes measured. Where substantial variation is identified, this can reduce certainty in the evidence.
4. **Imprecision**: Small samples and wide confidence intervals can also reduce the quality and certainty of the evidence.
5. **Publication bias**: If studies are absent due to being less likely to have been published (e.g. because of non-significant findings) this can bias and reduce confidence in the reported findings.

In relation to each of the five considerations, the quality of evidence can be downgraded one (where serious risks are identified) or two (where very serious risks are identified) levels (Guyatt et al., 2011).

Similarly, evidence can be graded up according to the following criteria (Guyatt et al., 2008b; Guyatt et al., 2011):

1. **The treatment effect is very large**: where large effects are observed in methodologically rigorous research without flaws in relation to the considerations above, this can indicate stronger certainty of evidence
2. **Dose-response gradient**: a consistent pattern reflecting greater effects from greater exposure may indicate stronger certainty in the evidence
3. **Plausible biases would decrease the effect**: where all plausible biases would be expected to decrease the effect, the certainty of an identified effect can be considered more certain

Considerations of how this applies to the systematic review presented in Chapter 3

In the review conducted as part of this thesis, the majority of quantitative studies were uncontrolled, pre-post designs, and as such, the starting point for the quality rating would be 'low' (Guyatt et al., 2008b). However, following review of the five considerations for downgrading the quality of

evidence, a final judgement about the evidence would indicate that the quality or certainty of the evidence is 'very low'.

On the one hand, the fact that the review included several unpublished doctoral theses means that no obvious concerns are raised regarding the risk of publication bias. Similarly, whilst there was a wide variety of intervention types and durations used, study participants were all trainee psychological professionals receiving interventions in a similar context, indicating no substantial concerns regarding the directness of the evidence. However, consideration of study limitations, inconsistent results, and imprecision raise concerns that warrant a downgrading of the evidence. Included studies had a variety of study limitations, including multiple comparisons being made without a clearly articulated primary outcome, under-powering, expectancy effects, absence of intention-to-treat (ITT) analysis, and some use of non-validated measures. Findings also generated some degree of heterogeneity, and concerns regarding the small sample sizes of multiple studies negatively influence precision. Collectively therefore, there are multiple reasons to consider downgrading the quality of evidence for this review. However, having started at 'low', the quality can only be reduced by one level, meaning the quality or certainty of this evidence should be considered to be 'very low'.

GRADE-CERQual

In recognition of the growing influence of qualitative research and qualitative syntheses on health policy decision-making, a sub-group of the GRADE Working Group developed the GRADE-CERQual approach (Lewin et al., 2015). GRADE-CERQual was designed to support researchers and policy-makers to make decisions about the extent to which confidence can be placed in individual review findings, making transparent and systematic judgements about the extent to which qualitative review findings adequately and reasonably represent the phenomenon under consideration (Lewin et al., 2015; Lewin et al., 2018).

In keeping with the GRADE approach, assessment of the confidence in review findings via CERQual results in one of four outcomes, termed high, moderate, low or very low. Judgements are made in regards to individual review findings, and reflect the levels of confidence that can be placed in a finding. These levels were defined by the Grade Working Group (Lewin et al., 2018) as follows:

High confidence: Highly likely that the review finding is a reasonable representation of the phenomenon.

Moderate confidence: Likely that the review finding is a reasonable representation of the phenomenon.

Low confidence: Possible that the review finding is a reasonable representation of the phenomenon.

Very low confidence: Unclear whether the review finding is a reasonable representation of the phenomenon.

As with GRADE, CERQual emphasises the need for researcher judgement in arriving at these conclusions (Lewin et al., 2015) with explicit note that the approach is not intended as a rigid checklist, or a tool intended to replace careful consideration. Instead, CERQual provides a systematic and replicable process that makes the decisions underlying such judgements open and explicit. The four domains against which considerations are made are as follows:

Methodological limitations: Factors relating to the design or conduct of a study (e.g. the appropriateness of data collection methods)

Relevance: The extent to which primary studies are perceived to be relevant for the focus of the review (e.g. considerations regarding whether the study population or context of the primary studies aligns with the focus of the review)

Coherence: The extent to which a review finding is grounded in the findings of primary studies, and provides a compelling account of the patterns identified in the primary data (e.g. whether data tell a consistent story, and whether/how outlying or disconfirming data are considered)

Adequacy of data: The richness and adequacy of the data to support each finding

Considerations of how this applies to the systematic review presented in Chapter 3

In keeping with recommended practice (Lewin et al., 2015; Lewin et al., 2018) considerations regarding the confidence of qualitative driven findings for this review are presented below in table format. In reflection of how results are presented in the review, three findings are considered, with one each for the influence of interventions on wellbeing, facilitators, and barriers.

Review finding	Contributing studies	Assessment of methodological limitations	Assessment of relevance	Assessment of coherence	Assessment of adequacy	Overall assessment of CERQual confidence	Explanation of judgement
A consistent theme ran across qualitative data indicating that trainees experienced wellbeing interventions positively, experiencing increases in positive emotion, and decreases in stress, anxiety or ruminative cognitive processes.	All studies reporting qualitative data (n=36), identified in the Study Characteristics Table.	Minor methodological limitations. Only a small minority scoring anything other than 'Yes' for all components assessed via the MMAT.	Minor concerns about relevance. Despite all participants being trainee psychological professionals and the review being intended for this diversity of roles, a combination of role (e.g. Clinical Psychology vs Counselling), educational level (e.g. PGCert vs Doctorate) and geographical location (e.g. studies from	Minor concerns regarding coherence. The account provided was firmly grounded in primary study data. Whilst some rare disconfirming instances were identified (e.g. a small number of participants for whom interventions had been unhelpful), a consistent theme ran across primary	Minor considerations about adequacy. A majority of studies provided rich and comprehensive data though a minority relied on thinner, more descriptive accounts	Moderate confidence	A moderate level of confidence was decided upon because of the minor concerns identified across each domain.

			multiple countries worldwide) diversity means some minor concerns about the relevance of findings for any particular professional role.	data indicating that interventions were well received and experienced as positively benefitting wellbeing.			
Delivering interventions in a group format, having a degree of choice over intervention content, being experiential and being brief were described as key facilitators of engagement and	Bohecker et al., 2016; Chrisman et al., 2009; Chlebak et al., 2013; Guse, 2010; Hopkins & Proeve, 2013; Lindo et al., 2015; Mumbauer-Pisano & Kim, 2021; Robins et al., 2019; Schure et al., 2008; Young et al., 2013.	Minor methodological limitations. Three studies with one or two areas rated 'no' or 'can't tell'.	Minor concerns regarding relevance. Some variation across psychological roles and contexts meaning some minor concerns regarding the consistency or meaningfulness of identified facilitators across the	No or very minor concerns regarding coherence. Findings grounded in data and reasonably consistent where the topic was identified.	Minor concerns regarding adequacy. Findings in this area were typically not a main focus of papers, meaning data in primary studies often not completely comprehensive and occasionally thin.	Moderate confidence.	A moderate level of confidence was selected given minor concerns raised regarding methodological limitations, relevance, and adequacy.

intervention success.			included settings.				
Time constraints, challenges with technical content, concerns about potentially negative consequences, insufficient choice, and a feeling that interventions were not sufficiently adapted to the trainee context were described as barriers to successful intervention.	Bell et al., 2017; Boellinghaus et al., 2013; Dorian & Killebrew, 2014; Gutierrez et al., 2019; Guse, 2010; Kumari, 2011; Lau, 2012; Nelson et al., 2023; Pakenham, 2015; Primavera, 2022; Spendelow & Butler, 2016	Minor methodological limitations. Three studies with one or two areas rated 'no' or 'can't tell'.	Minor concerns regarding relevance. Some variation across psychological roles and contexts meaning some minor concerns regarding the consistency or meaningfulness of identified barriers across the included settings.	No or very minor concerns regarding coherence. Findings grounded in data, and consistent.	Minor concerns regarding adequacy. Findings in this area were typically not a main focus of papers, meaning data in primary studies often not completely comprehensive and occasionally thin.	Moderate confidence.	A moderate level of confidence was selected given minor concerns raised regarding methodological limitations, relevance, and adequacy.

Consideration of the implications of these GRADE and GRADE-CERQual judgements for the conclusions of this review are given in the *Study Conclusion* presented in the overall thesis *Discussion* chapter.

3. Strengthened quantitative data presentation

An updated and strengthened quantitative data table is presented below.

Addendum Table 1. Quantitative outcomes

Author & Date	Sample (n)	Intervention Type	Measures	Direction of effect Increase ↑ Decrease ↓	Significant effect? Y/N	Effect size
Abel, Abel & Smith (2011)	Masters level counselling trainees (n=101)	Stress Management	State Trait Anxiety Inventory (Spielberger, 1983)	↓	Y	
			Perceived Stress Scale-10 (Cohen, 1994)	↓	N	
			Researcher created measure of general stress	↓	Y	
Bauman 2017	Clinical Psychology trainees (n=8)	Mindfulness	Mind Wandering Scale and Meta-awareness Scale (Levinson et al., 2014)	↑	Y	
			Mindful Attention Awareness Scale (Brown & Ryan, 2003)	↑	Y	
			Five Factors of Mindfulness Questionnaire (Baer et al., 2006)	↑	Y	
			The Ryff Scales of Psychological Wellbeing (Ryff, 1989)	Unclear	N	
Biberstein (2006)	Masters level Counselling trainees (n=62)	Stress Management	Social Readjustment Scale (Holmes & Rahe, 1967)	↑	Y	
			Internal-External Locus of Control (Rotter, 1966)	n/a	n/a	

			State-Trait Anxiety Inventory- Y1&2 (Spielberger, 1983) Perceived Stress Scale-10 (Cohen, 1994) Abel Research Questionnaire (Abel, 2005)	↓ ↓ ↓	Y Y Y	
Bohecker & Horn (2016)	Counsellors in training (CITs) (n = 22)	Mindfulness	Five Facet Mindfulness Questionnaire (Baer et al., 2006) Interpersonal Reactivity Index (Davis, 1980) Counseling Self-Efficacy Inventory (Larson et al., 1992) Perceived Stress Scale-14 (Cohen et al., 1983).	↑ ↑ ↑ Unclear	Y Y Y N	
Brat (2017)	Counselling trainees (n=17) at masters and doctoral level	Mindfulness	Perceived Stress Scale-10 (Cohen et al., 1988) Mindful Attention and Awareness Scale (Brown & Ryan, 2003) Self-Compassion Scale (Neff, 2003)	↓ ↑ ↑	Y Y Y	*d* = 1.19 *d* = 0.69 *d* = 1.24
Burkhart (2014)	Trainee graduate level clinical psychologists. (n=5)	Integral Life Practice	Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2003) Perceived Wellness Survey (Adams et al., 1997) Perceived Stress Scale (Cohen et al., 1983)	↑ ↑ ↓	N N N	
Chan et al., (2021)	UG Counselling trainees (n=50)	Mindfulness	The Five Facet Mindfulness Questionnaire (Baer et al., 2006) The Interpersonal Reactivity Index (Davis, 1980) The Self-Compassion Scale (Neff, 2003) Depression, Anxiety and Stress Scale (DASS); The Counselor Activity Self-Efficacy Scale (Larson et al., 1992)	↑ ↓ ↑ ↓ ↑	Y Y Y Y N	

Chandler et al., (2001)	Masters level counselling trainees (n=24)	Relaxation Therapy with biofeedback	The Symptom Checklist-90-Revised (Derogatis, 1983).	↓	Y	
Cohen & Miller (2009)	Masters and doctoral level clinical psychology trainees (n=21)	Mindfulness	Mindful Attention Awareness Scale (Brown & Ryan, 2003)	↑	Y	*d* = 0.485
			Perceived Stress Scale (Cohen, Carmack & Mermelstein);	↓	Y	*d* = 0.45
			Meaning in Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006)	↓	N	*d* = 0.358
			The Satisfaction With Life Scale (Pavot & Diener, 1993)	↑	N	*d* = 0.447
			The Social Connectedness Scale–Revised (Lee, Draper, & Lee, 2001)	↑	Y	*d* = 0.588
			The Self-Report of Emotional Intelligence (Schutte et al., 1998)	↑	Y	*d* = 0.401
			The Beck Anxiety Inventory (Beck, 1990);	↓	Y	*d* = 0.473
			Center for Epidemiological Studies–Depression (Radloff, 1977).	No change	N	*d* = 0.115
Collard et al., (2008)	Trainees in integrative counselling and psychotherapy (n=16)	Mindfulness	Freiberg Mindfulness Inventory (Walach et al., 2006)	↑	Y	*r* = 0.47
			Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985)	↑	N	Not given
			Positive Affect Schedule (Watson et al., 1988)	Unchanged	N	Not given
			Negative Affect Schedule (Watson et al., 1988)	↓	Y	*r* = 0.54
Costello (2015)	Masters level counselling trainees (n=5)	Mindfulness	Connor-Davidson Resilience Scale (Connor & Davidson, 2003)	Unclear	N	
			Mindful Attention and Awareness Scale (Brown & Ryan, 2003)	Unclear	N	
			State and Trait Anxiety Scale (Spielberger et al, 1983)	Unclear	N	

Dye et al., (2020)	Graduate Counsellors in training (n=32)	Mindfulness	General Self-Efficacy Scale (Schwarzer et al., 1999) Four-Dimensional Mood Scale (Huelsman et al., 2003) Perceived Stress Scale – 4 (Cohen et al., 1983)	Unclear Unclear Unclear	N N N	
Finlay-Jones et al., (2017)	Trainees in Counselling Psychology (n=8) and Clinical Psychology (n=29).	Compassion	Self-Compassion Scale (Neff, 2003) Perceived Stress Scale (Cohen et al., 1983) Authentic Happiness Inventory (Peterson & Park, 2008) Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004) Depression Anxiety and Stress Scales (Lovibond & Lovibond, 1995).	↑ ↓ ↑ ↓ ↓	Y Y Y Y Y	*d* = 1.15 *d* = 0.48 *d* = 0.23 *d* = 0.52 *d* = 0.31 (dep) / 0.52 (anx)
Fiorentino (2009)	Counselors-in-training (n=26)	Stress Management	Perceived Stress Scale (Cohen et al., 1983) State-Trait Anxiety Inventory (Speilberger et al., 1983) Self-Efficacy Scale (Sherer et al., 1982).	↑ ↓ ↓	N N N	
Goldwurm et al., (2003)	Psychotherapy trainees (n=112)	Subjective Wellbeing Intervention	Satisfaction with Life Scale (Diener et al., 1985) The PsychCap Inventory (Fordyce, 1985) Happiness Measures (Fordyce, 1988)	↑ ↑ ↑	N Y N	
Guler & Ceyhan (2021)	Counsellors-in-training (n=20)	Self-Care for Counsellors	Well Star Scale (Korkut-Owen et al., 2016)	↑	Y	
Gutierrez et al., (2016)	Masters level counselling trainees (n=60)	Mindfulness	Perceived Stress Scale-10 (Cohen et al., 1983).	↓	Y	*g* = 0.57
Harris (2010)	Doctoral trainees in Clinical Psychology (n=8)	Mindfulness	Five Facets of Mindfulness (Baer et al., 2006) Positive and Negative Affect Schedule (Watson et al., 1988) Perceived Stress Scale (Cohen & Williamson, 1988)	Unclear Unclear Unclear	N N N	

			Acceptance & Action Questionaire (Hayes et al., 2004) Self-Compassion Scale (Neff, 2003) Valued Living Questionnaire (Wilson & Groom, 2002)	Unclear Unclear Unclear	N N N	
Hopkins & Proeve (2013)	Clinical Psychology Trainees (n=12)	Mindfulness	Perceived Stress Scale-14 (Cohen et al., 1983) The Five Facets of Mindfulness Questionnaire (Baer et al, 2006) The Interpersonal Reactivity Index (Davis, 1983)	Unclear Unclear Unclear	N N N	
Jones-Trabatoski (2009)	11 graduate counselling trainees.	Stress Management	Perceived Stress Scale (Cohen, 1994) Abel Research Questionnaire (Abel, 2005)	Unclear ↓	N Y	
Katzenmeir (2014)	Graduate trainees in clinical psychology (n=20) across various years/stages of training	Stress Management	Perceived Stress Scale (Cohen et al., 1983) Coping Self-Efficacy Scale (Chesney et al., 2006)	Unclear Unclear	N Y	
Leppma & Young (2016)	Masters level counselling trainees (n=107)	Mindfulness	The Interpersonal Reactivity Index (Davis, 1983)	↑	N	
McMahon (2015)	Doctoral level clinical psychology trainees (n=45)	DBT and ACT	Five Facets of Mindfulness Questionnaire (Baer et al., 2006) Maslach Burnout Inventory-Human Services Scale (Maslach, Jackson & Leiter, 1996)	↑ ↓	N Y	
Meany-Walen et al., (2016)	Mental Health Counselling trainees (n=4)	Wellness Plan	Five Factor Wellness Inventory (Myers & Sweeney, 2005)	↑	Y	
Moore (2008)	Clinical Psychology trainees (n=17)	Mindfulness	Perceived Stress Scale-14 (Cohen et al., 1983) Kentucky Inventory of Mindfulness Skills (Baer et al., 2004) Self-Compassion Scale (Neff, 2003)	Unclear ↑ Unclear	N Y N	
Moyer et al., (2017)	Clinical (n=3) and Counselling (n=7) Psychology	ACT Experiential Training	Avoidance and Fusion Questionnaire for Youth; (Greco et al., 2005)	Unclear	N	

	doctorate trainees		Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004) Perceived Stress Scale (Cohen et al., 1983)	Unclear Unclear	Y N	
Mumbauer-Pisano & Kim (2021)	Masters level counselling trainees (n=62)	Wellness Plan	Perceived Wellness Survey (Adams et al., 1997) The Helping Professional Wellness Discrepancy Scale (Blount & Lambie, 2018)	↑ ↑	Y Y	
Ohrt et al., (2015)	Masters level Counsellors-in-training (CITs) (n=95)	Wellness Plan	The Five-Factors Of Wellness (Myers & Sweeney, 2005) Maslach Burnout Inventory-Human Services Survey (Maslach & Jackson, 1996)	No change ↑	N N	
Pakenham (2015)	Clinical Psychology Trainees (n=51)	ACT Experiential training	Mental Health Professional Stress Scale (Cushway et al., 1996) General Health Questionnaire-28 (Goldberg, 1978) Self-Compassion Scale (Neff, 2003) Counselor Activity Self-Efficacy Scale (Lent et al., 2003) Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989) Acceptance and Action Questionnaire (Bond & Bunce, 2003) Five Facet Mindfulness Questionnaire (Baer et al., 2006) The White Bear Suppression Inventory (Wegner & Zanakos, 1994) Valued Living Questionnaire (Wilson et al., 2010)	↑ ↓ ↑ ↑ ↑ ↓ ↑ ↓ ↑	N N N Y Y Y Y Y Y	
Pirtle et al., (2019)	Masters level counselling trainees (n=10)	Logotherapy	Purpose-in-Life Test (Crumbaugh & Maholick, 1969) State-Trait Anxiety Inventory–Form Y (Spielberger et al., 1983)	↑ ↓	Y Y	

Quigley et al., (2021)	Masters level graduate counselling students (n=123)	Do Something Different	Perceived Stress Scale (Cohen et al., 1983) Thoughts and Feelings Scale-Anxiety (Pine & Fletcher, 2016) Thoughts and Feelings Scale-Depression (Pine & Fletcher, 2016)	↓ ↓ ↑	Y Y N	*d* = 0.49 *d* = 0.30 *d* = 0.29
Rimes & Wingrove (2011)	Clinical Psychology trainees (n=20)	Mindfulness	Perceived Stress Scale (Cohen et al., 1983) Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) Five Facet Mindfulness Questionnaire (Baer et al., 2006) Self-Compassion Scale (Neff, 2003) Rumination-Reflection Questionnaire (Trapnell & Campbell, 1999)	Unclear Unclear ↑ ↑ ↓	N N Y Y Y	
Robins et al., (2019)	Trainee psychologists (n=74)	Skills Manual for treating Borderline Personality Disorder	Maslach Burnout Inventory —Student Survey (Schaufeli et al., 2002) Utrecht Work Engagement Scale for Students (Schaufeli et al., 2002) General Health Questionnaire-12 (Goldberg, 1972) Acceptance and Action Questionnaire-II (Bond et al.,2011) Mindfulness Attention Awareness Scale (Brown & Ryan, 2003) Mental Health Professionals Stress Scale (Cushway et al., 1996)	↓ ↓ ↓ ↑ ↑ ↓	Y Y Y Y Y Y	d = 0.80; 1.10; -0.90 for the 3 sub-scales *d* = -0.82 *d* = 1.68 *d* = 1.00 *d* = -1.39 *d* = 0.95
Roby (2007)	Clinical Psychology trainees (n=24)	Burnout Prevention	The Maslach Burnout Inventory - Human Services Survey (Maslach & Jackson, 1986)	↓	N	
Roembke (1995)	Graduate Trainees in Clinical Psychology (n=21)	Burnout Prevention Seminar	Purpose designed burnout test	↓	Y	

Schanche et al., (2020)	Clinical psychology trainees (n=28)	Mindfulness	Rumination-Reflection Questionnaire (Trapnell & Campbell, 1999)	↓	Y	*d* = 0.75
			State-Trait Anxiety Inventory (Spielberger et al., 1983)	↓	Y	*d* = 0.81
			Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004)	↓	Y	*d* = 0.57
			Five Facet Mindfulness Questionnaire (Baer et al., 2006)	↑	Y	*d* = 0.93
			Self-Compassion Scale (Neff, 2003)	↑	Y	*d* = 0.81
Scott et al., (2021)	Clinical Psychology Trainees. Study 1 (n=30) Study 2 (n=24)	CBT SP/SR	Generalized Anxiety Disorder-7 (Spitzer et al., 2006)	↓	N	
			Patient Health Questionnaire-9 (Kroenke et al., 2001)	↓	N	
			College Student Survey (Gold et al., 1989)	↓	Y	
Shapiro et al., (2007)	Masters level counselling trainees (n=64)	Mindfulness	The Mindful Attention Awareness Scale (Brown & Ryan, 2003)	↑	Y	
			Positive Affectivity Schedule (Watson et al., 1988)	↓	Y	
			Negative Affectivity Schedule (Watson et al., 1988)	↓	Y	
			State-Trait Anxiety Inventory (Spielberger et al., 1983)	↓	Y	
			Perceived Stress Scale (Cohen et al., 1983)	↓	Y	
			Reflection Rumination Questionnaire (Trapnell & Campbell, 1999)	↓	Y	
			Self-Compassion Scale (Neff, 2003)	↑	Y	
Stafford-Brown & Pakenham (2012)	Clinical psychology trainees (n=56) across masters, PsyD and PhD levels	Acceptance & Commitment Therapy (ACT) informed Stress Management Intervention.	Mental Health Professional Stress Scale (Cushway et al., 1996)	↓	Y	
			General Health Questionnaire-28 (Goldberg, 1978)	↓	Y	

			Satisfaction With Life Scale (Diener et al., 1985) Self-Compassion Scale (Neff, 2003) Counselor Activity Self-Efficacy Scales-Helping Skills Scale (Lent et al., 2003) Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989) Acceptance and Action Questionnaire (Bond & Bunce, 2003) Five Facet Mindfulness Questionnaire (Baer et al., 2006) The White Bear Suppression Inventory (Wegner & Zanakos, 1994) Valued Living Questionnaire (Wilson et al., 2010)	↑ ↑ ↑ n/a ↑ ↑ ↓ ↑	Y Y Y n/a Y Y Y Y	
Stalnaker-Shofner & Manyam (2014)	Masters level counselling trainees (n=73)	Wellness Plan	The Five Factor Wellness Inventory (Myers & Sweeney, 2005)	↑	Y	
Storlie & Smith (2012)	Masters level counsellor trainees (n=42)	Wellness Plan	Five Factor Wellness Inventory (Myers & Sweeney, 2004) Supervisory Working Alliance Inventory (Efstation et al., 1990)	↑ ↓	Y N	
Wolf et al., (2014)	Counselling trainees (n=41) at masters and doctoral level	Wellness Plan	Five Factor Wellness Inventory (Myers & Sweeney, 2004)	↑	Y	
Young et al., (2014)	Graduate level counselling trainees (n=43)	Wellness Plan	Five Factor Wellness Inventory (Myers & Sweeney, 2005) The Group Climate Questionniare (MacKenzie, 1983) The Curative Climate Questionnaire (Fuhrman et al., 1986)	Unclear Unclear Unclear	N N N	

4. Clarification of process and supporting information regarding qualitative data

Qualitative data on wellbeing was integrated narratively alongside quantitative findings, to provide context to quantitative findings, and to 'tell the story' (Popay et al., 2006) of how trainees had described the impact of taking part in interventions. A narrative synthesis approach was used which built up from descriptive content counting of qualitative findings. No formal interpretative meta-synthesis was undertaken for this data.

Notes kept at the time of completing the review and evidencing how qualitative findings were narratively synthesised are presented below, and following this, consideration is given to the implications and limitations of the approach used. Double-clicking the thumbnail image directly below will open up the file as a pdf.

Notes on synthesising qualitative data

Consider:

1. What do qualitative findings in individual studies show?
2. What sense can be taken from these as a whole, and how can the story of these findings be presented clearly?

1. What do qualitative findings in individual studies show?

Bell

Summary of key findings: Participants reported a range of positive outcomes relating to their personal and professional lives. Participants described an increase in self-compassion and resilience, as well as an improved ability to regulate and manage threat-focused emotions such as anxiety. Several participants described an upward shift in mood, a reduction in rumination and worry, and an increased ability to challenge unhelpful or critical cognitions. Whilst several participants described challenges associated with the practice (such as finding the time to practice, or conjuring a reliable image of a compassionate supervisor) the intervention was also perceived to impact positively on areas of their clinical work (such as improved client relationships and increased empathy).

Boellinghaus

Summary of key findings: 5 master themes generated that described (1) the experience of engaging in the practice of LKM, (2) the impact it had on the self, (3) the impact it had on their relationships, (4) the extent to which they brought the technique into their clinical work and (5) the extent to which they integrated it into life. All participants reported becoming more accepting of themselves, and many felt more aware of self-critical thoughts or feelings of stress following participation. Most participants experienced aspects of the practice as soothing or grounding, however many also reported the experience of difficult feelings of anger, sadness, guilt or anxiety. Whilst the findings lend support to the idea that LKM can foster improved self-compassion and self-care in TTs, it also highlights the potential challenges associated with it, with some participants describing the experience as feeling risky or even unsafe. Some participants reported a positive impact on their clinical work (a greater sense of empathy and compassion for clients).

Bohecker 2014

In designing this review, I sought to explore the effect of wellbeing interventions on diverse conceptualisations of trainee wellbeing, so as to capture the diversity of how wellbeing in this population was measured and conceptualised. As such, I wanted to be able to include qualitative evaluations of wellbeing interventions as well as quantitative ones. The purpose of this was to supplement quantitative findings with accounts of how trainees had qualitatively described the impact of interventions. As such, a descriptive content counting approach in which the focus was on the extent and frequency with which trainees perceived wellbeing interventions as useful, was

applied. This provided useful information regarding the ways in which trainees described the effects of interventions, and the extent to which interventions were perceived as having positively influenced wellbeing. As examples, the inclusion of qualitative data led to reflection on the nature and measurement of trainee wellbeing, having highlighted instances of disagreement between quantitative and qualitative findings. It also provided further information to be considered alongside quantitative findings regarding the extent to which interventions were considered to have positively influenced wellbeing. However, this descriptive and informal approach has several important limitations. The method was less systematic, robust, or comprehensive than formal meta-synthesis, something which impacts the trustworthiness of findings. However, the value and usefulness of the findings integrated alongside quantitative outcomes means that these findings were able to contribute usefully to the overall findings of the review.

Findings relating to Barriers and Facilitators were generated by drawing on recommendations for the practice of Barriers and Facilitators systematic reviews (Bach-Mortensen & Verboom, 2020). Building from a review of over one-hundred barriers and facilitators systematic reviews to provide a set of recommendations for future researchers in the area, Bach-Mortensen and Verboom recommend a need to define how barriers and facilitators are defined, explain how data relating to barriers and facilitators are extracted from primary studies, and evaluate the robustness of the findings presented. They also explicitly note the importance of not relying solely on frequency of report to establish the importance of a given barrier or facilitator.

In the present systematic review, the way barriers and facilitators were defined was stated explicitly (in the *Barriers and Facilitators* section of the *Results*). In the *Synthesis Method* section of the paper, I briefly outlined the process of how barriers and facilitators information was extracted from studies, and also how results were combined and presented. In the lengthier original version of this

review (when the barriers and facilitators findings were presented as their own standalone paper) a more comprehensive account of this process was described. This more comprehensive account is copied below. Following this, several notes/tables showing how the work was actually carried are presented.

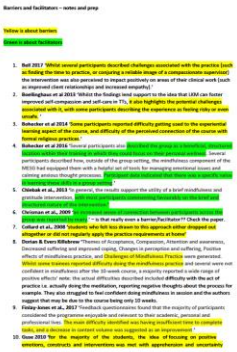
Synthesis Method (Copied from original write up of the barriers and facilitators findings)

The conduct of this review and the synthesis of results were informed by methodological recommendations for Systematic Reviews of barriers and facilitators (Bach-Mortensen & Verboom, 2020). The results of included studies were closely read, and all data pertaining to barriers or facilitators (as defined above) were extracted as part of the data extraction process. These extracts were subsequently categorised as barriers or facilitators, and coded on the basis of their content. Related codes from across studies were grouped systematically using tables in a word-processing programme, to facilitate a clear and structured organisation of the data. From these groupings, themes were created to capture the essence of the salient perceived barriers and facilitators as experienced by PTTs in the context under which interventions were delivered. In making decisions about the themes presented here, the primary author took account of the frequency with which particular topics were mentioned in included studies. However, given the short-comings of relying solely on frequency as the indicator of importance (Bach-Mortensen & Verboom, 2020), other factors such as the extent to which such barriers and facilitators were perceived by participants to impede or promote success or engagement were also considered. In the absence of established guidelines for testing the robustness of such groupings (Bach-Mortensen & Verboom, 2020), their rigour and usefulness were instead examined through discussion with the research team.

To further contextualise the findings, and to support their organisation, Protcor et al.'s Implementation Framework (Proctor et al., 2011) has been drawn upon to provide a conceptual framework to underpin the presentation of results. In recognition of the fact that inflexible adherence to a pre-determined framework for presenting results can restrict the value of a barriers and facilitators review (Bach-Mortensen & Verboom, 2020), the framework has been drawn upon in a flexible way. As such, the identified findings have been retrospectively interpreted in light of the relevant outcomes from the framework, but the framework was not used to restrict, contain, or shape the emerging topics themselves. Results identified and synthesised in this review relate to matters of intervention Acceptability, Appropriateness, Feasibility and Fidelity. The certainty of results for the identified topics has been assessed by clearly establishing the connection between the findings of included papers and the results presented here, by expressly considering the quality of the evidence drawn on, and by considering issues of heterogeneity in results.

Addendum Supplementary Material 1: Extracted barriers and facilitators data

This document combines extracted data from each relevant study on barriers and facilitators. I had compiled this following data extraction, and as a preliminary step to synthesising the barriers and facilitators findings. Double-clicking the thumbnail image directly below will open up the file as a pdf.



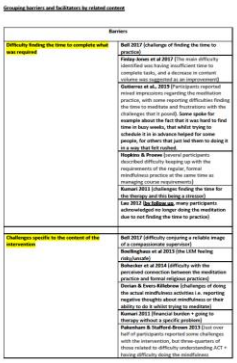
Barriers and facilitators – notes and prep

Yellow is about barriers

Green is about facilitators

1. **Ball 2017** 'Whilst several participants described challenges associated with the practice (such as finding the time to practice, or conjuring a reliable image of a compassionate supervisor) the intervention was also perceived to impact positively on areas of their clinical work (such as improved client relationships and increased empathy).'
2. **Boellinghaus et al 2013** 'Whilst the findings lend support to the idea that LKM can foster improved self-compassion and self-care in TTs, it also highlights the potential challenges associated with it, with some participants describing the experience as fleeting risky or even unsafe.'
3. **Bohecker et al 2014** 'Some participants reported difficulty getting used to the experiential learning aspect of the course, and difficulty of the perceived connection of the course with formal religious practices.'
4. **Bohecker et al 2016** 'Several participants also described the group as a beneficial, necessary practice with a clear focus on learning to be present in the moment. Several participants described how, outside of the group setting, the mindfulness component of the MESD had equipped them with a helpful set of tools for managing emotional issues and calming anxious thought processes. The shared class experience also came up recently, with participants describing their time in the group as'
5. **Chimbuk et al., 2013** 'In general, the results support the utility of a brief mindfulness and gratitude intervention, with most participants commenting favourably on the brief and structured nature of the intervention.'
6. **Christmas et al., 2009** 'As a result, there is a disconnection between what is taught in the classroom and what is required in reality' – is that really even a barrier/facilitator?? Check the paper.
7. **Collard et al., 2008** 'students who felt less drawn to this approach either dropped out altogether or did not regularly apply the practice requirements at home'
8. **Dorian & Even-Rikbrene** 'Themes of Acceptance, Compassion, Attention and awareness, Decreased suffering and improved coping, Changes in perception and suffering, Positive effects of mindfulness practice, and Challenges of Mindfulness Practice were generated. Whilst some trainees reported difficulty doing the mindfulness practice and several were not confident in mindfulness after the 10-week course, a majority reported a wide range of positive effects' note, the actual difficulties described included difficulty with the act of practice i.e. actually doing the meditation, reporting negative thoughts about the process for example. They also struggled to feel confident doing mindfulness in session and the authors suggest that may be due to the course being only 10 weeks.
9. **Finlay-Jones et al., 2017** 'Feedback questionnaires found that the majority of participants considered the programme enjoyable and relevant to their academic, personal and professional lives. The main difficulty identified was having insufficient time to complete tasks, and a decrease in content volume was suggested as an improvement.'
10. **Gaw 2010** 'for the majority of the students, the idea of focusing on positive emotions, constructs and interventions was met with apprehension and uncertainty

Addendum Supplementary Material 2: Grouping related content this document evidences how I then began to group related barriers and facilitators. Double-clicking the thumbnail image directly below will open up the file as a pdf.



Grouping barriers and facilitators by related content

Barriers	
Difficulty finding the time to complete what was required	Bull 2017 (challenge of finding the time to practice) Finlay-Jones et al 2017 (The main difficulty identified was having insufficient time to complete tasks, and a decrease in content volume was suggested as an improvement) Gutierrez et al., 2019 (Participants reported mixed impressions regarding the meditation practice, with some reporting difficulties finding the time to meditate (overall). Some spoke to this example about the fact that it was hard to find time in busy weeks, that whilst trying to schedule it in to advance helped for some people, for others that just led them to doing it in a way that felt rushed Hughes & Provoo (several participants described difficulty keeping up with the requirements of the regular, formal mindfulness practice at the same time as managing course requirements) Kumari 2011 (challenges finding the time for the therapy and this being a stressor) Lee 2012 (to follow up, many participants acknowledged no longer doing the meditation due to not finding the time to practice)
Challenges specific to the content of the intervention	Bull 2017 (difficulty conjuring a reliable image of a compassionate supervisor) Roellinghaus et al 2013 (the LKM having risks/unsafe) Rohrscheir et al 2014 (difficulty with the perceived connection between the meditation practice and formal religious practice) Dorian & Evero-Killebrew (challenges of doing the actual mindfulness activities i.e. reporting negative thoughts about mindfulness or their ability to do it whilst trying to meditate) Kumari 2011 (financial burden + going to therapy without a specific problem) Pakenham & Stafford-Brown 2013 (just over half of participants reported some challenges with the intervention, but three-quarters of those related to difficulty understanding ACT + having difficulty doing the mindfulness

5. Considering the findings of the published review in light of the additional content presented in this Addendum, and considering remaining uncertainties

The systematic review presented in Chapter 3 concluded that the balance of evidence tentatively suggests that psychological wellbeing interventions may be effective and are valued by trainees.

The additional quantitative data prepared for this Addendum compliments the findings of the published review; extending core ideas (e.g. that the balance of evidence indicates the potential of these interventions to be effective) but also re-emphasising the need to ensure that the positive signals are not over-interpreted as definitive support. Whilst a majority of the studies reporting on the magnitude of change highlighted large effect sizes for example, further caution is also needed in relation to this newly added information. Firstly, large effect sizes do not necessarily mean clinically important effects (Durlak, 2009). Secondly, the reported effect sizes themselves require caution in interpretation. Five of the eight studies reporting effect sizes regarding the magnitude of the changes experienced over the intervention period were uncontrolled, pre-post studies, meaning

that causal claims attributing the effect to the intervention cannot be made. Additionally, methodological limitations relating to expectancy effects, and per-protocol analysis also indicate that these effect sizes should be indicative only.

The newly included information on direction of effects similarly extends and broadly aligns with the findings of the review presented in Chapter 3. Whilst the review captured that a majority of studies identified significant improvements on at least one outcome, the more nuanced account given by the direction of effect findings indicates that a trend towards improvement was a relatively consistent outcome across studies. Notably, several of the studies that failed to find a significant effect did nonetheless see improvements in multiple outcomes. As such, the direction of effect findings offer further support to the idea that interventions may be effective. Despite the important caveats to all findings (e.g. relating to methodological limitations such as expectancy effects and lack of control groups for example), these findings may be considered to provide further support for interventions than was presented in the somewhat more mixed findings on statistical significance. Similarly, the small minority of outcomes that deteriorated over the study period reinforces the idea that interventions in this field can be beneficial.

A number of caveats and cautionary remarks are made throughout the published review, emphasising the need to interpret results carefully, and in a way that acknowledges the mixed-quality of reviewed studies. The process of producing GRADE and GRADE-CERQual statements for the review further emphasises this need. The quality or certainty of effectiveness findings was assessed to be very low, and the confidence in qualitative findings was assessed to be moderate. As such, careful consideration is needed when interpreting the findings of this review, and it is clear that several key questions remain unanswered. Whilst the published review highlights the need for more high-quality and controlled research in this area, the newly included information here further emphasises this point. The literature synthesised in this review is comprised of many small, uncontrolled studies with multiple methodological limitations. To answer questions about the

effectiveness of wellbeing interventions with trainees, the field needs larger, adequately powered, and well-designed studies, with clearly articulated primary outcomes, randomised control groups, and longer follow-ups.

Importantly, further key uncertainties left unaddressed by the studies in this review relate to the cost-effectiveness of delivering interventions in the field. This is a key feature of understanding the real-world value of interventions (Skivington et al., 2021), and appears to currently be an under-explored area in the field.

Further considerations of remaining uncertainties and next steps are outlined in the *Study Conclusion* for this chapter, presented in the overall thesis *Discussion*.

Chapter 4: How do psychological therapy trainees experience wellbeing in their role? A reflexive thematic analysis

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Abstract

The wellbeing of the Psychological Therapy Trainee (PTT) workforce is an important area of concern, with implications for practitioners, training providers, employing services and the wider population that trainees serve. To date, relatively little attention has been paid to how trainees experience wellbeing, meaning it is often conceptualised implicitly as an absence of negative correlates of wellbeing such as stress, burnout or mental ill-health. In this in-depth, qualitative study, we explored how a group of Psychological Therapy Trainees (PTTs) at a UK university experience wellbeing in their roles. The work proceeded from a phenomenological perspective, seeking to make sense of how the PTTs experienced, described, and made sense of wellbeing in their trainee roles. Individual, semi-structured interviews were conducted with fifteen PTTs and data was analysed using a reflexive form of Thematic Analysis. One overarching theme, and four themes were constructed. The generated findings indicated that the overarching theme of connecting with and embodying personal values was central to participant wellbeing. The four themes indicated that a sense of contributing to some perceived social good, perceiving oneself to be competent and progressing, feeling connected to peers on the training, and succeeding in maintaining other important life areas were central to the experience of wellbeing in the role. The findings make an important contribution both to the literature on PTT wellbeing specifically, and also to the wider literature regarding wellbeing more broadly. Findings are discussed in relation to the relevant literature, with particular emphasis placed on the important role that qualitative exploration has in understanding the nuance and complexity of wellbeing in specific contexts.

Keywords: wellbeing; psychological wellbeing; thematic analysis; phenomenological; psychological therapy trainee

Introduction

The wellbeing of psychological therapy trainees (PTTs) is an important area of concern. Research in the field indicates that PTTs experience a range of stressors that are distinct from qualified practitioners, report levels of stress and burnout that exceed those of their qualified peers (Owen et al., 2021; Pakenham & Stafford-Brown, 2012), and experience the impact of elevated stress levels from the very early stages of their training (Owen et al., 2022). With findings to suggest that outcomes such as clinical effectiveness (Delgadillo et al., 2018), intention to remain in post (Summers et al., 2021), academic learning (Pascoe et al., 2020), and academic and professional conduct (Barnett et al., 2007; Tindall et al., 2021) are all negatively influenced by poor wellbeing, efforts to better understand and support PTT wellbeing appear significant for ensuring the wellbeing and effectiveness of the developing workforce.

Increasing awareness of this issue has led to an expansion of work in the area, with a growing body of research designed to improve PTT wellbeing appearing in recent years. Despite this, the notion of PTT wellbeing remains a relatively poorly understood phenomenon. This is perhaps unsurprising, as despite significant advancements in the study and understanding of wellbeing more broadly, its essential features remain contested (Diener et al., 2002; Ryff, 1989) and the issue of how to define wellbeing remains unresolved (Dodge et al., 2012; Jarden & Roache, 2023; Seligman, 2011; Simons & Baldwin, 2021). In recent years, a growing trend has emerged for conceptualising wellbeing in contextually sensitive ways (Jarden et al., 2021). Researchers in this field draw attention to the fact that wellbeing appears to be conceptualised and experienced in different ways for different populations (e.g. different age groups, or employment types) (Jarden et al., 2021), an idea which has been present in some research for several decades (King & Napa, 1998).

Many researchers in the field of PTT wellbeing have focussed primarily on the reduction of symptoms of stress, anxiety or psychological distress (Abel et al., 2012; Bohecker & Doughty Horn, 2016; Chan et al., 2021; Gutierrez et al., 2016; Hopkins & Proeve, 2013), implicitly conceptualising wellbeing as an absence of 'negative' correlates of mental health or wellbeing. Whilst such a perspective dominated psychology for much of the 20th century and remains a prevalent idea (Seligman & Csikszentmihalyi, 2000), recent decades have seen a shift in focus towards promoting positive wellbeing and conceptualising wellbeing as different to – and more than – a simple absence of mental ill-health (Compton & Hoffman, 2020). Relatedly, a growing evidence-base has developed to support the idea that mental health and mental illness are not two opposing ends of a single continuum, but rather two related but distinct continua (Iasiello et al., 2020; Keyes, 2005). From such a perspective, an absence of stress, burnout or anxiety does not necessarily equate to wellbeing, meaning that attempts to improve PTT wellbeing through addressing and measuring such constructs alone may be capturing only part of the picture.

Given the complexity of defining wellbeing, and the indication that wellbeing may be at least partially context-dependent, there is a need for qualitative, data-driven research on wellbeing as it is experienced in context (Boniwell & Henry, 2007). Notably, PTTs may represent a particularly interesting population to consider in this regard, with research into the experience of training and working in this field indicating a complex and nuanced relationship with wellbeing. A growing body of research has repeatedly drawn attention to high levels of stress, burnout and psychological distress, as well as vulnerability to secondary trauma in psychological professionals and trainees (Ball et al., 2022; Pakenham & Stafford-Brown, 2012; Simionato & Simpson, 2018; Steel et al., 2015). At the same time however, work in this field has also been associated with meaning and purpose (Russo-Netzer et al., 2020) and high levels of job and life satisfaction (Rupert et al., 2012; Wiens et al., 2022). This complex interplay between different facets of wellbeing, emphasises the need for in-depth, qualitative and contextually-based explorations of wellbeing such as that undertaken here.

The question this study sought to answer was:

1. How do psychological therapy trainees experience wellbeing in their roles?

Study objectives

The present study used individual interviews and adopted a phenomenological-approach to explore how PTTs experience wellbeing in their roles. The study sought to deepen understanding on this topic, and generate findings of interest to researchers interested in the psychology of wellbeing, and all involved in the training of psychological therapy trainees (e.g. professional trainers, trainees, healthcare services etc.)

Method

Design

A qualitative design was used, and data was analysed using an experiential form of reflexive thematic analysis (Braun & Clarke, 2006, 2019). In keeping with the attempt to understand how PTTs experienced, described and made sense of their wellbeing during training, the research proceeded from a phenomenological world-view (Willig, 2013). From such a position, only the world of experience is meaningful, with human-beings seen as fundamentally intertwined with the world, and as a contributing component of 'reality' (Larkin et al., 2006). In the context of this research therefore, rather than seeking to attempt to define what wellbeing – in some abstract or universal sense – '*is*', the intentions were to provide a rich and detailed interpretative account of how wellbeing was experienced by included trainees. Data were therefore collected and viewed through this phenomenological lens; being seen to provide insight into how trainees made sense of their experience, and seeing the reality of wellbeing such as it was described as contextually-based, and fundamentally intertwined with the experience and meaning-making processes of trainees themselves. Efforts were made to capture and unpick variability in experience, (Levitt, 2021) and

careful steps were taken to describe both the participants and their accounts, in order to support readers in assessing the potential for these findings to be generalised or transferred to other contexts (Lincoln & Guba, 1985; Smith, 2018).

In keeping with the aims of the research, individual semi-structured interviews were chosen, given their suitability to in-depth exploration of how individuals experience and make sense of personally-relevant topics (Braun & Clarke, 2013). Given the primary intention of generating themes across the dataset as a whole, the decision to seek some diversity in psychological professions (e.g. PTTs across multiple training pathways and professions), and the intention to situate trainees' experience in the wider socio-cultural context in which trainees worked, a phenomenologically-driven, reflexive form of Thematic Analysis was utilised (Braun & Clarke, 2021).

In the attempt to make sense of wellbeing as it is experienced for these trainees, participants' descriptions were considered to give some genuine (though necessarily imperfect and partial) insight into how they made sense of their experience (Willig, 2013). The active, researcher-driven nature of the interpretative process was however always at the foreground (Braun & Clarke, 2019), meaning that the decisions made regarding the questions asked and the results generated, are also closely intertwined with the experience, knowledge and expectations of the primary researcher and research team. Informed consent was obtained and ethical approval for the study was granted by the employing university's Faculty Research Ethics Committee.

Participants, study setting and recruitment

In an effort to seek the perspectives of current trainees studying at the research team's institution, participants were recruited from across five psychological therapy training programmes at one UK university. Despite studying at the same university, students on these programmes were employed by a range of different NHS and third-sector organisations, working clinically across a wide geographical region and based within a variety of settings including primary care, secondary care,

and schools. Training programmes varied in focus and ethos. Therapeutic modalities also varied by programme, though all were primarily informed by Cognitive Behavioural Therapy (CBT). Trainees were enrolled on programmes leading to professional qualification, and covering Postgraduate Certificate, Postgraduate Diploma, Masters, and Doctoral-level training.

Interviews were held remotely via Teams and lasted on average approximately 1-hour each. Interviews took place with only the participant and researcher in the call. Interviews were recorded and transcribed (9 were transcribed by the primary researcher, and 6 by a professional transcription service) and all participants were offered the chance to review their transcripts (though none chose to do so). Students on these programmes were recruited purposively, being told about the study through verbal descriptions of the research and online adverts posted to their internal Blackboard (an online learning technology platform). As such, all members of included cohorts (approximately two-hundred trainees) were invited to take part. In keeping with estimates made in advance, and on the basis of broad guidance from the literature (Braun & Clarke, 2013) combined with expectations regarding the quality and depth of data to be generated (Malterud et al., 2016), a total of 15 participants were sought and included.

Inclusion criteria were:

- Currently enrolled on one of the universities' psychological therapy training programmes
- Completed a period of 2-months or more since beginning the first clinical work in their current role
- Consider themselves able to talk about their experience of wellbeing in the role.

It was expressly noted that there were no particular expectations or requirements regarding their experience of wellbeing in the role (e.g. participants were not expected to have consistently high, or particularly bad wellbeing).

In keeping with efforts to explore individual experience in-depth whilst also looking across the experience shared by trainees across multiple training pathways, a total of fifteen participants from five separate training programmes were recruited for the study. No trainees explicitly stated not wanting to take part, though many of the trainees advertised to had not expressed an interest in taking part before recruitment was closed. In keeping with study intentions, recruitment was closed after 15 trainees had consented to take part. Recruitment was designed to ensure representation of participants across multiple programmes. Within each programme, recruitment proceeded on a first-come-first-serve basis. To protect anonymity of participants, demographic information is presented below for the group as a whole. The fifteen participants included trainees on the Clinical Psychology (n=4), Cognitive Behavioural Therapy (n=4), Clinical Associate in Psychology (n=3), Psychological Wellbeing Practitioner (n=2) and Education Mental Health Practitioner (n=2) programmes. Of the fifteen participants, two described themselves as male and thirteen as female. Participants described their sexuality as heterosexual (n=9), bisexual (n=2), queer (n=1), lesbian (n=1), pansexual (n=1), or gay (n=1). All participants described themselves as White-British or White-European and selected age brackets ranging from 18-25 up to 46-55, with the age range of 26-35 accounting for the majority of participants (n=11). Eleven participants reported having previous clinical experience in a role before their current one. Regarding gender and age, the characteristics of this sample aligned broadly with those of the wider psychological professions workforce in the country in which the research was conducted (England) (Whittington, 2024). Against the national workforce however, White-British and White-European nationalities were over-represented (Whittington, 2024), a fact that places important constraints on the transferability of findings. The absence of participants from ethnic minorities requires that careful consideration is needed when making sense of these results then,

especially when considering to what extent findings might be seen to generalise to ethnic minority trainees.

Topic Guide development

A topic guide was developed to facilitate in-depth exploration of trainees' experience of wellbeing. The topic guide was developed iteratively through a process during which early ideas were set out, discussed with supervisors, refined, and subsequently piloted in two different settings. To facilitate detailed exploration of trainees' experience, decisions were made after an initial piloting exercise with a colleague to slightly change the focus of the guide, moving what had been the opening question ('what is your understanding of the term wellbeing?') to the end of the interview. It was decided that this more abstract and conceptual question moved the focus away from individual's personal experience, and so was better suited to being positioned towards the end, and as the interview was being brought to a close. In the later stages of preparing the topic guide, the primary researcher (who conducted 13/15 interviews) and the one other team member who conducted the remaining interviews (n=2), participated in researcher interviews. This provided an important opportunity to reflect on how personal experiences, attitudes and beliefs may inform the research process (Olmos-Vega et al., 2023), and also to consider how the proposed questions functioned and might be received. Following this, another subtle shift in language and focus designed to facilitate detailed exploration of specific moments and experience was agreed with the supervisory team. Questions that explored 'highlights', 'challenges', 'moments that have been most enjoyable/difficult' replaced those that asked more directly what it was like for trainees to experience wellbeing (e.g. 'Can you describe to me what it is like for you when you experience wellbeing in your role'). A copy of the final Topic Guide is presented in Supplementary Material 1.

Researcher positioning

The primary researcher is a male, qualified Psychological Wellbeing Practitioner (PWP), and the Programme Director of a PWP training programme at a UK university. He has worked as a professional trainer in the field for eight years and is currently undertaking a PhD on psychological therapy trainee wellbeing. Efforts were made to ensure that this professional and clinical background consistently informed the research in constructive ways. Extensive reflection – facilitated both by personal journalling, and reflective group discussions with the research team – supported efforts to capitalise on researcher subjectivity (Olmos-Vega et al., 2023). The interest in this topic, and the specific questions asked, were considered in light of the primary author's personal experience as a former trainee, as a researcher involved in the field of PTT wellbeing, and as an academic involved in teaching, advising and supervising trainees.

With several of the research-team working in the department that the research was conducted in, careful consideration was also given to potential power-imbalances between members of faculty and students, and how this may influence who came forward to participate in interviews and what they described. In order to promote openness, a decision was made that participants would not be interviewed by anyone primarily employed to work on the programme on which the participant was studying, and assurances were provided that taking part (or not) in the research would not in any way impact a student's progression through the training. Additionally, all communication regarding the study (including study materials, and discussion before and during the interviews) emphasised that no particular answers were being looked for, and that the focus and interest of the research was the individual participant, and how they described and experienced wellbeing in their role.

Data analysis and trustworthiness

Given the intention to explore how trainees experienced and described wellbeing in their role, analysis proceeded in an inductive, data-driven manner, open to unexpected findings, and grounding results in the ideas and words of participants. Examples of this included paying equal attention to all

aspects of the data, and not prioritising data that was seen to fit with known aspects of the current literature. The value of researcher subjectivity was however also constantly upheld (Braun & Clarke, 2019), and embraced as a source of positive influence on the research process (Olmos-Vega et al., 2023). As an example of this, whilst analysis was grounded in the data, the researcher used his reflective journal to (amongst other things) reflect on how features of the data related to components of the wider literature on wellbeing, anecdotal evidence from his experience supporting and teaching trainees for several years, and his own experiences as a trainee in the past. (Illustrative extracts of the reflective journal can be found in Supplementary Material 3). Notes were made by the primary researcher immediately after interviews, noting ideas or phrases considered to be important, and reflecting on how they related (or didn't relate) to the wider literature or earlier interviews.

Data analysis was informed by the six-stages of the reflexive form of Thematic Analysis described by Braun and Clarke (Braun & Clarke, 2006, 2019) and conducted by the primary researcher. Firstly, the primary researcher fully immersed himself in the data by transcribing many of the interviews himself, reading and re-reading all interviews multiple times, and listening back to recordings on multiple occasions to further grasp the subtle and nuanced details of what was said. Early thoughts and ideas in response to the dataset were discussed with the research team. Coding was done by carefully working through each interview and identifying 'chunks' of data perceived by the researcher to be meaningful in relation to the research question. (An illustrative example of a coded transcript is presented in Supplementary Material 2). A complete coding (Braun & Clarke, 2013) approach was employed, coding relevant material from across the entire dataset. In an effort to capture both explicit and implicit meaning within the data, both semantic and latent-level codes were generated, though semantic meanings were generally prioritised, and coded for earlier in the coding process (Braun & Clarke, 2006). This coding process resulted in over two-thousand codes, including both semantic and latent-level codes. The coding process was facilitated through input from the research team. In keeping with the phenomenological worldview underpinning the research, participant

accounts were considered to give genuine and meaningful (though necessarily imperfect) insight into how trainees made sense of their experience (Willig, 2013). Coding proceeded in line with this perspective, viewing the data as providing insight into features of participants' inner worlds and their sense-making processes. Coding was conducted in a broad and comprehensive manner, to capture and begin to shape all features of the dataset relevant to the research question. The first fully-coded interview was shared with the team and a collaborative discussion followed that encouraged in-depth and reflexive engagement with the coding process. As examples, consideration was given to how the primary researcher's personal and professional experience was interacting with the way the data was approached. Careful consideration was given to how to use the researcher's subjectivity positively, whilst also working in a manner which prioritised the data itself. As an example, data that hinted at features of the literature known to the researcher or that resonated with aspects of his own experience as a trainee in the past were coded broadly, interrogated from different angles, and discussed in supervision. Once all interviews were coded, codes were then grouped into related topics using blank PowerPoint slides, by copying and pasting codes from interviews onto slides with other, related codes. These groupings aimed to capture patterns of shared meaning in codes both across and within interviews, and reflected the way that the primary researcher was conceptualising and making sense of the meaning across the entire data set. These developing topics were shared at multiple stages with the research team, and examples can be viewed in Supplementary Material 4.3 - 4.5. As the process advanced, these initial topics were refined, combined and honed, to construct the themes presented here. Themes were eventually named following reflective discussions and by reading back through all codes and the complete dataset. At all stages, the primary researcher and research team sought to use their knowledge (e.g. of the literature regarding wellbeing and trainee wellbeing), experience (e.g. as professional trainers, researchers and student advisers) and beliefs (e.g. about why this was an important topic to consider, and how best the research could be used to positively influence the context in which it was being conducted) in ways that enhanced the research process. In keeping with recommendations for establishing trustworthiness (Lincoln & Guba, 1985),

a clear audit trail of the research was kept from project inception onwards (including raw data, reflective notes, and evidence of the process of analysis at multiple stages etc.). As described above, a reflexive journal was utilised throughout, and reflective discussions were frequently held between the research team, prompting in-depth reflection on topics such as the relative primacy of semantic vs latent codes, and how to make sense of ways in which preconceptions about anticipated variation between different training groups were challenged by the data. All such steps, and the consideration regarding which data extracts would be used to support the interpretation of the findings offered, were conducted with issues regarding the credibility and persuasiveness of the research in mind.

Findings

Four themes and one overarching theme were constructed. The overarching theme is intended to provide additional structure and organisation for the analysis, by sitting above and capturing something within each of the four main themes generated. The themes are depicted in Figure 1, and described in detail below.

Figure 1. Visual depiction of themes

Overarching theme: Connecting with and embodying personal values is at the heart of wellbeing in the role.

The importance of living in accordance with personal values permeated much of what was discussed by trainees throughout the interviews. For many participants, there was a nuanced relationship between their role and their values. The role was described as an important avenue through which trainees connected with and embodied their personal values, but they also reflected on how aspects of the training occasionally pushed up against or conflicted with these values in a way that generated feelings of stress, anger or vulnerability. Across the dataset, there is evidence of trainees reflecting on how much their enjoyment in and fulfilment from the role is defined by a felt sense of connection to their values, and a belief that they are living out those values through their work. Participants described how the role was an avenue through which they lived out personal values associated with helping others and contributing to some greater good, to feeling competent and successful, to feeling connected to peers in their role, and to continuing to uphold other important life areas whilst training.

Theme 1: *'It's for the greater good…'*: helping others provides life with meaning and purpose.

Having a felt sense of purpose was described by participants as being central to a well-lived life, and to the experience of wellbeing. Importantly, a perception that life is not simply meaningful or purposeful by default appeared to frame the way that trainees made sense of the important role their work played in their lives. Helping people through their work was described by Participant 12 for example as 'as close as I can get to a life's purpose'. Indeed, for many trainees, it was their role which enabled them to feel purposeful and to perceive their lives as meaningful and valuable. Central to this idea was the notion that helping others is a deeply valuable and significant activity that can give value to a life, and which transcends day-to-day activities by contributing to what Participant 11 called a 'grander scheme of things for what's important for people's lives and happiness'.

Trainees described the work they were training to do as psychological therapists and practitioners using phrases such as 'important' (Participant 2), 'worthy' (Participant 11), and 'for the greater good' (Participant 5). This felt sense of doing some social good by helping others was therefore central to the experience of wellbeing in the role, and at the heart of the sense of purpose the training provided to participants' lives. Not only was this sense of purpose a central component of the experience of wellbeing for many trainees, for some, it appeared to function as the central ingredient of a worthwhile life:

> "What's the point in existence, if you're not feeding into a purpose in some way? To me purpose is humans helping others, and that connectiveness in society I suppose" (Participant 6, 223-225).

For some trainees, there was also a sense that by training in this field they were paying back some sort of social debt; an interesting and novel finding suggesting that trainees sought in these roles an avenue for repaying the kindness and support they had received from others in times of need, or alleviating the guilt they felt for the comfortable start they had enjoyed in life. Participant 15 for example reflected on times they had benefited from the support of others, and how this role allows them to 'kind of give that back'. In a similar sentiment, Participant 11 described how training in this field 'makes me feel less guilty for having a nice start in life'. In this sense, whilst their work as PTTs was seen as important for contributing to a greater social good and the wellbeing of others, it also appeared critical for participants in coming to terms with features of their own lives and existence; a potentially significant idea that provides an important further context in which to see an individual's training journey. From this perspective, the centrality of helping others to the experience of wellbeing perhaps stemmed not only from a wish to support others in need, but also a need to find ways to live with aspects of themselves or their own lives. Those involved in training may helpfully seek to build on this through providing opportunity to trainees to reflect on what has brought them into the role, and what they hope to take from it.

When reflecting on how her work as a trainee helped to counter thoughts about her own perceived insignificance for example, Participant 8 noted:

> '… I think because I see it as a kind of a bit of a purpose for me. You know, I've had times where I don't feel like I've… you know, where you can get bogged down, you know… I'm just one person, just one small person living my little life. And then, you know, ways I've kind of overcome that, are maybe a more kind of spiritual approach even… thinking about what purpose do I have, and what change can I make? And I kind of have to believe that I have a bigger purpose, otherwise it's really easy to feel, you know, actually really insignificant. So that kind of drives me to kind of act on that.' (Participant 8, 164-171).

In noting that she 'has to believe' that she has a bigger purpose, an *all-too-human* vulnerability is revealed here by Participant 8, and the importance of the role for her own wellbeing and sense of self is demonstrated. Here, a nuanced relationship between helping others and personal wellbeing is discovered, with the drive to help others emanating also from a motivation to protect oneself. Importantly then, this deeply felt need for purpose in life described by many participants, and the centrality of their roles in providing that purpose meant that trainees were also left at times in a somewhat vulnerable position. Where the need to secure purpose by helping others was thwarted (e.g. by the realities of clinical work in practice, the needs of the service they worked in, or features of the role that trainees perceived to be less useful) trainees reported feelings of frustration and unease akin to elements of the developing literature regarding moral injury (British Medical Association, 2021). Notably, such experiences appeared to contribute towards a loss of direction that threatened to undermine not only the enjoyment of their work, but also a central feature of the way they imbued their lives with meaning.

Theme 2: *'I like to feel that I'm doing well…'*: achieving and feeling competent promote self-worth and are central to the experience of wellbeing.

This theme describes how a perceived sense of accomplishment, progression and competency was at the heart of the experience of wellbeing for these trainees. Many trainees spoke of the training as an intense period of personal and professional growth, in which they experienced themselves to develop into more fully rounded people as well as practitioners. Participant 8 for example described as 'really positive' the sense that through the training they had 'developed so much in ways that I wouldn't have even imagined before I started, both professionally, but just, also you know personally as well'.

A narrative that these courses demanded high standards, and were difficult to secure places for, provided a backdrop for this experience, feeding into a sense that trainees needed to prove themselves and earn their place. Trainees described feeling fortunate for securing the 'good opportunity' that this funded training role represented (Participant 15), and described how earlier in their careers they had considered not applying for the role after seeing friends they perceived as more competent than them being unsuccessful (Participant 7). On the training itself, a sense of self-doubt was also frequently evidenced. Participant 6 for example spoke about 'being really fortunate' to get good feedback from their supervisors, attributing the positive feedback to good luck or generous supervisors rather than their own abilities, in a way indicative of the self-criticism and 'imposter syndrome' commonly reported in the wider literature in this field (Clark et al., 2022). In such a context, the importance for wellbeing of achieving and being competent appeared significant, and the implications when this was not met were notable. Several participants described the experience of failing something or receiving what they perceived as negative feedback with strong emotional language, reporting that feedback was 'savage' (Participant 7), that it 'broke them down' (Participant 10) or that it undermined their 'self-image' (Participant 12). This reveals a nuanced relationship between competency and wellbeing for these trainees. Trainees repeatedly spoke about the joys of being positively stretched to develop and feel competent in new areas. Participant 11 for

example described how they ‘just love learning’, and when describing the positive feelings associated with developing new skills through their training, feelings of ‘accomplishment’ (Participant 10) or ‘fulfilment’ (Participant 6) were commonly described. When asked to describe highlights in their roles, trainees often spoke of moments in which they’d succeeded with new skills, or in which they had achieved and progressed. Positive emotions such as happiness and joy were consistently attached to such experiences, and a sense of pride dominated many of these narratives. At the same time however, several trainees reported a strong resistance to being challenged or pushed beyond limits they perceived as attainable:

> ‘Feeling… being like you're going to try and work with somebody and you don't actually know what you're doing… that's a really… even if maybe you’ve talked it through, and on the surface other people feel like you do… just feeling like you haven't quite got enough, like you're not the right person, or you haven't got the right, whatever it is to work with that person at that time. That's kind of such a horrible feeling to sit with…’ (Participant 9, 752-771)

Elsewhere in their interview, Participant 9 had described the value of being stretched, and pushed into new domains through their training. In this extract however, features of social comparison and self-doubt appear to work against this, perhaps contributing to a reluctance to taking the risks that may be required during a period of growth and development. Such moments suggest that the stretching that trainees were seeking may in fact be a modest and comfortable one, in which they were not compelled to step into the occasional feelings of incompetence that are typical whilst developing new therapy skills (Bennett-Levy & Beedie, 2007). This important finding suggests perhaps that those involved in training have important roles to play in expectation-management, and in supporting trainees to feel more comfortable with the challenge of being meaningfully stretched.

The complexities of this relationship between competence and wellbeing are clearly set out in the following quote from Participant 11:

> ‘You are in a training role and therefore you do not know, not that you ever know it all, but you definitely don’t know it all in a training role. And that’s really difficult for me because if competence is a big part of something that sort of – if that’s a big rule for living, to be competent in everything all the time, training is a real big risk. And especially when I had to resubmit one assignment, that was a real moment of difficulty because you’re not living that rule anymore, you’re now – the terrifying belief is exposed.’ (Participant 11, 325-332).

This complex interplay between a need to achieve and feel competent, the sense of joy and pride in implementing new skills effectively, and the felt risk involved in being stretched into new domains, emphasises the significant place that achievement and competency held in these trainees’ experience of wellbeing in their roles. For many trainees, the need to achieve and to demonstrate competence were made sense of in terms of long-held drives to be productive and successful, with trainees framing it occasionally as a way of validating themselves, and countering negative personal beliefs about their own competence. As such, whilst feelings of competence and achievement dominated much of what trainees enjoyed most in their roles, the stakes were perceived to be high. After receiving a fail-grade for a first submission for example, Participant 10 described how they were ‘severely depressed for two weeks... I just didn’t understand how I could fail something that I felt I was really good at’. Perhaps in this light, efforts were sometimes made by trainees to protect themselves from the risks of training by resisting elements of being stretched, or by attempting to downplay the importance of the opinions of lecturers and academic markers (‘I told my lecturers on the last week that no offence, but I don’t care about your feedback’ (Participant 10)), in ways that conflicted with the strong emotional reactions reported upon failing marked work.

Theme 3: *'I don't think you'd get a bond like that anywhere else…'*: feeling connected to like-minded others is central to surviving and enjoying the training.

Participants spoke in-depth about the significance of strong relationships with course peers. A sense of comradery, shared-identity, and connection with like-minded peers was described as a defining feature of the experience of wellbeing in the role, and this felt sense of connection with peers permeated many of the highlights in the role described. 'Being on the course with like-minded people [who] experience similar stress' Participant 6 noted 'is a big thing for wellbeing'. Participants spoke of making 'really good friends' (Participant 4) and 'lifelong connections' (Participant 2) through the training, and frequently alluded to the unique nature of these course relationships.

Trainees described relationships with course peers as different from – and in some ways more than – relationships with family and friends outside of the course, and the shared experience of the challenge of training appeared important in fuelling this. A perception that course requirements were fundamentally unrealistic, unsustainable, or detached from the realities of 'real-world' practice provided an important context from within which these relationships developed and were experienced. Participant 5 for example described the training year as 'unsustainable', and manageable only for the reason that 'it is just for a year'. In much of what was said, a feeling of *surviving* and *getting through* the training together with peers appeared to provide the context from which such significant relationships could blossom in often short periods of time; something that mirrors findings from social psychology that sharing what are perceived to be extraordinary experiences facilitates the forging of close relationships (Min et al., 2018). Describing how peers on the course had an understanding that could never be reached by their wider social circle for example, Participant 9 reflected:

> 'I feel like people beyond the course, they want to hear how you're doing… But I think, you know, people can ask how you're doing, but you can't constantly say how challenging it is sometimes. But people in the course, you don't have to explain… They get it. They know you're exhausted, they don't mind if you don't

> message back at different times, they don't mind because they know everyone's in kind of isolation…' (Participant 9, 209-217).

Similarly, Participant 3 described the occasional frustration that could be felt when well-meaning family members enquired about the course or offered advice to issues faced there: 'that can sometimes feel a bit like 'I know you're trying to help me, but it doesn't feel very helpful at the same time'' (Participant 3, 220-223). In these extracts, there is an implication that the challenges and stresses of the course are such that they could not be meaningfully understood by someone outside of the experience; a feeling which appeared to result from a perception that the course stresses and requirements extended beyond what could reasonably be anticipated from such training. This feeling appeared to generate a sense of togetherness amongst trainees, perhaps related to a perception that the odds were stacked against them. Trainees spoke about supporting each other through the training in a way that suggested a shared goal, and a conviction that the roles they played for each other in this regard were significant.

Whilst clinical supervisors and academic course staff were spoken of positively as individuals, a sense that they were frequently detached from the reality of being a trainee appeared to further foster this sense of connection between trainees. Participant 10 for example explained that 'some of them [lecturers] are very rigid'. They subsequently went on to describe the challenges trainees faced due to the fact that rating scales commonly used to assess CBT competence during training 'are not reality, not how the NHS works... [and] not how the patients present'. In a similar vein, Participant 13 described believing that some course staff were so committed to an inflexible, ideal standard of what was required by 'the protocol' that they had lost touch with what was realistic to achieve. Cohort peers were described as critical to countering the challenge this posed. Participant 14 described how they 'definitely wouldn't be coping as well as I am if I didn't have them [course peers]' and Participant 3 spoke of how it was 'reassuring' to hear from colleagues who experience the same

challenges as them. In a similar vein, Participant 8 commented how relating to memes shared in a trainee WhatsApp group:

> ‘makes you feel kind of validated in how you're feeling and actually [that] you're not alone. You know, whether you're reaching the level that you know, the course leaders expected you, you're at the level that everyone else is, so that's OK’ (Participant 8, 676-680).

In these extracts, peers are portrayed as a necessary and supportive counterbalance to the unattainable standards of course staff. The expectations of course leaders are framed as occasionally detached from reality, and sometimes detrimental to wellbeing through setting unrealistic aspirations. The meaningful relationships therefore that developed in this context – with likeminded others, who ‘get it’ – were central to the experience of wellbeing in the role, and an important buffer to the stresses and challenges of the role.

Theme 4: *‘There’s more to life than training…’*: a well-lived life is a full one

Despite the significant position that the training held in the lives of trainees, a sense that a full and well-lived life was one not wholly or uniquely dedicated to psychology and to training was evident in much of what was reported. Trainees described the importance of ‘having a sense of balance across things’ (Participant 14) and making sure that work and family life could ‘fit together’ (Participant 15). Similarly, trainees commented that ‘not making the course your life is really important’ (Participant 7) and reflected on the ‘central’ place that hobbies continued to have in their experience of wellbeing (Participant 2). ‘I think for me it’s about keeping that identity which feeds into both your professional side of things and your personal side of things’ Participant 6 explained. ‘There is life outside of the course’ they went on to say, ‘so if you lose who you are you’re probably going to lose people or your relationships are going to change with other people, and that’s pretty sad’. Trainees often described having made significant sacrifices to get to a position of being on the training.

Several had gone back into education later in life to re-train, or persisted through years of failed applications to secure the post they were currently on, and this had often required a period of intense commitment to psychology and study. Now into their roles, there was a sense in some of what was described that stepping back a little and allowing other important and valued life areas to return closer to the foreground of their lives was important. Participant 7 reflected how 'putting all of your effort into a course is just exhausting', and Participant 6 described how now on the course, she was 'trying to see it more as 'this is a job', and 'this is a training course', and focusing a bit more on other stuff as well is important' (Participant 6).

A sense that getting through the course required active self-care underpinned much of what trainees described, and a recognition of how easily this work could engulf the whole of a life appeared apparent to many. Participant 9 for example described not letting the training 'take up all your life' as 'a hard balance to strike', and Participant 7 explained how they had come to learn the importance of having periods of giving less to the training, in order to 'recharge your batteries a little bit'. Trainees' position specifically as psychological practitioners and trainees appeared important for framing the way that they made sense of this aspect of their experience. As trainees in the field of mental health and psychological therapy, notions of mental health and wellbeing were central to much of their training. Whilst several trainees spoke of the importance of systemic or societal issues to wellbeing, many also spoke in terms which assumed a significant degree of personal influence or control over their own wellbeing. Participant 15 for example described thinking 'the onus would be on myself to take care of my own wellbeing'. The context of participants training to work primarily from a CBT-informed perspective (a therapeutic model which assumes a high level of individual control and responsibility for managing personal wellbeing) perhaps provides an important context for this conviction, reinforcing a notion that they could and should take proactive steps at an individual level to maintain their own wellbeing.

When reflecting on the importance of work-life boundaries, Participant 1 commented:

> ‘It's something that I've always felt was important to strive for in certain jobs, [to] have those boundaries, and have enjoyment to do things that are important to me. I suppose like it's important in general, in life… to be able to *live* it’ (Participant 1, 1353-1356).

Along similar lines, when asked what advice they might give to a new trainee in order to help them most fully enjoy the training, Participant 9 spoke of the importance of ‘trying to live a life as well’.

In these extracts, a notion that ‘real’ living takes place outside of the training is implied. From such a perspective, despite the significant place that the role was often described as having for trainees, the true task of living is framed as sitting outside of this sphere. This idea creates an interesting tension with some of the other perspectives discussed in the interviews, and the themes presented here. Training and work in this field was frequently described as a fundamentally meaningful endeavour, and something that filled a life with purpose and provided a source of joy and pride. Helping others was described by participants ‘a main motivation’ in life (Participant 1) and something which was ‘part of who I am’ (Participant 15). A sense nonetheless ran throughout interviews that wellbeing could never be founded *solely* on this; a sentiment encapsulated by Participant 6 warning against the risks of becoming so absorbed in the training that upon qualification you have lost other important aspects of your identity and find that you are now ‘just’ a psychologist.

There was then an important sense amongst trainees that despite the significant place the training held in their lives, completing it in a way that also enabled and supported continued engagement with other valued life activities was critical to wellbeing in the role.

Discussion

The wellbeing of psychological therapy trainees and practitioners has become an increasing area of concern in recent years (Pakenham & Stafford-Brown, 2012; Simionato & Simpson, 2018). However, low levels of conceptual clarity exist regarding the precise nature of the problem, or the outcome at

which to aim when seeking to remedy it. In this light, the findings of this research offer an important and potentially significant contribution to the literature, highlighting important facets of wellbeing not well reflected in much of the existing literature on the topic. Prior research in the field has rarely engaged with questions regarding how trainee wellbeing is conceptualised or experienced by trainees themselves. Instead, wellbeing is frequently conceptualised implicitly as an absence of negative correlates of wellbeing such as stress, burnout, anxiety or psychological distress (Abel et al., 2012; Bohecker & Doughty Horn, 2016; Chan et al., 2021; Gutierrez et al., 2016; Hopkins & Proeve, 2013). Whilst on one hand, the well documented challenges and increased vulnerabilities associated with work in this field (Maslach & Leiter, 2016) may appear to lead intuitively towards prioritising efforts to minimise negative components of wellbeing, this risks neglecting important aspects of psychological functioning and overlooking the increasingly well-developed body of research indicating that a simple absence of stress, burnout or mental illness does not equate to wellbeing (Compton & Hoffman, 2020). In this context, the findings of this in-depth qualitative exploration of how PTTs experience wellbeing in the role makes an important contribution to the literature, by exploring how a group of trainees experienced and made sense of their own wellbeing in context. Trainers, trainees and others involved in psychological therapy training may consequently draw on these findings to help facilitate and conceptualise wellbeing in ways that look beyond simply seeking to reduce stress, and towards embracing positive components of wellbeing, such as described here.

As well as strengthening understanding regarding the literature on trainee wellbeing in particular, this research also makes an important contribution to the literature on wellbeing more broadly, by responding to the call made recently for wellbeing researchers to begin utilising qualitative and mixed-method approaches to enhance understanding regarding the nuances of wellbeing in context (Hamling et al., 2020).

The description given to the experience of wellbeing in the role by this group of PTTs was one which centred around the notion of embodying and connecting with personal values. Values can be

considered as central features of who we are; aspects of our identity that can both shape our behaviour, influence our interpersonal relationships, and inform our perceptions of how we should or should not live our lives (Boer & Boehnke, 2015). The emphasis placed here on values, and the significance it appeared to have in participants' experience of wellbeing in the role echoes similar findings from the literature in which acting in accordance with values has been associated with hedonic and eudaimonic wellbeing (Bojanowska et al., 2022) and improved workplace wellbeing and resilience (Pavlova et al., 2023; Vivolo et al., 2022). The central place that connecting with values held in the experience of wellbeing for these PTTs however is important, indicating the potentially vital role that connecting trainees with their values may have in the design of any attempt to support trainee wellbeing; something which many such interventions do not routinely do at present. Importantly, it may also indicate that expectation management early in training may be important. Trainees in this study reported entering the workforce with strong values associated with helping others, values which were occasionally challenged by the realities of clinical work in real-world services. Efforts therefore to manage expectations regarding the extent to which trainees will be able to consistently fulfil aspirations to help others in the role, may be important.

Trainees also spoke in depth about the importance of meaning and purpose for their sense of wellbeing, and the central role that their work and training held in providing that purpose. A sense of meaning and purpose are central components of well-established models of wellbeing (Ryff, 1989; Seligman, 2011), and the quest for meaning in life has been described as a fundamental human endeavour (Frankl, 1946). For the trainees in this study, the connection between meaning, purpose, and their roles as trainees appeared particularly important. For these PTTs, meaning and purpose were not given to life innately. Instead, they were forged through action, and their work as psychological practitioners appeared central to this task, a finding that resonates with related research in which therapists have described their work as significant for the role it plays in providing life with meaning (Russo-Netzer et al., 2020). Interestingly, despite describing their training as

psychological professionals as central to their sense of self and the perceived meaningfulness of their lives, many participants in this study nonetheless also maintained that their work did not (and should not) wholly define them, a finding that echoes those reported in a qualitative study of newly qualified GPs describing a new form of practice in which an all-consuming commitment to one's work was seen as unhealthy both for practitioners and their clients (Jones & Green, 2006). Whilst perceiving your work as a calling has been associated with increased job satisfaction and wellbeing (Duffy & Dik, 2013), recent qualitative research also highlights how it can lead to negative outcomes such as a tendency to neglect other important life areas like family and friends (Duffy et al., 2012). Perhaps implicitly acknowledging this, PTTs in the current study described how thriving in the role was as much about what one did outside of work as what one did within it. Trainees maintained a conviction that the experience of wellbeing in their roles was one shaped by and comprised of a nuanced relationship with their positions; one in which their roles were both central to their lives, and yet nonetheless contained. Training was projected at times as something that took place outside of the 'real' business of living, and there was an implicit acknowledgement throughout of the importance of work-life balance for wellbeing (Lunau et al., 2014). In order to support trainee wellbeing therefore, it appears important for those involved in training to develop environments and working cultures which enable practitioners to invest themselves with commitment into their work, but also support the maintenance of other life interests and values.

Trainees also spoke in detail about the importance of developing and growing through their roles, and of the unique relations they forged with peers on the course. Again, notions of competence, environmental mastery, and positive relations with others all feature heavily in well-established models of wellbeing (Deci & Ryan, 2016; Ryff, 1989; Seligman, 2011), and the accounts of trainees can be helpfully understood in this context. The qualitative methodology utilised in this study however promotes further sense-making of these results, helping to unpick the nuance of the findings in the specific context in which trainees' function. Psychological therapy training

programmes are known to be challenging and stretching, and to attract applicants motivated to excel (Jones & Thompson, 2017). For trainees in this study, the feelings of meeting the challenge of being stretched, and seeing oneself to be developing were central to the experience of wellbeing in the role. The tension outlined above however regarding a desire to develop and feel competent on the one hand, and the perception that failing assignments or working outside of one's perceived zone of competence posed serious threats to one's self-image on the other, draws attention both to the pivotal nature that feelings of competence have in their experience of wellbeing in the role, and the potentially vulnerable position in which trainees find themselves during training. Such findings indicate that giving space to the discussion of this tension during training may be helpful, by acknowledging the central and multi-faceted place that feelings of competence may have in the experience of wellbeing in the role.

This sense of feeling somewhat exposed and vulnerable through a training that was often perceived as unrealistically challenging appeared closely connected to the central role that connections with peers had to trainees' experience of wellbeing in the role. The notion that trainees were 'in it together' and sharing in an experience which was not meaningfully comprehensible for those outside of it, appeared to infuse these relationships with an intensity that rendered them different from other social connections. The felt experience of these connections, and the feeling that others were there for them and sharing in their experience, were portrayed as a central and critical aspect of how trainees experienced and made sense of wellbeing in the role. These findings suggest that those involved in training should actively seek to maximise opportunities for trainees to develop and maintain a sense of cohort-bond during training.

When considering the current findings in the context of the broader literature on wellbeing, it is notable that the results generated here sit within the 'eudaimonic' tradition (Ryan & Deci, 2001; Waterman, 1993). Whilst some researchers have questioned the scientific utility of the hedonic-eudaimonic division in the psychological study of happiness (Disabato et al., 2016; Kashdan et al.,

2008), it is notable that concepts typically aligned with eudaimonic wellbeing (such as self-actualisation, growth, and acting in accordance with values) were at the forefront of the accounts provided by trainees. Importantly, and in keeping with contemporary psychological theories of eudaimonia (Waterman, 2008), hedonic pleasure was also central to the experience of wellbeing described by trainees. When feeling connected to peers, when perceiving themselves to be developing within their scope of competence, when believing themselves to be contributing to some greater social good, or when maintaining other valued life areas, trainees described feelings of joy, pleasure, contentment and excitement. As has been maintained elsewhere, it *feels good* to achieve, to develop, or to act in accordance with what is best in you, meaning hedonic pleasure will naturally accompany eudaimonia (Waterman, 2008). Importantly however, wellbeing in the role was described such that pleasure and enjoyment were not presented as the primary focus, or central component of the experience of wellbeing. In this way, the qualitative, phenomenological method utilised here has played an important role in making sense of the phenomenology of wellbeing for these trainees; providing important and novel evidence for the meaningful, qualitative differences in type of wellbeing (eudaimonic as opposed to hedonic) that some researchers have previously claimed to be absent (Kashdan et al., 2008).

The findings presented here therefore contribute to the developing literature regarding the study of wellbeing, both in general, and for PTTs in particular. By providing an in-depth, qualitative exploration of the experience of wellbeing in the role for PTTs, they help deepen understanding regarding how wellbeing is experienced by individuals in particular contexts. In keeping with the phenomenological method utilised here, the knowledge generated through this research does not pertain to an imagined abstract or pure conception of wellbeing that sits outside of human experience or context (Larkin et al., 2006), nor does it aspire towards producing the statistical-probabilistic generalisability aimed at in quantitative research (Levitt, 2021; Smith, 2018). Instead, the knowledge generated builds up from an exploration of how wellbeing was experienced by this group of trainees, in this

context, and it represents the combined meaning-making processes of both the participants and the researchers (Willig, 2013). As well as offering this rich and detailed interpretation of wellbeing in the role for this group of trainees however, the results may also hold some *naturalistic generalisability* or *transferability* (Lincoln & Guba, 1985; Smith, 2018) and it is hoped that readers who are themselves PTTs, or who are involved in training, supervising or employing PTTs, will consider in what ways the findings presented here capture something that resonates with their own experiences, or the settings in which they work or train. The ways in which the results presented align with relevant previous research, and the fact that participant trainees employed across multiple different services, working in a range of different clinical contexts, and working towards several different professional qualifications described similar experiences of wellbeing in the role indicates to us that this may be possible (Braun & Clarke, 2013; Lincoln & Guba, 1985), though ultimately, the transferability of these findings will be determined by readers and those involved in psychological therapy training.

Strengths and limitations

As described above, steps were taken to ensure the researchers and participants had no direct working relationship. However, it is possible that the fact that this research was being led by academics based in the department in which trainees were studying could potentially have impacted both who came forward to take part, and what was said by those who did. Further, despite variation in course requirements, teaching ethos, placement locations, and work settings, the fact that all trainees in this study were drawn from one university is a potentially important limitation, and the extent to which findings would resonate with trainees across a wider geographical region or studying in different institutions remains unclear. It is possible that including trainees from different institutions would have led to the generation of meaningfully different data both in regards to the way the institutional setting may influence trainees' experience, and the way that speaking with researchers completely detached from your place of training may have influenced what trainees felt

able to say. These are potentially important contextual factors and limitations that should inform the way results are interpreted. Notably, all the trainees who took part in this research described themselves as White-British or White-European. Evidence indicates that wellbeing and mental health have complex and often pronounced relationships with ethnicity (Williams, 2018), including in educational settings (Tausen et al., 2024). As such, the findings of this research, drawn as they are from the experiences of White-European and White-British participants, have important limitations that place constraints on the transferability of the findings presented here. It is possible for example that the experience of trainees from ethnic minority backgrounds may have differed significantly from that of White British and White-European trainees, meaning their accounts of the challenges and highlights of training in the psychological professions may have led to the generation of data and themes unlike that included and generated here. It is possible that challenges, obstacles, or experiences that are unique to trainees from ethnic minority backgrounds may have been raised and that as such, the themes generated regarding the experience of wellbeing in the role may have differed meaningfully from those developed on the basis of the perspectives of only White British and White European trainees. These limitations should be held in mind by readers when assessing the relevance of these findings for other contexts and settings. Finally, our sample included trainees from five separate psychological professions, meaning that their experiences varied in several regards (e.g. whether trainees were employed in one service throughout training, or moved between multiple 'placements'). Whilst on one hand, this may be seen to increase *transferability* to other similar contexts as suggested above, it is true that relatively little attention has been paid here to exploring the potential differences between professions and training pathways. Importantly, this followed from an impression encountered throughout the research that what was shared in these PTTs experiences frequently outweighed what set them apart, and the experience described often appeared to transcend the details of their specific training programme per-se.

Conclusion

This qualitative, phenomenological study sought to explore how psychological therapy trainees experience wellbeing in their roles. The centrality of connecting with and embodying personal values ran throughout the accounts offered by trainees. The results generated have further suggested that trainees experience wellbeing in terms of feeling purposeful and as though they are contributing to some greater social good, feeling connected to like-minded peers, feeling competent, and feeling connected to and invested in other important life areas. The findings emphasise the important role that qualitative approaches can have for exploring the psychology of wellbeing. Findings further indicate that training programmes and services employing PTTs may benefit from conceptualising trainee wellbeing broadly, not simply as an absence of stress or burnout, but also as comprised of feelings of competence, purposefulness, connection, and alignment with personal values.

Chapter 4 Supplementary Material

Supplementary Material 1 – Topic Guide

The experience of wellbeing in the Psychological Therapy Trainee (PTT) role

Aims and purpose: To provide a detailed account of the experience of wellbeing in the PTT role, as described by PTTs.

Research Question: How do psychological therapy trainees experience wellbeing in their role?

Format: Individual, semi-structured interviews.

Before beginning:

- Thank them for their time and for taking part.
- Reiterate the expected timeframe/check their availability.
- Thank them for signing the consent form and check they are still happy to progress.
- Reiterate that answers can be anonymised but that we can't absolutely guarantee anonymity due to nature of this kind of work.
- Reiterate that the information will be used only for the purpose of the study unless in rare circumstances something came up which meant thee were serious FTP/safeguarding/risk concerns – in which this info would need to be shared.
- Explain that the purpose is about understanding their personal experience, reiterate there is no right or wrong answer with any of this, and I'm interested in hearing about their individual and personal experience.

Opening descriptive question

1. **Can you explain why you chose to train as a psychological professional?**

   Prompt/follow-up:
   Can you tell me a bit more about that?
   Why did X feel important to you?
   Was there a particular moment or event that led you to choose this path? Can you describe it to me?
   How has the role so far compared with your expectations?
   How do you feel about that? What are your thoughts about that?

Topic: Experience of wellbeing

Questions:

1. **Thinking about your own life and experience in general, what's most important for you to feel happy, or to be pleased with your life?**

   Prompt/follow-up:
   What is it about that that is important for you?
   Can you give me any examples of that?
   How do you feel when things are going like that/when you're experiencing that?
   What features of that were most important or salient?

2. **What do you think contributes most to your wellbeing?**

   Prompt/follow-up:
   What is it about that that is important for your wellbeing?
   Can you describe what it's like when you're doing that/when that is present?
   What effect would it/does it have on you if that is absent?

<u>Topic: Experience of wellbeing in the PTT role</u>

Questions:

1. **Can you describe the nature of your role as a PTT?**

   Prompt/follow-up:
   What would you say are the defining features of being a trainee X?
   How do you feel about that/those aspect(s) of the role?
   Why do you think those features of the role are most important?
   How important is your role to you in terms of the way you see yourself? Can you explain why that is?

2. **Are there any particular parts of the role that you enjoy most?**

   Prompt/follow-up:
   What is it about those aspects that you enjoy?
   Can you take me back to a moment that illustrates this?
   Can you describe how you felt at that time?
   What would you say have been the highlights of your time in the role so far?
   Can you explain why these examples stand out for you as highlights?
   Can you describe how that made/makes you feel?
   How does that make you feel now, describing this experience? Why do you think it made you feel that way?

3. **Are there any particular parts of the role that you find challenging?**

   Prompt/follow-up:

What is it about those features that you find difficult?
Can you tell me more about this?
Can you describe an example of this? What did that feel like?
What do you think are the consequences of this?
How do you feel about that?

4. **Are there any ideas you'd share with someone about to start the role, that you think would help them enjoy it most fully?**

   Prompt/follow-up:
   Why do you think that is important?
   Can you describe an example of how this has worked for you?
   Why do you think this worked in that way for you?
   What would the role be like for you, without doing this?

5. **In what ways does your role as a trainee influence or contribute to your wellbeing?**

   Prompt/follow-up:
   Can you say more about this?
   How do you feel about describing this relationship? If there is anything difficult in thinking about how your trainee role influences your wellbeing, why do you think this is?
   Can you describe an example of a time/way that your role has contributed positively towards your wellbeing?
   Can you describe an example of a time/way that your role has contributed negatively towards your wellbeing?
   How do you feel about describing this relationship?

<u>Topic: Understanding of wellbeing</u>

Questions:

1. **How would you describe wellbeing?**

   Prompt/follow-up:
   Can you tell me more about that?
   Could you give me an example of that?
   There are lots of different ideas about what wellbeing is. Some people for example think about it in terms of pleasure or positive emotion, others think of it as having to do with living a 'good', full or flourishing life. How important are those ideas to the way you think about wellbeing yourself?

2. **In what ways have your thoughts about wellbeing shifted over time?**

   Prompt/follow-up: Why do you think your thoughts about it have changed in this way?

3. **In what ways has your professional training shaped the way you think about what wellbeing is or what it means?**

4. **To what extent do you consider yourself to be able to control or influence your own wellbeing?**

   Prompt/follow-up: How do you feel about that? Can you explain why you think this?

To close: mention the debrief information.

Supplementary Material 2 – Extracts from an anonymised coded interview transcript

START OF DATA

0:0:52.130 --> 0:0:58.650
Joel Owen (MED - Staff)
But before I start asking you those questions, I wonder whether I could just begin by asking you a bit about what sort of led you here? So why you chose to train as a clinical psychologist in the first place?

0:1:4.50 --> 0:1:8.370
P7 (MED - Postgraduate Researcher)
OK. That's an interesting question and what I've been debating for a while.

0:1:9.850 --> 0:1:17.490
P7 (MED - Postgraduate Researcher)
So it's really, it's interesting actually. 'cause, I don't know. I've just kind of always grown up thinking that I was gonna do psychology.

REDACTED INFO ABOUT AN EARLY PERSONAL EXPERIENCE……, so that was obviously like my first kind of experience of people having difficulties, and that, I was fascinated by that. And then I stole a few of my mum's books and then I was like, 'oh, this psychology stuff sounds really good'.

……

0:15:46.840 --> 0:16:0.40
Joel Owen (MED - Staff)
Thinking more broadly, just about your own life, your own experience in general. What do you think is, what the things that are most important for you to feel happy or, you know, pleased with your life or however you might want to describe it?

0:16:4.670 --> 0:16:8.110
P7 (MED - Postgraduate Researcher)
Definitely something around like achievement in life, like I need to feel like I'm achieving something.

0:16:14.690 --> 0:16:19.50
P7 (MED - Postgraduate Researcher)
There's definitely something… and like my… have a purpose in life.

0:16:20.730 --> 0:16:50.690
P7 (MED - Postgraduate Researcher)

That's very broad and I guess, and the reason I'm saying that is because when I was an assistant psychologist for a number of years, it took me quite a long time to get onto the course, and I definitely felt quite stuck in that time. Like especially comparing - not comparing myself to other people - but you can't… naturally, you do like… when you go to uni and because I graduated years ago now and then people that I graduated with were like, well, like, well into their career and I was still on like a band 5 AP Post, so that was really hard… feeling like I didn't have a career. So yeah, direction in my life is definitely something that's really important to me.

0:17:4.30 --> 0:17:7.310
P7 (MED - Postgraduate Researcher)
Connections and relationships and family and friends are really important to me too and I definitely found that out during COVID when all that kind of slipped away and I was living on my own at the time.

0:17:17.190 --> 0:17:17.310
Joel Owen (MED - Staff)
Hmm.

0:17:17.960 --> 0:17:20.360
P7 (MED - Postgraduate Researcher)
So yeah, that's really important to me.

……..

0:28:40.560 --> 0:28:54.880
Joel Owen (MED - Staff)
OK, great. Thank you. So let's talk a bit more about the training then if if we can. You you've you've said already that you've actually enjoyed a lot of it which which is great. So what what bits of the role do you enjoy the most?

0:28:58.545 --> 0:29:26.385
P7 (MED - Postgraduate Researcher)
I think I probably enjoy well, I definitely enjoy the clinical aspects of it most, and my placements are where I've really enjoyed myself. But probably most importantly like the the relationships that I've had with supervisors and the kind of learning and that I've made with them and yeah. More around like supervisory relationships and learning from that side of things I think has been my biggest kind of highlight, I guess, rather than the academic side of stuff.

0:29:33.465 --> 0:29:46.25
Joel Owen (MED - Staff)

OK. So the clinical work and and the sort of supervision, learning relations. Kind of two things, the kind of where you've learned supervisory the relationships that you've developed through that, is that right?

0:29:44.635 --> 0:29:47.395
P7 (MED - Postgraduate Researcher)
Yeah. Yeah, that's right, yeah.

0:29:48.545 --> 0:29:52.265
Joel Owen (MED - Staff)
OK. And and what what is it then about those things that you that you enjoy?

0:29:59.765 --> 0:30:2.845
P7 (MED - Postgraduate Researcher)
I just think it's because I… like I've said, I prefer like the direct work with people and, I know the course is meant to be like 5050 research 5050 clinical, but I do like the research, but it's definitely… where I am now, it's not something I want my career to be focused on research. I definitely want to have a more clinical role. So yeah, I think it just fits probably more with my experience and where I feel more confident as well, I guess.

0:30:37.235 --> 0:31:3.595
Joel Owen (MED - Staff)
And I wonder if you could think of any examples of times, so as a trainee, like some clinical work that you've done, obviously without needing to give me details of the case as such, like whether you could describe what does it feel like for you when you're working with somebody in a way that feels positive? You're enjoying it, you're doing something that you really like. Can you describe what that's like, how you feel?

0:31:5.255 --> 0:31:7.415
P7 (MED - Postgraduate Researcher)
God I have trouble describing how I feel! Yeah, I'm… I'm just trying to think like about a specific CBT case that I did with somebody around, like social anxiety. I guess another important thing in terms of my career is I'm I really like neuro. So I like the individualised kind of working with people and adapting materials to support people's, like cognitive needs, or like whether they've got like autism or ADHD, you know so, being quite person centred. So yeah, I don't know. I just… When I think about my work, the times that I have the biggest moments of joy is like when I've done like a behavioural experiment with this person I'm thinking about, around panic… just going out and walking around and I don't know, it just felt good that my time had been of help to somebody. I can't really explain it. I don't know. Again, I don't know if it's like a feeling of like proud? or whether it's just I've got that sense of purpose. But it definitely is like a really positive thing that I feel. Like I can remember walking back to the car being like, ‘oh, I did a good job today’.

0:32:28.525 --> 0:32:32.45
Joel Owen (MED - Staff)
Great, great. And then and I recognise that it's not an easy thing to describe, is it? I mean,

you've actually done a very good job of doing that, but like it's not an easy thing to describe, is it how you know… you said it felt good, like in what way, what was telling you it was good? What about it was good? That's not an easy question to sort of answer actually, is it? But what you're saying is then it's a sort of purpose, pride, that feeling that the sort of sense of having achieved something was the kind of salient feature for you. Is that right?

0:33:6.185 --> 0:33:13.305
P7 (MED - Postgraduate Researcher)
Yeah, definitely. And just the sense that I'd help somebody with it, something that they really struggled with.

0:33:17.365 --> 0:33:17.845
Joel Owen (MED - Staff)
OK.

0:33:17.705 --> 0:33:21.425
P7 (MED - Postgraduate Researcher)
And I guess I was just gonna say, and I guess there's something about the kind of like… I don't know what the word is, how I would explain it, but empowering other people… like when people have been quite stuck or their mental health's really affected them to see like their confidence grow. It's just really… I don't know, can't really describe it. I don't know. It's just a really nice feeling to know that actually… I don't know. I always feel like when I do things, it feels like common sense. So it's like… I'll do some, like, common sense things or like something really basic, but that can have like a significant impact on somebody. I don't know. I'm not really making sense…

0:34:1.865 --> 0:34:11.465
Joel Owen (MED - Staff)
No, I think you are and and you're you're also you're trying to describe something that's not easy to describe. But I I think I think you are you are making sense. I'm I'm I'm following you.

0:34:13.575 --> 0:34:24.855
Joel Owen (MED - Staff)
And so yeah, that, that, that sort of… I wonder even maybe to take a step back and think like now just thinking about this now you know and describing, hearing yourself describe those moments and to describe them as positive. How do you sort of, how do you think about that now? Do you make sense of like, how do you make sense of other of why? Why those things were so important to you and why why they left you feeling that way when you sort of think about them now?

0:34:47.605 --> 0:34:49.765
P7 (MED - Postgraduate Researcher)
Do you know what's really interesting? I feel like… I don't really have these conversations where I focus on like the good side of things. Like if I'm taking things to supervision, it'll be like, 'Oh yeah, I did this piece of work that went well. OK, but let's spend the next hour thinking about something that's more challenging and how we're going to kind of navigate

this situation'. So yeah, it's interesting. I don't think thinking about it now… it feels like nice. And I do feel like the work that I've done has been helpful, but it's a rare thing to really think about that. Normally I'm thinking about, 'Oh, I said that word, and I wonder how that was interpreted. And oh, I could have done this better. Or I could have done this slightly different' so, yeah…I don't really think about the positives very much.

0:35:56.665 --> 0:35:56.785
P7 (MED - Postgraduate Researcher)
Hmm.

0:35:39.335 --> 0:35:57.975
Joel Owen (MED - Staff)
Yeah, yeah. Again, I guess that's probably again, it's something that lots of us in lots of different roles probably relate to. It's easier to sort of… natural in lots of ways, isn't it to think more about the things that we would like to have done differently or the challenges or the problem solving. But yeah, it is… I think also for lots of reasons, useful and important to think about why something is good and what about it is good. Because that is also a nice way of potentially using that to get more of that. I guess isn't it.

0:36:12.475 --> 0:36:21.515
P7 (MED - Postgraduate Researcher)
Yeah. Yeah. And I think there is also something about as a trainee, I do feel like we're constantly being assessed and we're having to kind of prove that we've got the skills and we've got the competencies… Um.. I had a point in my head then that's just gone… Oh, I don't know where I was going with that, sorry!

……

0:40:23.675 --> 0:40:34.75
Joel Owen (MED - Staff)
Have there been any parts of the role that have been kind of particularly challenging? That you've enjoyed much less?

0:40:50.565 --> 0:40:52.965
P7 (MED - Postgraduate Researcher)
Yeah, yeah, definitely.

0:40:56.885 --> 0:41:4.845
P7 (MED - Postgraduate Researcher)
I don't know if it's something that I've enjoyed less, but it's more of like a frustration with the course. If if that fits in with what you're asking?

0:41:4.855 --> 0:41:5.695
Joel Owen (MED - Staff)
Yeah, yeah, yeah.

0:41:6.575 --> 0:41:13.95
P7 (MED - Postgraduate Researcher)
So… and I guess this kind of relates well, it does relate to the well-being kind of side of things. But one of the things that I found quite difficult is that I feel like the course has this kind of… like saying about how we all need to take care of ourselves, and we need to look after our own well-being, but then it doesn't always necessarily show in aspects of the course. So like on a one to one situation like with my research supervisors and advisors, and when I've spoken to staff individually, I've always felt supported. I mean, I think there's more of a relationship in placements because obviously you spend a lot more time with clinical supervisors, you get to know them as people more than I would the academic staff. But there are certain things with like the course that I do struggle a bit with, in terms of like keeping a work life balance and the pressure. And although there's this kind of thing about, 'oh, you need to look after your self-care and well-being' in reality, I feel like you can't really do that to meet the expectations of the course.

0:42:25.665 --> 0:42:33.905
Joel Owen (MED - Staff)
Mm hmm, yeah, and that's the real challenge, isn't it? What? And so how, how do you, how do you kind of feel about that in the moment? Like, yeah, how does that make you feel?

0:42:37.45 --> 0:42:49.885
P7 (MED - Postgraduate Researcher)
I think just a bit frustrated, but then I've kind of got over it a little bit. I kind of just like I'm, I don't... So if I give you an example, and tell me if this is not helpful, this is not what you're looking for, but like we'll be doing an assignment and it'll… we'll get told, you know, 'Oh, don't push yourself… like you want a good piece of work, but… you're not striving for perfection - and to be honest, you can't really strive for perfection when you're doing placement and you've got 15 different assignments to go - but then you'll get the feedback from an assignment and it can be quite savage and quite cutting I think at times! So yeah, that's a little bit like, 'oh!' like, yeah… it just feels unnecessary. It can feel quite frustrating. And I think for somebody like me who can be quite self-critical, I can take those bits quite personally.

0:43:37.915 --> 0:43:46.75
Joel Owen (MED - Staff)
And I guess particularly if you feel if you feel like you've not necessarily been… I guess it's about expectation, isn't it? And you what you're saying you're sort of… if one message is sort of pointing you towards 'get it done, don't expect to be perfect' and then feedback says 'this isn't perfect'.

0:43:59.605 --> 0:44:0.45
P7 (MED - Postgraduate Researcher)
Yeah.

0:44:0.885 --> 0:44:5.405
Joel Owen (MED - Staff)
Yeah, and. And so you said that that that has felt kind of frustrating. Any other ways that you've experienced that? Like you said, that that that you take quite personally?

0:44:19.645 --> 0:44:20.245
P7 (MED - Postgraduate Researcher)
I think. And again, I don't know if this is on the right track, but I feel like maybe it's like a a course kind of like narrative in terms of like, we're meant to be adult learners… and but then we're not always treated that way. I found that quite difficult at times in terms of like… I can't really explain it. So we'll get emails sent to us about certain things and like, for example, they messed up our placement dates, so it finished like a week, a few a week earlier or later, or something... I can't remember. A week later, I think. And rather than kind of like, get an apology, it was like, 'oh, well, what a good, good use of time and you can take your annual leave then', but people have lives, they have children. They've booked in holidays and things like that. And there's things like it feels like when we kind of take things to the course, it's not always listened to. But if there's an error kind of on there side it's not always like… considered how I feel like we would be expected to deal with it if we made the mistake sort of thing.

0:45:31.735 --> 0:45:36.55
Joel Owen (MED - Staff)
Yeah. Yeah, OK, that, that, that is interesting and… yeah, perhaps not feeling like there's a sort of equal approach there. And then in terms of, you know, the expectations you want… not feeling like there's a sort of given give and take on the same same sort of level.

0:45:49.305 --> 0:45:49.945
P7 (MED - Postgraduate Researcher)
Yeah, mm hmm.

0:45:51.395 --> 0:45:58.275
Joel Owen (MED - Staff)
Yeah. OK. Yeah. So that, that that's I can. Yeah. Well understand why why that would feel feel challenging.

0:46:0.315 --> 0:46:2.395
Joel Owen (MED - Staff)
You also talked earlier about the fact that you, you know, you're just sort of being constant as a trainee, you are being constantly assessed. And has that, has that been difficult? So how have you experienced that sort of in general terms?

0:46:16.265 --> 0:46:34.945
P7 (MED - Postgraduate Researcher)

Yeah. I think as the courses progressed, I've kind of chilled out a bit more in terms of that. I think when I first started, I was like… I don't know, I got like my first assignment that I got back that I got really savage feedback and I got just like 58% or something. It wasn't the best. And I I think I was like *gutted* at that because I, I felt like I'd spent so much time and so much effort on that assignment and I didn't have a good grade. And yeah, I was absolutely gutted, especially with the savage feedback 'cause... it was like, 'why did you choose this case? This was a really hard one to do' and I was like… But I think as time's gone on, that's got easier because I feel like… I mean, I don't know if it's helpful for me, but I've got less time to do a lot of things, so I can't physically make everything perfect anyway. And interestingly, my grades have got better… so maybe that's that's the thing. Maybe if you don't focus on it too much, it's better.
But I also feel a bit more relaxed about it, like I do feel now if I got like 58, I'd probably be like, 'oh, well, that's good because I've passed'. So I don't know. I feel like I've kind of lowered my own expectations in terms of assessments. And just kind of like, talking to people like… I had an OSCE - do you know the OSCEs that we have? - Yeah. So I had one of those and some of the feedback I got was like, I didn't mention that I would write the report and send it to my supervisor to get feedback before sharing it with the client. So, obviously I got marked down for that. But I would always share my report with my supervisor first because obviously we have to do that. So again, I think it's just been about like applying my own common sense a little bit like… In the clinical world where you want to work, how much of an impact has this one assessment going to have like? Yeah. So maybe just thinking about how I kind of interpret things, and the value I put on things in the long term has been helpful in terms of like all these assessments and things.

0:48:34.55 --> 0:48:51.455
Joel Owen (MED - Staff)
Interesting, I see. There's like, there's a shift in your thinking about things to some extent. Perhaps to some extent as you've said, almost sort of kind of through necessity. You've kind of, you're now so busy, you've got… you that you've said you can't, you can't kind of invest hopefully in that and that that's actually been helpful for your experience overall, by the sound of things.

0:48:58.295 --> 0:48:59.55
P7 (MED - Postgraduate Researcher)
Yeah, definitely.

……

END OF DATA.

Supplementary Material 3 – Extracts of reflective journal for developing early ideas for analysis

Reflective journal on noticing ideas early for analysis

- Lots of people so far talk about the importance of purpose and meaning in their work. Clear that for most trainees so far, they value helping others, and see is relatively central to themselves, their role etc. Doing this job then supports their wellbeing by connecting them with this
- Most people so far have described the predominant features of wellbeing in eudaimonistic rather than hedonic terms (i.e. people talking about feeling pride, achievement, purpose and connection – with discussions of positive emotions by no means absent, but seemingly less central)
- Clear that overall so far being a trainee impacts people's wellbeing in mixed ways – some positive and negative
- The connection with others has appeared very important for some. A felt sense of connection, support and validation from others has been central to the experience of wellbeing in the role for some
- I think a few things coming up so far suggest that the experience of wellbeing is one of feeling competent and productive. When trainees feel safe, competent and confident. So maybe one finding will be that a big role to be played for services and environments to ensure that clinicains are supported to feel competent (e.g. given appropriate cases)
- Several trainees are clearly describing the work of helping others and working in psychology as important, meaningful, significant work. It feels important that their descriptions of the role have it as something valuable – a good use of time, something worth doing. The notion of pride also comes up quite a bit. Positive moments and experience being defined by pride
- Lots of them seem to describe wellbeing in terms akin to resilience (being able to manage and keep going despite what is thrown at you) – this actually links very closely to what I've called eudaimonistic resilience
- In the one I've just read, it's not just social support and connection that was important, but specifically this in relation with other CAPs or people in the field. She said about that being different to the support and connections you have with others outside of work
- SDT has just come to mind whilst reading an interview. Competence, autonomy and reletadness all seem central to the experience of wellbeing for trainees. They seem to be describing wellbeing as feeling competent (though stretched and developing), related (especially to others in the same situation). Autonomy perhaps to a lesser extent, but is there some link here to the idea I keep coming across of helping others beig central to who they are.? And this notion of self-actualisation? Doing something through this role that is central to who they are and how they see themselves?
- The notion of purpose seems important. Gives life a purpose to be doing this sort of work

- I think quite a lot of people are describing the clinical work as bits they enjoy the most. (P7 for e.g. explicitly says it's this, not the academic bits). Is there something important in this then about the role that employing services have in supporting wellbeing. It's mainly these bits that are central to their enjoyment (and mainly those bits that are most challenging really too) so the work environment seems to be central to experience of wellbeing
- At least 2 trainees (PX and PX) have alluded to the fact that although the see themselves as helpers and feel this important for their wellbeing and sense of purpose in life, that role does come with a cost that they recognise (it can leave them overwhelmed or stressed out themselves). This is maybe interesting, is there something in here about the fact that these kind of roles are important for people's wellbeing, but also bring inherent difficulties (but that on balance they see it as worthwhile?)
- Almost all trainees so far have described that they always wanted to do something caring or helping. So I think the work speaks to something central in who they are. Fulfilling something about the kind of person you are will obviously have a big impact on your wellbeing. Enable action in accordance with values and that will be good for wellbeing, but do something against it and that will be bad (e.g. so if the work doesn't let them feel like they're actually helping because they are just on a conveyer belt, they won't feel good wellbeing)
- There is lots that indicates throughout that feeling competence is part of the experience of wellbeing as a trainee, and I think there is also stuff in there about confidence (which is obviously connected in some ways). But I think there is also stuff that relates to a wider confidence (anonymised and – I think anonymised?) have spoken about confidence in terms of moving out or into different areas and getting on on their own. And there's a sense that wellbeing for them in some ways is also about feeling confident (e.g. to engage broadly with things) – this is perhaps a broader point about training as a time of personal as well as professional development/growth
- Lots of the participants have used the word 'overwhelming'
- Overall, I think I've been struck more by the similarities across training programmes than the differences. This is interesting given how different the training programmes actually are (but they all talk about so many of the same things – importance of peer connection, challenge of the volume of work, coming into the role because it strikes with core values etc.)
- In some respects what I'm finding might be suggesting that a better way of understanding wellbeing for trainees would be to understand things like the extent to which they feel connected to others, extent to which they feel competent and purposeful etc., rather than just measuring whether stress goes down
- As well as the importance of competence and confidence for wellbeing, I'm also getting some stuff where the opposite of that (e.g. self-doubt or imposter syndrome) is key to the experience of poor wellbeing. So this notion of felt competence/confidence in the role (or the absence/lack of that) does seem important)
- In P1, the two primary topics that come up are around social connection, and certainty/direction. Good wellbeing about being connected with others, and bad wellbeing it's opposite. Certainty/stability and direction in the role as good wellbeing, and it's opposite, the opposite
- P11 has just said about how she doesn't like the trust she works in and so doesn't feel loyal to it. i.e. enjoyment of the role influences whether you want to stay in it. And this reminds me of the same idea (but from the other side) in one of the EMHP interviews, where they were basically saying that although based a long way from home, they liked their service so much they wanted to stay there

- Strong sense in P11 that training is valuable for your wider personal growth and wellbeing – not just learning work skills. Interesting thoughts in there too about the fact that it can help you address some of your own issues
- Sense of competence comes through as important for many participants. Notion that wellbeing is closely linked to feeling competent. That when you don't feel competent that can be challenging and unsettling (and I also thought interesting that P11 spoke abut the fact that this experience is unavoidably to some extent in training, as you're learning new skills there!)
- Interesting that P11 mentioned (and I'm certain others have said the same) that having the space to reflect on positive sides of the role, and think about what they do/don't like about it etc was itself beneficial
- The notion of competence and confidence continues to be important. Sometimes it's shown as positive wellbeing is experienced as feeling competent/confident. But others (e.g. P10) it's absence dominates the negative experience of wellbeing in the role. Lots of talk about the fact that the worst and most upsetting/challenging bits of the role were to do with feeling 'broken' by the course and the feedback, and made to feel like you don't have competence (and this was particularly challenging I think in that interview, because they fundamentally disagreed with the markers of 'competence' as seen by the course too)
- Interesting that as with above, you often see both ends of lots of things. Wellbeing in the role experienced as feeling competent. Poor wellbeing marked by a sense of feeling incompetent, or out of your depth.
- Similarly (and again the negative side of this continuum comes up in P10) wellbeing often described in terms of felt connection with others on the course – a feeling that you're connected in a meaningful way and sharing some experience. Poor wellbeing is also described in terms of feeling isolated and cut off from others on the course
- Lots of people (e.g. P13 and others) talk about the fact that doing something valuable or meaningful speaks to some deeply held personal beliefs about life and values. Often the things that have driven people into this work relate to core aspects of who they are and what they value (believe it's important to help others, to keep developing, to contribute to some greater good etc.) and those beliefs are usually core and central to them. So work is likely to have a big influence on wellbeing – the extent to which they are or aren't really in touch with these
- Remember that I'm interested in the experience of wellbeing itself – not just what leads to it
- Key facet of P13's experience seems to be frustration. Frustration that the course is more stressful than it needs to be, and that wellbeing is spoken about but not supported
- P12 said that when he failed something 'feeling a bad therapist, feeling a bad person' – highlighting the close connection for him between his personal and professional life. Helping others and being a therapist, so central to who I am and how I see myself, that if I fail at uni, it is saying something deep about core aspects of not only my qualities as a therapist, but who I am as a person
- P6 talking about the best version of herself being one that supports other people. This feels like it chimes with what others have said about the purpose that helping work gives them – they're hear for a bigger reason and contributing to something more than them. Link to best version of self?
- I think at least a couple of people (p6 and somewhere else – was it p9?) have said about the role being less central to their sense of self now than it once was? This is interesting in the

sense that there's a shift, perhaps once you're on it, you don't have to strive for it in the same way. And you also realise the older you get, how much other things are also important

- Notion of competence coming up as important again. P6 talking about finding the research part the most challenging, because it's less naturally who she is and comes less easily to her – so again, this relates to feeling competent as important to wellbeing. She gets most enjoyment from the clinical work, partly because that links most directly to her values and who she is, but also partly because for this reason, she feels more competent and natural with it
- Lots of talk throughout lots of interviews of personal as well as professional growth,. The training as a period of this. And of course, growth is important part of some conceptions of wellbeing

Thoughts so far – 30/1/24

Key developing ideas so far seem to be about:

1. **Competence** – the experience of wellbeing in the role (or absence of it) seems to be experienced significantly as feeling competent (or not). When doing things you feel competent with, when getting feedback that suggests you are competent, when seeing the positive effects of your work, you feel competent, and this seems to be central to wellbeing in the role (just as feeling incompetent is central to its absence)
2. **Purpose (helping others and core life values)** – feeling like you're contributing to some greater good, having a sense that what you do matters and that it benefits others seems central to experience of wellbeing. Wellbeing and highlights in the role often described in terms of feeling useful, valuable and purposeful
3. **Connection (feeling supported and needed)** – the experience of wellbeing seems very closely tied to other people. When feeling useful to and supported by peers, it feels good. People talk about that felt sense of connection and shared experience, and that seems to be significant in terms of how you experience the role
4. **Achievement and growth** – a sense that the training provdes life direction, gives opportunity grow and develop (personally as well as professionally) and engenders feelings of achievement and **pride**, seems at the heart of the best moments of many trainees' experience
5. **Helping as central to self-concept and core to personality** – this idea keeps coming up and seems really important in the sense that it shows how and why the role can and does have such a big impact on wellbeing. Helping others often described as just something abut who they are (in personal and professional life) so it's to be expected that it effects how you get on (and also explains why getting a fail mark can be so deeply destabilising – as it's suggesting you're a bad version of yourself!)
6. **Feeling of overwhelm** – this has been an important pat f the challenge of the role

- P14 talking much more explicitly about control as being important for wellbeing than any others have. But it is now making me think about the fact that others have sort of implied it (i.e. it's stressful when the course changes things without telling you, or when there's too much going on around the time of some deadlines, or when you don't feel supported by your supervisor, or when you can't change the venue of your placement etc., all this because you don't have control!!) So maybe this is something
- It's interesting to reflect on what I'm maybe bringing to this. I'm trying to consciously not bring my own thoughts about what to find here – not forcing the idea that some stress is needed for example
- When I was a trainee, I know that I found it stressful at times, and I do sometimes feel less than positive about the NHS talking therapies services – but I'm trying to hold that feeling where I can see it
- The context of ideas is important isn't it. P14 saying that wellbeing is a sort of absence of chaos, things not falling apart, and just ticking along and feeling in control – making sense of that as someone working in an overstretched NHS service is like them saying – there's a low bar to aim for in terms of wellbeing; things can and do easily fall apart and the wheels come off, so if that isn't happening, then things are basically good
- I've been thinking more about the context of the person recently. P15 as a mother, training whilst supporting a family has come through a lot. Emphasis there about how the funded training place made this opportunity available (and a sense of gratitude that accompanies that)
- Interesting to reflect on this idea that it will all get easier post qualification – many saying just get head down, qualify, and then there's something better. My sense is that this seems unlikely – NHS context and increased responsibility in role post qualification is hard. So I shouldn't just take this idea as fact. But nonetheless, I should take it to reflect what they *think.* And I think that's interesting. They may be in for a real shock when it isn't the promise land. But at the same time, maybe at least they are only focussing on one thing (work) and not having the challenge of balancing multiple roles together
- Notion of authenticity important? Being authentically yourself when acting in this work, because it algins with your values

5/2/24

- I've just finished the first interview pulling all codes into broad topics. I've worked on PPT. There are loads (probably 20 or so) different topc groupings just from that first interview, so there will be so many when working through all of them. Will be important to then start to look at the connections and see how they pull together
- In this one I've just done (P1) his context felt really important. He's had some very serious health challenges during training, and so he was definitely speaking as someone who has been through some really challenging times, and this is colouring how he thinks of wellbeing in the role. For him, the negatives are outweighing, and colouring, the positives

- When I did the second interview today, I only added 5 more areas (from 29 to 34). This was a much shorter interview, but probably indicates that on average there shouldn't be too many new ones with each completed interview
- Todays (P14) felt very different to the first – focus was clearly someone earlier in their journey of MH working – filled with optimism and enthusiasm for how they can help change things for the better. They had a very pragmatic and realistic view of things
- I'm actively trying to take a slightly more interpretative stance in the second round of coding (I'm re-reading every coded interview, checking against the codes and adding a small number of new ones/tweaking a few existing ones – before I then go through and out the codes into groups)
- I'm trying to just push a little below the surface a bit this time. Most of my initial codes have been largely semantic, so I'm adding some latent codes in there where appropriate, pushing a little beneath surface, allowing some interpretation in and also trying to really keep the context in mind (e.g. in P2, she described happiness as safety, security and peace. This in the context of just having described how the role has been more challenging than anticipated, led to some strong negative emotional experiences that she can't make sense of etc. So it's like, the idea of happiness being the absence of threat has to be understood in the context of her feeling constantly under threat of some kind in the training)
- There's something important in the fact that some of the things I'm coming across seem to be describe what *leads to* wellbeing, and *what it is.* E.g. social connections with peers on the course, that leads to wellbeing, but at the same time, feeling that connection, feeling validated and supported *is also part of what the experience of wellbeing itself in the role actually is.*
- Interesting too that flow is also about competence being stretched but within limits. So to achieve flow, you should be stretched but not out of your overall competence level. So again, suggests that feeling competent in the work is important.
- In terms of starting to think about how some developing themes hold together: there's clearly something important about the connection people feel to course peers. Lots of people have said how important this is, and how it is different/more than other social connections. Does the way that all holds together look something like, a felt sense of shared experience, and a belief that the connection forged through training means you have a shared experience that would be difficult/impossible for others outside the course to understand/share in? So this part of wellbeing in the role is about a felt sense of comradery, shared experience and support (and the opposite includes isolation and poor wellbeing)
- There's also something important in the fact that working in accordance with values seems to be at the heart of good wellbeing in the role. And the experience of work going badly is meaning that some no longer find the value in this work that they once did. So in the values theme (whatever I end up making it as) there should reflect something about the negative side too (i.e. the inverse of wellbeing is working in a way that no longer feels fulfilling or in accordance with values)
- Also, always keep context in mind! They're talking a lot about values – they are in training, so typically early-ish in their careers, so you would expect the values to be significant because it's probably what brought them into this field (it's not for the money!) and so their context as trainees, and people working in a difficult NHS and political environment is probably very important – helpful personally perhaps to really align this with your values, see it as some greater good etc. as this makes it easier to carry on in the face of challenging work circumstances?

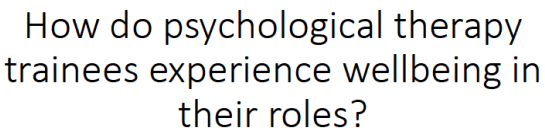
Notes from the final re-read of interviews

- A few interviews (P15/P4/P5 esp) have been talking about the importance of balance and time for life/family etc., as important for wellbeing in the role, but I don't think my currently proposed themes do capture that do they? Is this something that is important and needs to come back in? Participant 6 also frames wellbeing in general as being very closely connected to family and friends.
- I think the idea of uni staff being more detached from reality and service supervisors more open/authentic is important. It's clear in P7 and elsewhere
- The further I'm going with the analysis the more I'm feeling the need to be really aware of my own thoughts and beliefs. I'm at the stage here now where I'm really making active deciswions about the results, and what will be presented, and so I'm particularly aware of what I'm bringing to that. Lots of content about the uni course being somewhat detached and less well placed to support wellbeing or measure competence, is something to really think about
- As I'm working through creating up the final themes, I'm finding that I'm shifting them around a fair bit. I've been thinking a lot about the importance of making sure I'm capturing themes that really do answer the research question. There is quite a lot of data in there that feels important, and is definitely relevant (and maybe I can do something with it overall in the PhD) but that I have now come to think doesn't go in this specific analysis. Particularly the theme around frustration with the course not being well set up to support wellbeing. This seems perhaps more something about what causes good or bad wellbeing, but less about what it is/how it is experienced?
- Similarly, the one about perceived control over wellbeing doesn't seem to quite fit
- On going back through all the interviews though, I've found myself creating one new theme (there's more to life than training). I think this actually does capture something important about the experience of wellbeing in the role – that the course is a big part of life, but that wellbeing is experienced when it doesn't totally eclipse other important areas of life (this also links with the values overarching theme, because wellbeing in the role seems to be about having this important and valued training in life, but also not losing other valued life areas like friends and family)
- I'm also wondering about the emotions theme. Does this also somehow get absorbed into the overarching theme somehow? IN a way I want it to – because it also sits over and above all other themes (i.e. you feel pride, stress, joy, accomplishment etc. when working in the service of something greater, feeling competent or feeling connected etc.) but I worry that adding this in to the overarching theme makes that overarching theme too thick/multi-faceted
-

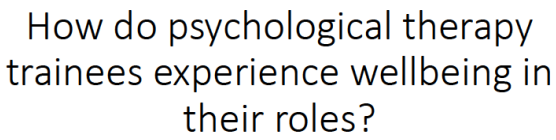
Supplementary Material 4.1 – 4.5*

*These are embedded pdfs. Double-click the image of a slide (each of which has the words 'How do psychological therapy trainees experience wellbeing in their roles?' written on it) to access the full pdf.

Supplementary Material 4.1 Supplementary Material 4.1 - Developing themes - snapshot of how it looked after first 3 interviews



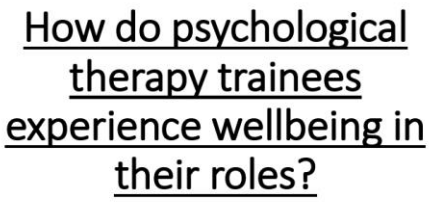
Supplementary Material 4.2 - Developing themes - snapshot of how it looked after first 7 interviews



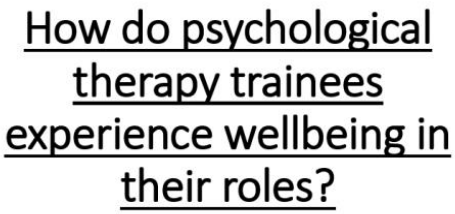
Supplementary Material 4.3 - Developing themes - snapshot of how it looked after first 11 interviews

How do psychological therapy trainees experience wellbeing in their roles?

Supplementary Material 4.4 - Developing themes – early attempt at grouping content



Supplementary Material 4.5 - Developing themes – more developed (but still unfinished) attempt at grouping related content



Supplementary Material 5 – Sketching ideas for the themes

Sketching ideas for the themes

1. **Experience of acting in accordance with values in the service of some greater good**

There is a sense that doing therapy work/helping others is significant, meaningful work. Participants voice the idea that this is really contributing to some bigger good, something that transcends them (people talk about this work providing meaning to an individual life, as being a societal good, as being a moral responsibility, and a social debt).

Several participants described helping others as a fundamental human task, and the reason we are on this planet. The idea that we have limited time on earth, and so should use it in ways that seeks to make the world a better place is also important.

There's also a sense that participants think not only that this is important work, but also that it is something central to who they are, and something that relates to authentic versions of themselves. Many participants described helping as central to how they see themselves personally and professionally. Helping others is explicitly stated as a value by several participants, and it's clear that most consider this as something important about how they live their lives (so it comes naturally to them/they were doing it even not as a trainee/they have often been like this since youth, various life experiences have shaped them towards this etc.)

Given all this, you would indeed expect it to be a central feature of wellbeing in the role: realising a core feature of who you are, by acting in accordance with deeply held values, to do important, life changing work (many speak about the life changing qualities – helping people do things they couldn't before/seeing MH as the foundation of everything else etc.).

Importantly, many participants also state explicitly that doing all this is good for their own wellbeing: i.e. I feel good when I help others, it's important for my wellbeing to know I'm doing something useful, and I get happiness from acting in accordance with my values etc. (Often the feeling of helping others is described in terms to do with feeling pride, having purpose, warmth, good about yourself, useful, authentically yourself, and good that you are working in a way that is true to who you are etc.) And the experience of doing so seems to be central to the experience of wellbeing in the role. Notably, when they don't feel useful, or when participants report working in a way that doesn't align so well with their values, it's often described as a source of stress or poor wellbeing).

Because this work is seen as central to who trainees are/how they see themselves, when it doesn't go well, it has a big negative impact on wellbeing. (So does the stuff about the connection between training and wider life wellbeing actually come in here??? i.e. because of the close connection between personal and professional lives (my job is my life, my is my job) how I'm doing on the course has a huge impact on overall wellbeing, and when I'm judged to have failed on the course, that really shatters my self image).

Notably, several participants talk about how clinical work helps them put up with the stresses of the rest of the role. i.e. because they feel useful, proud and as though they're doing something good in that aspect of the work, it makes the overall experience of the role (which often brings lots of other stresses) more manageable.

I think the notions of fulfilment and purpose are important to the experience of working in accordance with values and in the service of a greater good.

2. Personal and professional development/direction

Participants described a felt sense of progressing and working towards either a desired goal, or some form of improvement as an important part of wellbeing in the role. Many participants described the value they placed on the sense of career progression gained through the training (several spoke about how they'd worked in the field previously, but that this training was leading to a qualification which brought with it more direction, stability and progression). Is there a bit here about social expectations and not feeling stuck – i.e. being seen to self and others to be progressing in career?

Several people spoke about how in personal and professional lives, a lack of progression ('feeling stuck') was poor for wellbeing, with people describing feeling restless, stuck or unfulfilled if not busy and engaged. Some participants spoke about how being busy, productive, and developing were ideas instilled in them from a young age.

There seems to be something about the enjoyment of learning/development, and the sense of accomplishment and pride that comes with this that is important. Wellbeing in the role was often described as feeling like they had direction and were learning new things. The felt sense of achievement seems to me to be important.

It's interesting how many people spoke about personal (as well as professional) development. For many participants, training was experienced as a period of personal growth. The reflection required from a training like this leads to new insights about oneself, and the fact that you're so often pushed out of your comfort zone means that you also develop in a variety of ways. Several participants spoke of being better able to face their own personal challenges, feeling more empowered (e.g. by having moved to new area and lived alone) and tackled personal issues (such as speaking in public) that have long been challenging for them.

Many participants described a sense of pride as central to this experience of personal and professional growth. Often, the training experience was described as challenging but rewarding (i.e. people saying about how much they've learnt in service and at uni and how they've enjoyed learning in lectures etc.)

It's also stated explicitly by several participants that they put a lot in to the training (and so take a lot out too). It's described as a big personal investment (and so again, it makes sense that it would be a significant component of wellbeing, because the stakes are high/you're so invested in it). Several participants talk about the personal cost of this growth (i.e. you develop, but because you give so much to it/invest in such full reflection/fact that you're so often pushed out of comfort zone etc.)

There is a sense that people are taking pleasure, pride, sense of achievement and even excitement (I think it was P9 who discussed how exciting this was) in seeing themselves grow into more rounded people through the training. It's also stated that they want to be stretched – this is seen as positive (even when it's challenging) as it's essential to the notion of growth and development).

The notion of direction (knowing where you are going) and being purposeful, i.e. having a sense of how you are developing also seem important. (But does having 'a purpose' sit more naturally in the top theme?)

3. Competence

The self perception of competence in the role was described as important by many participants. This included being stretched and challenged, but always in a way that felt within reach, or that was contained/supported by supervisor. When participants felt competent and confident about what they were doing, they described this as leading to feelings of joy, excitement, pride and enjoyment. When they described feeling incompetent (or working outside the remit of their self-perceived competence in a way that extends beyond simply being stretched, then they described this as challenging for wellbeing, and associated with difficult thoughts of self-doubt and imposter syndrome (often leading e.g. P2 to consider withdrawing).

The role that other people play here seems important to me. How competent trainees reported feeling was often influenced by feedback from supervisors, course teams, or patients. When patients reported positively on therapy (i.e. when they succeed where others hadn't P7?) they felt pride and competence. When supervisors commented positively on them and showed trust in their judgement they experienced this as feeling validated, competent and proud. At the other end, when failing uni work, this was often received as a global judgement about their competence, and hearing that was hard.

The actual experience of feeling competent is the heart of this theme I think. Most enjoyed moments are those when they feel competent – often including feeling stretched too.

Several participants talk about how features of the training or service influence how competent they feel, and this seems important. If you're being asked to work too far beyond your competence, or not given the time/space to reflect and feel competent, then you feel deskilled, unsure of yourself, and lose enjoyment (or rather, it is replaced by feeling stressed and deskilled).

Interesting too that self-perceived competence influences enjoyment of things at the time and on reflection. P2 spoke about enjoying 1-1 clinical and hating the workshops, because she felt more and less competent in them. P7? Spoke about not enjoying research as much as feels less competent in it (but then also said that when she found out she got good feedback for the thesis proposal, this made her think ok, this is alright actually).

Notions of competence also seem closely related to social expectations around this. Competitive nature of the courses makes it easy to assume that everyone around you is more competent than you/that you should be doing more than you can/that others would do a better job than you. Participants spoke of comparing themselves to others, or thinking that qualified staff were some distant and unattainable ideal of competence. High/unrealistic expectations from the course (about what a good clinical session/clinician is for example) might also feed into this. Similarly, they spoke about how uncertainty about key parts of the job (what my remit is/what level of competence I should have/how the CTSR is operationalised and how it relates to actual competency etc.) also influence self-perceived competence. If you feel unsure about what you should be doing, it's hard to feel competent at it!

Perhaps the experience of constant assessment slide is also part of this theme? The constant assessment being perceived as challenging, and pushing up against notions of competence/it feeling deskilling at times, seems relevant here.

I think that maybe some of the disconnect slide is relevant to competence theme (fact that patient outcomes are better indicator of competence than uni marking/fact that uni training doesn't actually set you up well for realities of clinical work etc.) But I think some of it really isn't. Perhaps it's more relevant to connection with others theme? (fact that it's often easier to feel connected to/supported by service supervisors, because academics are too distant and cut off from reality.

4. **Feeling valued by and connected to others**

Connections to peers, family, colleagues and patients.

Perhaps the CoC for this theme is feeling valued (i.e. valued by supervisors when trusted and supported, by patients when getting good feedback, by peers when mutually supporting each other.)

There seems to be something important in the notion of mutual support – feeling supported by others, but also feeling as though you support them in return.

Other people clearly come through as a highly important theme in this research. There is a clear sense that other people and the social environment in which one works and studies are central to wellbeing in the role. Not only in the sense of leading to wellbeing, but being part of what it is about. When trainees report *feeling* supported, valued and respected, they experience that positively, and as part of what wellbeing is. Many of the best moments have to do with feeling connected to other people (peers/patients/colleagues).

I think this theme almost certainly also encapsulates some of the stuff about not feeling as well connected to/validated by course staff team. Whilst some spoke positively of course staff as individuals, there was frequently a sense that overall, the course staff team were detached from the reality of the trainee experience, and were in some way 'against' them. The experience of that (i.e. the subjective feeling of that) is part of poor wellbeing in the role.

As you would expect, whilst many of the best moments were described as those where participants felt connected to and valued by others, many of the lowlights were described in terms of feeling isolated or not listened to. When they didn't feel fully part of their team or cohort, this was described as an isolating experience. Similarly, when not feeling well supported by service or unii staff this was described with words such as anger, frustration and disappointment.

The relationship with course peers seems particularly important to me. Almost everyone spoke about what seemed to be to them a somehow specific relationship with course colleagues. Something about the shared experience bringing you together so that you are connected (in almost intangible ways i.e. knowing when each other do or don't want to talk about the course, knowing

how to support and validate each other when experiencing challenge etc.) meaning that the connections with peers are more than other types of connections. There is a felt sense of comradery and shared pain that unites you in a strong and felt way.

Interesting too that many allude to the fact that connections with others is a basic human need.

Interesting that may trainees have framed the connection with peers in terms of 'having each others back', 'mutual support' etc. Indicating that there's something about how this shared (and difficult) experience unites you.

The notion of belonging might also be important here. Several trainees spoke about feeling at home amongst peers, feeling a sense of belonging in their team, and feeling connected/valued. This is important and is the opposite of isolation and loneliness.

5. Range of emotions

Many trainees described conventionally 'positive' emotions in their work, and this appears to be a central feature of the highlights, and the moments they enjoy. Most commonly, people described pride, though many also spoke of joy, gratitude and 'warm' or 'fuzzy' feelings. A physical aspect to this was also described, with many people talking about feeling energised and motivated when things were going well, with one even describing positive clinical work as energising and 'revitalising'.

For some trainees, wellbeing represents an absence of conventionally 'negative' indicators; people described feeling secure, or not too overwhelmed when having good moments. But many others also described the presence of some conventionally negative emotions in the context of positive moments (e.g. times when people described anxiety at using a new intervention but enjoyment with it working, or stress when doing so much work but pleasure and satisfaction with how much was learnt. Interestingly, no trainees said they thought that the training without any stress would be good/realistic (though they all said, less stress would be better).

It seems then that wellbeing in the role encapsulates a range of emotions, dominated by positive ones, and with a smaller number (but not complete absence) of emotions less conventionally associated with wellbeing. (But I think these were nonetheless important, as wellbeing in the role almost necessitates some stress and anxiety in the sense of being pushed, learning new things and occasionally not feeling competent etc).

Many trainees described their best moments in the role as those that induced 'flow' – being in clinical work and so absorbed by it that you lose track of other things or self-doubt etc.

Experience of stress and burnout as significant factor in trainees' experience, and that excessive stress or changed attitude towards work that accompanied feelings of burnout were key to the experience of poor wellbeing in the role.

Similarly, maybe the positive and negative aspects of training also comes in here too? The experience along the training journey is one with both positive and negative sides to it (and these are often

related by being the two sides of the same coin – i.e. stress because learning so many new things). For some, the negatives outweighed the positives, but for others, not.

Note: this is important isn't it. Joy isn't the opposite of stress. I might reduce stress, but if I don't feel pride or joy, then I haven't reached the goal perhaps. Similarly, I might feel stressed, but also proud.

6. Perceived control over wellbeing

Most trainees reported believing that they had a significant degree of control over their own wellbeing. Several mentioned explicitly that when wellbeing is low or circumstances challenging, it's harder to influence wellbeing (compared to when everything is going well). But on the whole, trainees reported experiencing themselves as having a significant degree of control over their own wellbeing.

Whilst several mentioned systemic issues, or the role of society in supporting wellbeing, most trainees tended to conceptualise responsibility for wellbeing as being a matter for individuals. This may well be informed by the fact that CBT is the main form of therapy all trainees are learning (and some specifically said training had influenced things for them on this).

The felt sense of having agency over wellbeing led some trainees to describe their own wellbeing as something they sought actively to influence and maintain, and the notion of taking responsibility for a good work-life balance was a commonly discussed idea. Many trainees described it as being quite hard to maintain that balance, but most indicated that they experienced it as important (i.e. if/when they let that slip, they felt it).

7. Frustration / beliefs about the training

The frustration with the course one seems to have stuff about how the work/training sometimes prevents you from working in accordance with values (this content could/should probably go in first them).

There's also lots of stuff in there about how the course talks about wellbeing but doesn't really allow for it, and how poor course design/communication often make it actively worse than it needs to be. There's a clear sense that trainees often felt that the requirements of the training are fundamentally opposed to work-life balance and personal wellbeing, and so this is experienced both as stressful and annoying. It perhaps raises important points about how courses can/should approach this topic. Taking steps to improve trainee wellbeing should be done, but courses need to be careful to avoid this looking simply like lip-service. If you tell trainees to look after themselves, but design a course so

opposed to wellbeing that it's impossible to, then this will just be annoying. It also suggests that course design, communication, timing of holidays etc could be done in ways that improve wellbeing quite a lot.

Many trainees described the training as a sort of necessary evil – a period of extreme and unsustainable stress that getting them to a desired goal. There is an obvious belief that somehow life will get easier after training. Part of the experience here seems to be one of overwhelm. Many trainees experienced the volume and pace of work as overwhelming and destabilising.

There's something important I think in the ideas that people have about the training (that it's hard to get on, that it will be challenging, that others around them are so competent etc.) that influences their experience of it in important ways. Others spoke of basically experiencing things more positively because they had more moderate expectations about it, and because people have it up on soe high pedestal, it is turned into something more stressful/pressured.

The content around experience of constant assessment also seems important. I don't know if it fits here, but it does seem important. Trainees described feeling exposed, vulnerable (clash between perfectionist/high performing traits and the frequent assessment – which is often perceived as harsh and arbitrary), makes a big difference to wellbeing in the role. The feeling of being exposed, of being vulnerable and being frustrated by unattainable ideal is a central part of their wellbeing experience in training.

Maybe the content on disconnect between uni and service actually goes here?

Is there an overarching theme about how they think the training connects to something deep about who they are and what kind of person they are?

- Values and contributing to something bigger connects to how they see themselves
- PPD as demonstrating the close connection between their personal and professional identities?
- The notion of competence being linked to their suitability to the role/ability to do it well, and the fact that if they do badly at therapy they are a bad person?/a perception that when your competence is questioned, it can push up against deeply held beliefs about yourself (as someone competent and caring for e.g.) (see especially P11, 324-332)

Supplementary Material 6 – Theme definitions and quotes v2

Theme definitions, illustrative quotes and considerations for analysis

Overarching theme: connecting with and embodying personal values is at the heart of wellbeing in the role.

All participants spoke extensively about the importance of feeling connected to personal values through their work, and a sense of being connected to such values was described as being at the heart of wellbeing in the role. Across the data set, there is evidence of trainees reflecting on how much their enjoyment in and fulfilment from the role depends on a felt sense of connection to their values, and a belief that they are living out those values through their work. This idea captures something that sits across and within all of the themes below. Participants described how the role was an avenue through which they lived out personal values associated with helping others and contributing to some greater good, to feeling competent and purposeful, to feeling connected to other people in their role, and to continuing to uphold other important life areas. Similarly, the range of emotions frequently described as being central to the experience of wellbeing in the role were also often framed as being related to a sense that aspects of the training were either facilitating or impeding connection with personal values.

Illustrative quotes

Participant	**Line numbers**	**Quote**
P1	1034-1036	'But, I guess that's when I'm following those values is when I get that sense of satisfaction we talked about earlier, sort of thing. When I recognised that this is what I enjoy doing, what I want to do'
P3	70-74	'I think that's just within my values really, to be able to treat people well and help people and support them. That can obviously, it makes other people feel good, but it can make me feel good as well, knowing that I can provide some support to others and yeah, I just think it's, yeah, one of my values to be able to support people and help people where I can.'
P3	880-893	(*reflecting on the consequence of sustained stress and poor wellbeing in the role*) 'In particular, I would say it's kind of made me lose that kind of sense of enjoyment, of fulfilment and achievement, and all the things which I have previously enjoyed about work; and my values… So it's kind of reduced that satisfaction at work as what I previously enjoyed.'
P4	739	(*describing the trainee role*) 'it is definitely who I am… That's how I define myself'
P15	82-86	'I think working is a necessity, we have to – I need to work, get a salary and things, but because we spend such a lot of time at work it's important it's something I enjoy, and want to do things worthwhile with my time'
P12	172-177	'I've always felt that some things in life, whether it's being a doctor, being a nurse, being a therapist, a lot of these things are callings more than they are careers. So, it's something I see myself doing first and as a job second. If I wasn't a therapist I'd still be helping people but for me at least my professional and my personal life are quite entwined with this'

1. **Provisional theme title**: ‘It’s for the greater good…’

Central organising concept: a perceived sense of working in the service of some greater good is central to the experience of wellbeing in the role.

Theme description: Participants described working in a way that contributes to some greater good as central to the experience of wellbeing in the role. Most participants described helping others as a central aspect to how they see themselves both personally and professionally, and so their trainee role was described as supporting them to realise a core feature of themselves through their work. Trainees often described their life experiences/trajectories as having shaped them towards this type of work, and it therefore being a fundamental component of their self-concept and values. Trainees perceived work in this field as significant, meaningful, life changing and socially powerful work. It was described as providing meaning and purpose to their lives, and supporting clients was described as a source of pride and enjoyment for trainees. The felt sense of purpose, value and meaning experienced when working with clients was at the heart of much of what participants enjoyed and valued most highly in their work. Significantly, when features of their trainee role prevented them from working in ways they perceived to be meaningfully contributing to some greater social good, or when they did not feel as useful in their roles, this was described as a negative influence on their wellbeing, with trainees describing feelings of guilt, frustration and stress.

Illustrative quotes

Participant	Line numbers	Quote
P2	368-370	‘Because it's talking, you know you're talking about people's mental health. And the people's mental health underpins everything else in their life; their quality of life. So you know, it's so important. And, you know, as I see it, it's so important’
P3	116-118	‘So although yeah, some of the work, it does feel helpful, it's also… Yeah, not… I don't know. I don't enjoy it as much as I have my previous roles’
P15	192-207	‘It just gives me a sense of I suppose, what’s the word I want, like – there’s the value in it. When you’re going to work you’re getting your salary but as well as that you’re also gaining – I’m proud when I do help people… Just that sense of – you’ve done good. You’ve done something worthwhile. I think that sense of satisfaction that you’ve done something good rather than just you’ve done something. You’ve doing something to make positive change’
P5	165-168	‘but I think more it's actually about being useful, feeling like I'm actually being useful in my role. I'm actually helping young people. I'm actually helping families and actually being able to see the benefits and get those waiting lists down and and just feeling like I've got a purpose really’

P5	511-514	'It just it [the role] just sits well with me. It's given me that purpose. I feel like I'm doing something that's valued. It's going to benefit other people and hopefully prevent long term issues. So it's for the greater good, for want of a better phrase. And yeah, hopefully it's gonna have a wider impact than just benefiting me'
P6	222-224	'I don't know, I kind of have this sense that if you can't support other people or be there for other people, and yourself, then what's the point in existence, if you're not feeding into a purpose in some way. To me purpose is humans helping others, and that connectiveness in society I suppose'.
P14	53-59	'I think what's really important to me is… that I'm doing something that is properly in alignment with my own morals, my own beliefs, and the things that I'm passionate about. I think it's having a purpose; it's having something… I feel like I'm making a slight difference, it's only a small difference, but I'm actually making a difference to people's lives in a positive way hopefully'
P14	156-157	'I think what we're doing – I think it's incredibly important, I think it's hugely important, and I know that we definitely do make a difference to people's lives.'
P8	164-	'… I think because I see it as a kind of a bit of a purpose for me. You know, I've had times where I don't feel like I've… you know, where you can get bogged down, you know… I'm just one person, just one small person living my little life. And then, you know, ways I've kind of overcome that, are maybe a more kind of spiritual approach even… thinking about what purpose do I have, and what change can I make? And I kind of have to believe that I have a bigger purpose, otherwise it's really easy to feel, you know, actually really insignificant. So that kind of drives me to kind of act on that.'
P9	102-104	'I still feel like I make a difference and so, yeah, I think I would really struggle with going to a role where I didn't feel that… '
P10	165-168	'I feel good because I give back to the community. I am an empath. For me it's important that my life has purpose. That I leave the world a better place than when I found it.'
P11	212-231	(*what is most important for you to feel happy*?) 'I've done something of value, I think. OK, so what do I mean by that. It's very cliché, but presumably cliché because it's true for a lot of people, I guess that make a difference feeling. Doing something of value. Feeling like there's a point to my job and it's important. Not necessarily essential but certainly needed for quality of life I guess, and I think that's probably the most driving factor for me… And I guess it's in my perception of what's important or significant, for example, when I was doing my degree part time I was working in hospitality and some aspects of it I enjoyed. And now not working in it, and going out to a hotel or a restaurant I really like, I appreciate nice service, but I

		wouldn't – that's not as worthy or valuable, that's not – I think there is more important ways to spend time, my time maybe. I want someone to serve me at a restaurant, so I guess I don't want everyone to stop it. But yes, it feels more important what I seem to have in my head as a grander scheme, or bigger scheme of things of what's important for people's lives and happiness I suppose'
P12	190-193	'for me this is as close as I can get to a life's purpose as I can find. For me learning about people, helping people, supporting my community, those are things I see as the purpose of my life on earth if I can be a bit cheesy about it.'

Thoughts/considerations for analysis and interpretation: Trainees are working in a context in which:

- Post-COVID and cost of living crisis
- NHS and public sector services enormously stretched
- Challenges for many people related to this are widely documented/reported in media

Notion of 'doing my bit', contributing positively to society in this context may be particularly salient? Important to feel like you're doing something positive/constructive in these circumstances?

2. **Provisional theme title**: 'I need to feel like I'm achieving something…' OR 'it makes me feel more whole and developed as a person…'

Central organising concept: having direction, and experiencing yourself to be progressing, developing and achieving are central to the experience of wellbeing in the role.

Theme description: Many trainees described a felt sense of progression, direction and achievement as important features of wellbeing in the role. For many trainees, the training period was experienced as a period of intense personal and professional development, during which they invested a lot of themselves into the training, and enjoyed learning a range of new skills. Trainees reported valuing the sense of career direction that their training supplied. The development and progression experienced through training also extended to wider areas of life too, with several trainees describing how they experienced the training to be helping them address personal challenges, or develop into more fully rounded people. Many trainees reported that they had long felt driven to be productive in their lives, and that without working towards some goal or form of development, they often felt 'stuck' or frustrated. For many trainees therefore, the experience of achievement and progression in the training was highly important, and the feeling of being stretched and positively challenged by the role was experienced as a central component to wellbeing in the role.

Illustrative quotes

Participant	Line numbers	Quotes
P3	280-282	'I just like to make best use of my time to be able to do something with it, and I don't know, maybe feel more productive or like I'm not wasting the day away'
P4	353-357	'I like to feel that I'm doing well. So um, they talked a lot about the course, the fact that it is a pass/fail course. That drives me crazy, cause I like to do well. So I like getting my grades back and I like to do well academically, but not just not just at courses and university, but at anything. If I'm doing anything, I like to do well enough, so I can see I'm doing well. That makes me happy' (*when asked why that felt important she then said*: 'I think it's just for my own validation, I guess? I think it comes back to that fear of, umm, you know doing something wrong. And I just want to make sure that I'm doing it right, maybe'
P15	254-256	'And I think with some of those transferrable skills and being able to – like the listening skills – it just makes me feel more whole and developed as a person. It's just that learning'
P6	350-354	(*when asked what it is like when you feel useful to others/colleagues*) 'I think it's the fulfilment thing. I set out to help with X, Y and Z, and actually that's been reinforced that it has been helpful, so it's a sense of achievement, fulfilment, and that I'm helping somebody else develop which is a happy feeling isn't it. It's also a feeling that you're progressing as a person and a trainee'
P14	315-317	'I do tend to drop, if I'm not being challenged, if I'm not learning, it becomes quite monotonous and a bit stagnant, that's when I start to kind of disengage, and I find that my wellbeing starts to drop'
P7	328-332	(*When asked what most important for wellbeing*) 'Definitely something around like achievement in life, like I need to feel like I'm achieving something… There's definitely something… and like my… have a purpose in life'
P8	692-	'I think it's, it caused like a huge kind of… um, advancement. I guess in my how I see myself as a kind of professional, you know. I've developed so much in ways that I wouldn't have even imagined before I started, both professionally, like with knowledge and and that kind of thing and applying it, but just, also you know personally as well… just how I see myself. Um, so that's really positive.'
P9	148-151	'I've learned... I feel like I've learned loads actually. And I feel like it's been quite a change point for me as well. I would, like in terms of lots of my own things… so confidence, and just putting yourself outside of your comfort zone, and it's been challenging, but also really good I think'

P9	460-464	'You want the challenge of of the different placements and the different experiences and those sorts of things because I don't feel like I'm… because I maybe don't feel like I'm gonna be a clinical psychologist in two years. I think part of that is, I need to... I know I need to push myself in that way, to to feel like that for myself.'
P10	223-226	'So, having come from extreme poverty now I am comfortable, I am happy. Just working hard and getting where I am, and improving myself, makes me happy.'
P10	124-126	'The real sense of accomplishment and success I suppose. I suppose it feels like success, whatever that really means. I guess it's that sort of punch the air moment a little bit if I were to think about what I would do.'
P13	625-627	(*asked whether the training should at times be stressful*) 'I think that absolutely there does need to be – nothing can ever be without it's challenges or difficulties. I believe that if it is, potentially we've got to ask is it worth our while doing'
P11	721-725	'it's helped my wellbeing because I've been able to understand being on the receiving end of teaching is just – I love it. I love learning about different theories or different approaches, or discussing – it's mainly the learning, I like hearing about it I suppose really, and thinking about how that could be used in work.'

Considerations and thoughts for analysis and interpretation: all these trainees are on highly sought-after training roles, that are considered an important step towards a desired career goal. In a sense, direction and progression are at the heart of a training place as you're working towards a goal, but the fact that trainees on these programmes are also frequently very bright and often high performing young people with high standards and deeply held ideas about the importance of development and aspiration is perhaps also important.

3. **Provisional theme title**: 'Maybe I'm getting the hang of it…'

Central organising concept: Feeling competent, capable and confident in your work is at the heart of it being enjoyable.

Theme description: A felt sense of competence was described as being central to the experience of wellbeing in the role. Many trainees described the best and most enjoyable moments in their trainee role as those in which they felt positively challenged, confident in applying new skills effectively, and competent in the work they were doing. When trainees felt inadequately supported, or when

working in ways or on areas that were perceived to be outside their scope of competence this was described as de-skilling, and feelings of self-doubt, stress and imposter syndrome were commonly described. The felt sense of responsibility they described in relation to their clinical work resulted in feelings of stress, frustration and even anger (with supervisors or the service) when they perceived themselves to be working too far out of their competence zone. Many trainees spoke about how the experience of being in training (where by definition, you are frequently not yet competent, and you are constantly receiving feedback and assessment) effected their self-perception of competence, in ways relevant to their wellbeing. Receiving feedback (from university or supervisors) perceived as negative, was reported to feel exposing, and occasionally pushed up against deeply held beliefs and rules for living (e.g. that I am a competent carer, or that I should be competent in my work). Conversely, when trainees received positive feedback (from marked work, patients or supervisors) or felt positively challenged and stretched through their work, they reported pride and enjoyment in a sense of competence and accomplishment.

Illustrative quotes

Participant	**Line numbers**	**Quotes**
P1	990-996	'I guess when I started doing clinical work again, getting sort of positive encouragement and sort of validating my abilities - That was a real eye opener for me based on before. So it's sort of a lot increasing confidence and positivity from members of staff can effect my positivity and motivation and drive and feelings that I can do this. Erm, I guess other highlights on the course was doing really well on my first assignments and getting good grades.'
P1	1014-	(*when asked what the highlights have been so far*) 'I guess recently it's just feeling more confident and competent, and comfortable with my caseload, and having this sort of validation from the like senior psychologist that actually I do, I am competent, and this going well, all these things'
P3	-448	'So to have that like positive response based on work I wasn't also like super familiar with, kind of made me think that 'ohh okay, maybe I'm yeah, getting the hang of it and being able to share it in a way which is helpful to her'. And so I guess it was yeah, achieving that goal and using the type of intervention in a helpful way for the client. And, yeah, being fulfilled in the sense that it brought them happiness and improved wellbeing, which, as I say, fits in with my values and made me happy, so yeah….'
P6	407-410	'Other than being really fortunate to get really good feedback from most of my supervisors so far, that's quite reassuring, especially when you have a bit of imposter syndrome. And you think what am I doing?!.'
P6	445-462	'the research side of the course is just – it's OK, it's not awful, but it's just not me… not like awful, it just feels like it gives me less enjoyment. It gives me less fulfilment and I find it harder to do it. And I'm not as good as it. I can be pretty crap at it' *but then interestingly she goes on*

		484-487 'I just don't get much enjoyment out of it. But then I don't know – we had to do a thesis proposal last year and I did quite well on that, and that quite surprised me, and I thought OK, this is manageable. It's not going to be too awful'
P7	684-689	'I guess a highlight for me was like in not my last placement… like seeing the confidence that my supervisor had in my abilities and kind of her, yeah... being confident in my skills and that just being like a massive boost. Especially when I felt like I was being myself and I was being really open about some of the things that were difficult, or some of the things that I personally found difficult. Yeah. So that was really nice, knowing that I could kind of be myself, but still be respected and appreciated, I guess'
P8	487-492	(*why does it feel like a highlight when getting positive feedback from supervisor*?) 487-492 'But then there's also the element of, you know what that feels like for me in terms of who I am as a kind of psychologist, and who I am in my development. Then you know, if I get positive feedback, I feel like I've done a good job, and I feel like… you know, it kind of, um, conflicts with what I see more as my weaknesses or, you know, things that I struggle with in that, you know… '
P8	511-518	(*when asked what most challenging about the role so far*) 'I think most challenging has been… stepping into the role, like… uh, you know… you you start training as a trainee, and suddenly now you are that role. But nothing's changed from when you left your like assistant job, like the week before. And so you haven't… you kind of don't really know what the difference is. You're just you. And so you never know if that is, if you're meeting trainee standards or what that even means! And that all the competency that reports are like, 'are they meeting expected training level?' or whatever. But I have no idea what that means to be honest! So, it's like that element of it, of actually, 'am I being the role of a trainee, right?' '
P9	176-194	'I think I think something about this course is that you're constantly being kind of pushed. You sort of have to do things that don't feel very comfortable… You know, you have to meet these pieces of work, and that covers such a wide range, so you can't really shy away from things that maybe you don't like to do, like people do, in kind of like normal jobs… On one hand I find it is really difficult, but also I think actually I maybe wouldn't have had these experiences, as I may have picked something that I felt more comfortable with. So I might have picked a job or a population or whatever, that I thought more comfortable with. And I don't necessarily think that you know that's always good, but it does, it does push you outside, your comfort zone'
P9	752-771	'Feeling… being like you're going to try and work with somebody and you don't actually know what you're doing… that's a really… even if maybe you've talked it through, and on the surface other people feel like you do… just feeling like you haven't quite got enough. I think one of the most horrible feelings for me is just feeling like you're not the

		right person, or you haven't got the right, whatever it is to work with that person at that time. That's kind of such a horrible feeling to sit with… , I think, yeah, that one is horrible... I think that can really wear you down if you have that for too long. And it's like frustration. It's also kind of anger at, maybe if it feels like it's coming from not having enough support from somebody else, it's kind of anger and feeling like disappointment. Kinda let down there. But it's also like disappointment in yourself, because it's feeling like you know… 'If somebody else was here, they would be able to do this differently'. And that's not very nice really'
P10	309-313	'there's nobody looking over your shoulder, you are free to go, you are trusted and for me that trust is huge. And actually, people trusting in my skills and what I have to give, and that I am not going to do much harm, trying not to do harm, and actually just letting me explore my own self'
P10	357-359	'I mean initially it broke me down, first time I failed an assignment I was in tears, I never failed anything in my life, so this was kind of all new'
P11	324-332	'I think as I imagine is incredibly common certainly for me when I've done training roles, you are in a training role and therefore you do not know, not that you ever know it all, but you definitely don't know it all in a training role. And that's really difficult for me because if competence is a big part of something that sort of – if that's a big rule for living, to be competent in everything all the time, training is a real big risk. And especially when I had to resubmit one assignment, that was a real moment of difficulty because you're not living that role anymore, you're now – the terrifying belief is exposed.'
P12	443-447	(*reflecting on how it felt when he failed a clinical assignment*) 'It really undermined my competency as a therapist, and about my self-image. So again, going back to my job is my life, my life is my job, my values are my work. Feeling a bad therapist I felt a bad person, I was very – again, going back to the dissonance, having glowing feedback from clients and then a complaint failure on the CTSR, it felt so just mind racking'

Considerations for analysis: context of working in overburdened NHS, on training courses perceived as 'squeezed' into the timeframe over which they're delivered, and frequently being asked to do things outside supposed realm of training. Similarly, the perceived notion that training is hard to get on, and so you need to prove yourself/trainees may compare themselves to others and imagined levels of competence. Also note competence is a central feature of eudaimonic wellbeing as described by SDT, and a basic psychological need according to that theory.

4. **Provisional theme title**: ‘I don’t think you’d get a bond like that anywhere else…’

Central organising concept: Feeling connected to and valued by others in the role is at the heart of wellbeing in the role.

Theme description: Trainees described the felt sense of connection with peers as a central feature of wellbeing in their roles. For many trainees, the relationships forged with peers on the course were experienced as uniquely deep and supportive connections. Trainees described a felt sense of comradery, connection and understanding that rendered these relationships different to those with people outside of the course. Trainees described a felt sense of belonging, and spoke of feeling ‘at home’ around peers and like-minded people. Consequently, the experience of wellbeing in the role was both shaped by and comprised of these connections, with trainees describing how many of the best and worst moments in the training so far were accounted for by this felt sense of connection (or its absence). Several trainees reflected on how connections with other people are a basic human need, and framed the importance of course relationships during training in these terms.

Illustrative quotes

Participant	Line numbers	Quotes
P1	356-357	‘We share a sense of purpose with the team, there's some sort of like we look out for each other, there's warmth, amongst us, support’
P1	487-489	‘It's just a really difficult time in service and all services, so we sort of take the wins we can, and we sort of share them with other people in the team’
P1	738-740	‘I think that's, that has been one of the most important things. I guess with a sense of belonging, it's, it's more, just, a basic need of being human. Sort of having that connection, and friendships and things like that, and shared experiences’
P2	535-541	‘I mean, I'm not a huge fan of face-to-face stuff [teaching], but to be honest, it has been helpful. And even though it was extremely anxiety inducing to begin with, that quickly dissipated. And I think the reason that it did, and as we know it, it does…. the reason it was so quick was because I was amongst people that were understanding, calm, compassionate, caring. It was a safe space and I quickly, you know, that quickly became quite apparent that everybody in the room was there and had that intention’
P2	838-842	‘I guess social connections is really important for sort of wellbeing generally speaking and you know, we’ve all talked about the fact we will continue to be supporting each other once we qualify or once we’re no longer doing the course. So I've made some hopefully some lifelong connections there, which I think will be hugely beneficial to me as a person even if I don't carry on doing this role so’

P3	752-760	(*speaking of the difficulty of the training and the importance of course friends*) 'I've got friends outside of the course and things like that, but like I said, they can offer their advice and support, but again it, it's not always as helpful. Like I'm yeah able to kind of like keep myself busy and maybe like, distracted with friends, like outside the course. But I feel like in particular, my course friends have been able to offer the most helpful kind of support and advice. And yeah, that has kind of really lifted my mood and enabled me to, like, keep going with things. So yeah, without them on the course, times would be tough.'
P4	923-929	'I've made some really good friends on the cohort that are just wonderful people. And this has been such a change from where I came from before… not in the NHS, but when I was [in a previous career], the sort of culture, I guess there is so different to where I am now and it's just so refreshing. So that's what's really contributed to my wellbeing, and feeling of, yeah, positivity. Much better, yeah.'
P6	761-781	'but being on the course with people that are likeminded, and also experience similar stress, and are going through the same thing and understand – because I think you can have family and friends that are empathic but they don't really get it. So, I think course people and cohort, and that sort of togetherness is a big thing for wellbeing as well… I don't think you'd get a bond like that anywhere else… I think that bond is just different, and you're not going to get that with somebody that is removed from the process'
P8	676-680	'You know even when people just send memes in the group chat and and, you know, you kind of relate with them. Um it it just makes you feel kind of validated and in how you're feeling and actually you're not alone. You know, whether you're reaching the level that you know, the the course leaders expected you, you're at the level that everyone else is, so that's OK'
P9	206-217	'I think the people on my course are just like, you just hold each other through it. I think that's such a big, like I can't even like, overestimate how much support that is. Cause I do think it's really hard to explain… I feel like people beyond the course, they want to hear how you're doing, and your friends outside of the course, when I like, and family and things… But I think, you know, people can ask how you're doing, but you can't constantly say how challenging it is sometimes. But people in the course, you don't have to explain… They get it. They know you're exhausted, they don't mind if you don't message back at different times, they don't mind because they know everyone's in kind of isolation, you know… being a hermit or whatever it is. So yeah, I think that's been something extremely helpful'
P10	684-686	(*asked whether she had felt connected to peers*) 'Not really. It was very clicky. I was the only one from my service so from my area, obviously, the county is huge but everyone kind of stuck to their own office. So, for me it was even more difficult'

Considerations and thoughts for analysis and interpretation: relatedness and social connection as central component of wellbeing in SDT, and a basic psychological need. The shared sense that these training programmes are an uphill battle, and something to 'get through' or 'survive' increases the extent to which the comradery described feels important (literature around shared experience of challenge bringing people together?)

5. **Provisional theme title**: 'it's been a really interesting, dynamic, changing, exciting, exhausting year…'

Central organising concept: Wellbeing in the role spans a breadth of emotional experience.

Theme description: The wellbeing of trainees was described as being comprised of and indicated through a range of emotional experience. Emotions such as pride, joy, fulfilment, excitement and gratitude, as well as their physical components (e.g. feeling energised, motivated and excited), were commonly described, and trainees reported that these were at the heart of the experience of wellbeing in the role. Many trainees also described a range of conventionally 'negative' emotions (e.g. stress, frustration and burnout) experienced whilst in training. Whilst it was frequently reflected that some conventionally 'negative' emotions (such as anxiety about starting new clinical work, stress when starting in new placements, or self-doubt when learning new skills) were an inherent component of an enriching and stretching training in which one was challenged to learn, develop and succeed, several trainees did also report that at their most intense, 'negative' emotions such as excessive stress and emotional exhaustion 'drowned out' the feelings of pride or joy that were otherwise felt when carrying out their work. Where the balance of being stretched and challenged was appropriately struck, trainees often described experiences of 'flow' when carrying out their work.

Illustrative quotes

Participant	Line numbers	Quotes
P3	-1150	'I don't think wellbeing's always about being happy and overjoyed or whatever. It's just like being OK and feeling able to manage things'
P15	251-252	'when it all goes well with a patient and you see them improving, you get a sense of achievement I suppose and pride.'
P5	228-229	(*what is a good day like?*) 'I think your day flies by. And you don't feel tired when you get home. And just that sense of achievement, really, I think at the end of the day.'
P5	561-562	'Um, but yeah, no, it's just that sense of pride that I'm doing something worth while I guess, and it's those positive feelings that we talked about earlier, I think'

P5	581-582	'I feel overwhelmed quite a lot, so it's really hard to identify the highlights'
P7	166-168	'yeah, I guess I just felt a bit proud of myself that I stuck with it because it was a hard piece of work as well. So just having that determination and just being like 'see, that was hard, but you got through it and that was a job well done''
P7	578-580	(*when asked to describe how she feels when enjoying clinical work*) 'I don't know if it's like a feeling of like proud? or whether it's just I've got that sense of purpose. But it definitely is like a really positive thing that I feel. Like I can remember walking back to the car being like, 'oh, I did a good job today''
P9	879-880	'I'd say it's been a really interesting, dynamic, changing, exciting, exhausting year… where I probably feel like I've aged quite a bit!'
P11	66-71	'Because it feels like a sense of achievement but what that – what does it feel like. I'm struggling to pin it. Euphoric is too strong a lot of the time, I'm not saying that never happens but that probably feels too strong a word to use generally, but just sort of a lighter feeling. That sense of achievement you get, and I guess a connection, worthiness, those sorts of feelings or words spring to mind I guess'
P11	-771	'I feel like my wellbeing is good if I'm doing things or engaged with things that are of importance to me. Whether it's because I like it or it makes me achieve, or whatever. It brings some sort of calm I guess or satisfaction, like a peaceful sense. I feel just sort of content, I guess it's a contentment'
P13	336-342	'I think at the moment I find it difficult to pick out the bits that I've most enjoyed… because my experience particularly lately has not been positive. So, I do find it difficult. I mean saying that it is great to learn new skills, and it's great to learn new things, and that's always – that is great, but sometimes it feels like it gets overshadowed by the other stuff so it's hard to say that that's a highlight in its own right'

Considerations and thoughts for analysis and interpretation: Something in here about the fact that this data better fits a dual-continua model of mental health and wellbeing? In the sense that most participants weren't saying that wellbeing was the absence of negative indicators, and many were saying that some of their most positive moments (of pride, stretching and enjoyment etc.) were also linked closely to those in which they felt stressed or anxious (i.e. when doing clinical work for the first time)??

6. **Provisional Theme title**: 'There's more to life than training…'

Central organising concept: A felt sense of balance between the training programme and other important life areas is important to wellbeing in the role.

Theme description: This theme describes how trainees experienced wellbeing in the role as a felt sense of balance between the training and other important life areas. All trainees spoke about the significant place that the training held in their lives and sense of self. However, many also described how their wellbeing was also experienced in terms of a continued and felt connection with other valued life areas. Many trainees reported that the training was therefore experienced most positively when it didn't drown out other important life areas. A felt sense of balance between training and other life areas (e.g. being a parent, engaging in hobbies, sustaining other interests etc.) was therefore an important feature of wellbeing in the role for many trainees. For these trainees, it was described as important that the training did not totally define them, or cause them to lose other aspects of their identity.

Illustrative quotes

Participant	Line numbers	Quotes
P1	1356-1361	'I suppose like it's important in general, in life… to be able to *live* it. Because sometimes it's, if you're in certain roles, you're sort of earning, working to survive, not earning to live, sort of thing. So, having an opportunity to live and enjoy life, is necessary. Which is why I said about, the camaraderie with the cohort and taking a step back, and working with them and doing things beyond work and supporting each other is so important too'
P6	370-376	(*When asked whether the trainee role was fundamental to how she sees herself*) 'I think it started off as central and it's shifted slightly to the left or the right, I'm not sure which way. And why that is I don't know. I think I've just sort of realised that there's more to life than – I think now I've got on to the training it's less of a focus to get on to the training, and it's trying to see it more as this is a job, and this is a training course, and focusing a bit more on other stuff as well is important. And I don't have to do the whole application thing anymore'
P6	628-641	'I think if you come out of the course and you've changed who you are or you lost sight of who you are then I don't think you're necessarily going to be the psychologist that you wanted to be, first and foremost. It comes back to that central vision and that peripheral vision a little bit I think for me, and I think if everything is central to the course then you can lose your way a little bit and then your sense of identity is a bit lost, and then you're literally just a psychologist. And you're not whoever. I think for me it's about keeping that identity which feeds into both your professional side of things and your personal side of things. And there is life outside of the course so if you lose who you are you're probably going to lose maybe people or your relationships

		are going to change with other people, and that's pretty sad. And your support systems might change as well if you start losing that'
P14	87-93	(*when asked what contributes most to wellbeing*) 'I think realistically it's having a real nice balance of things across everything, so I don't feel like I'm having too much of something and not enough of something else. Having a nice balance between working, that's manageable, it's not too stressful, but it's demanding enough to be interesting and invoking. My friends and family, very, very important to me, and it's nice that I obviously stay engaged and keep up with them, but again not so much that that takes over. And then my dog, I just love her'.
P15	68-76	'I think balance, it has to – everything kind of has to fit together. I think when you've got children and you're working it's being able to do the two things and not sacrifice one or the other. It's the balance really. That's the most important, that things fit together. I wouldn't like to be missing out on lots of kind of areas with my family, like a sort of – I've done unsociable hours before, I don't want to do that anymore, I want to be available. I want to be able to take the time if I need it to do things with the family. And have that sort of – a little bit of flexibility, it's for everything to kind of fit together really'
P15	95-102	(*what's most important to your wellbeing*?) 'I suppose being able to reach that balance because if I feel overwhelmed in one area then that will affect me. If I feel that I'm neglecting my family or I'm not seeing enough of the children then that will impact me. Or if I was working too much. And being to have the time to do the things that I enjoy, so my family and I we try to travel quite a bit, so that's really important to me, that we have those holidays and get sort of travel and – or do the activities that we enjoy together which is very outdoors sort of stuff.'
P4	307-308	(*what's most important for your wellbeing?*) 'I'm very much a family person. I've got two daughters and obviously my husband and I, tend to feel 'as long as they're happy, then I'm happy'.'
P6	85-87	'I think being around family and friends is probably – and having the time to do that, is probably when I'm my happiest. And if they're OK then I'm more OK. I think that's probably – quality of life and balancing work life.'
P7	855	'not making the course your life is really important I think.'
P7	863-869	'I don't massively have major hobbies. Like I like to go to the gym and run, but I don't really have any massive hobbies outside of that, but I don't know. There's just something about putting all of your effort into a course is just exhausting. And there are times when you need to do that, like if you've got an assignment coming up and you've got a few days left to cram and get it done. But there are also times where actually you just need to not care a little bit, just to kind of like, keep your reserves. And to just, yeah, to recharge your batteries'

P9	818-819	‘I think one of the biggest ones is you trying to live a life as well… not taking up all of your life. That I find a hard balance to strike.’
P9	1034-1035	(*what advice you’d give to a new trainee?*) ‘I would say try and keep a life. And try and do non-psychology things’

Considerations and thoughts for analysis and interpretation: trainees have often worked hard and for a long time to get onto these courses. Once on, it seems there may be some increased acknowledgement of the fact that other aspects of life are important too, and so any sense of wellbeing in the role has to actually also be experienced as a connection to other important life areas? In the sense that the training is held as more important until you get on it (no longer pursuing it). Context of overburdened NHS is perhaps also important here. A recognition once in these roles that they can very easily take over your life or demand more of you than you can realistically give unless you learn to be actively boundaried.

Supplementary Material 7 – COREQ

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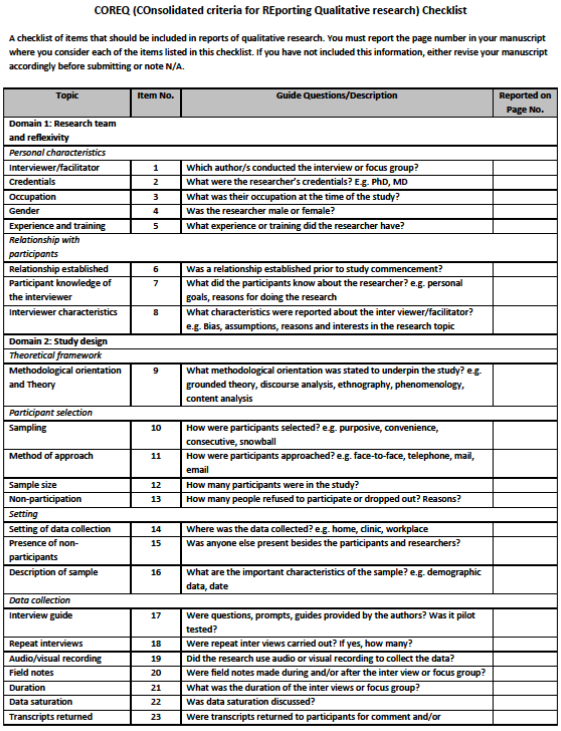

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Chapter 5: Acceptance & Commitment Therapy (ACT) and psychological flexibility

Developing an intervention based on Acceptance and Commitment Therapy (ACT) for Psychological Therapy Trainees (PTTs)

When planning the design of the intervention to support trainee wellbeing that would be trialled in this thesis, several key findings from earlier stages of the PhD were held in mind. In the Systematic Review reported in Chapter 3, evidence had been identified for interventions based on a range of therapeutic techniques, with no one single therapeutic approach demonstrating more robust evidence than others. Notably however, evidence suggested that trainees valued interventions that had been designed specifically for their context and provided them with some degree of choice or autonomy in the way that interventions were offered and delivered. Another important finding of the review identified how wellbeing was both addressed and conceptualised in a range of different ways across studies in this area, with the link between how an intervention functioned and what it was targeting frequently unclear. In an effort to address this, the qualitative interview study reported in Chapter 4 was undertaken. Findings of this qualitative piece were considered central to decisions made about how to design and implement the intervention that this thesis was working towards. In the qualitative study, trainees described wellbeing in their roles as centrally related to connecting to their values through training. Training and work in the psychological professions was described as often challenging, but highly meaningful, and personally fulfilling; enabling trainees to connect with and pursue things which mattered to them, and to feel as though they were contributing to something about which they cared. The significance of valued action, and the central position that values, meaning and purpose had in the way that trainees described wellbeing in their roles was therefore significant in the initial decision regarding the general approach on which the intervention would be based. By drawing on the combined findings of the systematic review and the qualitative interview study therefore, it was decided that the intervention would be based on Acceptance and Commitment Therapy (ACT). It was hoped that by developing the intervention based on ACT, the

intervention would function in a way that addressed several of the issues outlined in the systematic review, by being designed to support wellbeing in terms that aligned with how trainees had themselves described experiencing it. The further ways that the systematic review informed the intervention design are discussed in depth in the intervention development study reported in Chapter 6.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is a psychotherapeutic model built on a foundation of basic behavioural and evolutionary principles (Hayes et al., 2012). It is known as one of the 'third-wave' cognitive behavioural therapies (Luoma et al., 2017), and has grown significantly in interest and popularity since the appearance of the first ACT text-book in 1999 (Hayes et al., 1999). Whilst developed and applied as a psychotherapeutic model, ACT is considered to be useful not only for the treatment of psychological distress or disorder, but rather 'as a unified model of human suffering and human resiliency' (Hayes et al., 2012). ACT is a process-driven approach, meaning that it identifies and addresses core psychological processes considered to underpin psychological functioning, rather than seeking to identify and target specific 'symptoms' of distress or disorder. It is therefore distinctly transdiagnostic, and naturally linked to positive growth and flourishing (Luoma et al., 2017). For such reasons, ACT is sometimes considered under the broad umbrella term of Positive Psychology (Howell & Passmore, 2019).

Whilst many earlier studies in the field of trainee wellbeing have focussed primarily on stress reduction and challenging the symptoms of burnout or mental ill-health, a striking finding of the interview study was that wellbeing was described by trainees less as an absence of stress or difficult internal feelings, and more as a sense of purpose, accomplishment and contribution, even despite the occasional and real stresses experienced through their work. This feature of how wellbeing was

described also aligns very closely with an ACT-based conception of psychological flexibility and wellbeing (Hayes et al., 2012). A primary goal of ACT is to facilitate an increase in the extent to which personal values are a prominent guide for behaviour, and to support an increase in values-driven behaviour, even when difficult internal thoughts or feeling threaten to get in the way of such action. As such, ACT appeared particularly well suited to supporting wellbeing in ways consistent with how trainees themselves reported experiencing wellbeing in their roles.

Whilst the findings of the systematic review reported in Chapter 3 had reported tentative support for interventions based on a range of different therapeutic approaches, and suggested therefore that the specific therapeutic approach selected may not necessarily be the most important feature for promoting positive outcomes, it was considered critical to carefully align the chosen intervention approach with the target population. Given this, it was decided that ACT would be an appropriate overall approach to base the intervention on.

Many questions about the intervention design remained (questions regarding the length and intensity of the intervention example, the mode of delivery, and the specific techniques chosen) and the ways in which wider research findings were used alongside stakeholder input to resolve these questions is described in the next chapter (Chapter 6). In the current chapter a detailed account of ACT is offered, to demonstrate its relevance to the current context, to outline its key features, and to consider its empirical support for the current context.

ACT background and underpinning theory

ACT distinguishes itself from most mainstream Western psychological models in several important ways. Central amongst these is the challenge to contemporary psychology's assimilation of medicalised models of human suffering and wellbeing (Hayes et al., 2012). In such medicalised models, health and wellbeing are considered the natural and normal homeostatic state for human beings, with illness or injury conceptualised as a deviation from that norm and a problem to be

cured. In physical health, a broken leg or a cold are both deviations from the natural state of health. Each come with a range of clearly identifiable biological or physiological symptoms (e.g. an observable break in bone, or an increase in body temperature and a sore throat or runny nose etc.). Whilst an equivalent model predominates in most current models of mental health, evidence to support the utility of such an approach in this sphere is remarkably weak, and limited progress has been made in the efforts to identify reliable biological markers of mental ill-health (Abi-Dargham et al., 2023)). Despite this, the number of disorders described and outlined in the primary classification manuals continues to expand with each new update (First et al., 2022).

Through the assimilation of the medical model into the study of psychology and mental health, unpleasant and subjective thoughts, feelings, emotions or urges have come to be conceptualised as symptoms of disease or disorder. Like the runny nose or sore throat, feelings of anxiety or distress, or thoughts of guilt, shame or self-criticism are conceptualised as disruptive aberrations from the normal state of psychological health (Hayes et al., 2012). Opposing such views, ACT proposes the *assumption of destructive normality*; a perspective from which unpleasant or challenging thoughts and feelings are considered an inherent and natural feature of human experience (Hayes et al., 2012). On this view, it is *psychologically normal and healthy* to experience difficult or unpleasant thoughts and feelings. Indeed this will be an almost inevitable feature of living a full or meaningful life, and can be considered to be a natural consequence of the way that our minds have evolved.

ACT theory details how the very same processes which account for the enormous successes of human beings, also account for much of human suffering. A central feature of the ACT model is that human language (considered in its broadest terms to include all symbolic activity) accounts for both the achievements and the suffering of human beings (Hayes et al., 2012). Human language enables us to plan, evaluate, analyse, compare and predict. Language enables us to imagine potential futures, and to learn from both remembered pasts and invented possibilities. Clearly, such capacities have enabled enormous successes and the flourishing of human beings as a species, and at an individual

level, they enable us to navigate the complex challenges and situations we encounter in our day-to-day lives. Faced with a problem, we have an incredible capacity for problem-solving. Lost in the woods and running out of food and things to drink, we can recall past advice for survival, plan ahead and conserve what little water we have left, and look out for signs of activity that might point to a trail to be followed for example. At the same time however, these same processes account for an enormous amount of human suffering. Through our capacity for language, we can worry about distant or unlikely events, go back over past mistakes long since learnt from, and compare ourselves to others or to imagined ideals. Our incredibly refined problem-solving skills – skills that work extremely well when dealing with the external world – are frequently far less useful when turned internally. A central assumption of the ACT model is that we are frequently not well skilled at telling apart the instances in which these skills are or are not helpful and as such, we regularly attempt to use these problem-solving skills to address internal 'problems' such as feelings of anxiety or unsatisfied desires (Luoma et al., 2017). We can – and often do – therefore, torment ourselves with unhelpful judgements, comparisons, predictions and beliefs, and as our propensity for language has deepened, we have come to spend more and more of our time 'in our heads'; out of direct contact with the present moment or world as it is.

Thanks to the vivid reality of our inner worlds, we can not only imagine a future threat, but we will often shape our behaviour and respond physically to this imagined event as though it were truly taking place right now. Indeed, our inner worlds can be so present and vivid, and our constant stream of thinking, planning, evaluating and comparing is so ubiquitous, that we often lose sight of the fact that we are interacting not with the world as we directly experience it, but as we make it appear to ourselves in thought (Hayes et al., 2012).

Functional Contextualism

ACT is based on a philosophy of science known as functional contextualism (Bennett & Oliver, 2019). Functional contextualism is a form of pragmatism, involving pragmatism's radical assertions regarding notions of truth and its commitment to the utility of knowledge (Gillespie, 2024). From this perspective, the search for 'timeless truths' is an illusory and futile quest, and knowledge is considered to be generated through the interaction of human beings and the world with which they interact (Gillespie, 2024). Unlike traditional correspondence accounts of truth, in which the truth of an idea is the extent to which it corresponds with an objective reality, truth here is defined in terms of utility. An often-used example relates to a house for which we have an architectural blueprint and a photo taken from the street. From the perspective of pragmatism and functional contextualism, neither the photo nor the blueprint is 'truer' than the other in any general or abstract sense (as though there were one, objective 'true' account of the house out there for us to compare against), and the truth of one or the other is dependent on its utility. Rather than asking a question of truth (in the sense of correspondence with reality) then, the pragmatist will ask a question of utility. Which of the photo or the blueprint will better serve us achieve whatever aim we are working towards? In order to locate the house on a long street of similar houses, then the photo will likely best serve the purpose. To build a replica house however, then clearly the architectural blueprint will offer the 'truer' and more useful account.

When applied to the psychological realm, the implications of this perspective for psychological functioning are significant. Rather than seeking to engage with and alter the content or *form* of a thought as many other therapeutic approaches do, ACT instead encourages a focus on shifting the *function* of the thought, by altering the relationship the individual has with the thought (Hayes et al., 2012). In the literature on stress and wellbeing in trainee psychological therapists for example, it is commonly reported that trainees report high levels of imposter syndrome (Owen et al., 2022; Richardson et al., 2020). In this context, a trainee may report having thoughts such as 'I'm not competent as a therapist' or 'everyone else is learning this better than I am'. Whilst many therapeutic

models would encourage some form of engagement with the content or form of that thought ('is it really true that you're not competent?', 'is there any evidence to suggest that you are competent?', 'what evidence do you have that others are genuinely picking this up more quickly than you?' etc.), an ACT-consistent approach would concern itself instead with the *function* of the thought. The question is no longer, 'is that true?' Rather, it becomes, 'is this thought useful?' (with 'useful' here being considered in relation to the overarching aim of ACT to increase value-driven behaviour). The question 'is this thought true?' assumes there is a single truth about this matter 'out there' in the world, against which the thought can be compared. For the functional contextualist however, there are multiple versions of truth and reality, and the question is to determine what will be useful in a particular context. As such, an ACT-informed perspective would encourage the trainee to step back and see that thought *as a thought*, rather than to see the world *through* the thought. The question can then become, 'will engaging with the thought 'I'm not competent as a therapist' as though it were some literal fact about things as they are in the world, help me to live in the way I want to in this particular situation?' In the ACT literature, the concept of 'workability' is used to describe the extent to which behaviour moves an individual towards what they value (Bennett & Oliver, 2017; Lindon et al., 2017). Engaging with the thought 'I'm not competent as a therapist' for example may lead to behavioural patterns such as avoiding opportunities for feedback or even withdrawing from training. Starting from a position where it is assumed that training as a therapist, helping others through clinical work, and developing personally are all valued ends for an individual, such behaviour from an ACT perspective would therefore be considered 'unworkable'. Whilst avoiding opportunities for feedback for example might reduce or remove some unpleasant thoughts and feelings associated with being observed by others and receiving feedback expected to be critical, it is unlikely to move an individual towards what they value. Questions regarding the 'workability' of behaviour are therefore often central to ACT, and increasing 'workable' behaviour can be considered as an important ACT goal.

To support such moves, ACT details a range of techniques and approaches for getting psychological distance from thoughts, and for promoting workability by moving towards what an individual values even in the presence of difficult thoughts or feelings.

A further central and defining feature of functional contextualism is the assertion that both function and context are essential for understanding behaviour (Bennett & Oliver, 2019). From such a perspective, the topology of a behaviour tells us little about its meaning. ACT theory observes how behaviour never occurs within a vacuum; rather it always takes place within a specific context (a psychological as well as cultural and situational context) and with a specific function (even if the function is not immediately observable to others). To understand any given behaviour therefore, an understanding of its function and context are required. An important and interesting consequence of this perspective is that seemingly unrelated behaviours can come to be grouped together in functional classes. To give an example relevant to the topic of this thesis, we can see how the use of deflective humour in a supervision session, avoiding being observed by colleagues in a clinical skills simulation activity, or spending an inordinate amount of time over-preparing for a presentation could all be considered to be functionally equivalent behaviours – all intended to avoid or minimise feedback predicted or previously experienced to be aversive. To understand any of those behaviours, an understanding of the function and the context are required. Indeed, both function and context are themselves deeply related. The function of the behaviour (to avoid feedback) is intimately connected to the behavioural context (a training environment experienced as replete with evaluation, a personal learning history in which feedback has been experienced in particular ways etc.). The meaning of any of those behaviours therefore simply cannot be understood without taking account of this full picture, and thus in ACT and functional contextualism, the interest is always in the whole act-in-context (Bennett & Oliver, 2017).

The ACT model of psychological flexibility

At the heart of the ACT approach, is a model of what is termed 'psychological flexibility'. Psychological flexibility is the outcome of six interrelated processes, posited by ACT research to account for human flourishing and positive psychological functioning. ACT's model of psychological flexibility is useful then at least in part, as it explains the processes that underpin not only psychological distress and dysfunction, but also psychological wellbeing and adaptability (Hayes et al., 2012). Given this, and unlike many other psychotherapeutic approaches such as 'second wave' CBT, ACT focuses not on identifying and removing symptoms of particular disorders, but on targeting the psychological processes posited to underpin all aspects of psychological functioning.

Psychological flexibility is described as resulting from the interaction of six core processes; defusion, acceptance, flexible attention to the present moment, self-as-context, values, and committed action (Hayes et al., 2012). Psychological flexibility's opposite – psychological *inflexibility* – is similarly seen to be underpinned by the inverse of those processes: cognitive fusion, experiential avoidance, inflexible attention to the present moment, attachment to a conceptualised self, disruption of values, and inaction, impulsivity and avoidant persistence. ACT theory and evidence indicate that psychological inflexibility is associated with increased psychological distress and suffering, whilst psychological flexibility is associated with wellbeing and higher quality of life (Ong et al., 2024; Yao et al., 2023).

In what follows, I further outline these six core processes, and provide examples that link them to the topic of this thesis:

Acceptance/experiential avoidance: Acceptance in an ACT context is not simply tolerance or a resigned, passive form of accepting. Acceptance is an active movement; a willingness to experience and 'make room' (Harris, 2008) for difficult thoughts and feelings, in the service of

moving towards personally meaningful values. Experiential avoidance describes how unpleasant thoughts and feelings (such as anxiety about an upcoming clinical assessment, or self-critical thoughts about one's ability to perform well in an upcoming supervision session) are often avoided, dampened or sought to be removed. Through acceptance however, such thoughts and feelings are seen as part of human experience, and accompanying features of living a vibrant, stimulating and values-driven life. Experiential avoidance is to a large extent a natural consequence of our human capacity for language and higher order cognition. Our ability to compare, contrast, problem-solve and remove unwanted events and stimuli that works so effectively in the external world, becomes problematic when turned to the inner world, leading to futile and unhelpful attempts to remove thoughts and feelings experienced as aversive (Luoma et al., 2017). Acceptance on the other hand implies both behavioural willingness (e.g. a willingness to approach that clinical assessment even in the face of difficult thoughts and feelings) and psychological acceptance (a stance through which we adopt an open, non-judgemental and observing attitude towards such internal content) in the service of increased behavioural and psychological flexibility.

Defusion/Fusion: Defusion is an invented construct to describe *de*-fusing with internal content such as thoughts, feelings, urges and emotions. When fused, entangled or bound up with thoughts, the world is seen *through* those thoughts; as though what the thought represents is exactly what is says it is, and is something about the world, rather than a perspective constructed by the mind. The concept of cognitive fusion has been likened to a pair of sunglasses that an individual has forgotten they are wearing (Luoma et al., 2017). An individual who has forgotten that they are wearing glasses in this way sees the world coloured through the glasses, but has become unaware of this fact, experiencing things as though this was the world as they directly encountered it. In cognitive fusion too, one sees and interacts with the

world as it is presented through thought, whilst missing out on direct experience with the world and losing sight of the fact that what is being experienced is in fact the world as it is being constructed and described in thought. Defusion then is the process through which one becomes aware of the sunglasses; noticing the difference between encountering the world as it appears through the glasses, and the moments in which the glasses are removed. When a trainee for example is fused with the thought that 'I will fail this exam', the thought appears as though it is something the individual has discovered 'out there' in the world; a fact about the way things are, rather than a thought generated by the individual about a particular situation. When fused with a thought in this way, the individual removes themselves from actual present moment experience; interacting not with the world, but rather their thoughts about it. This is a central feature of cognitive fusion; the tendency to get so caught up in the inner world of our thoughts that we lose contact with the present moment and other direct forms of experience (Luoma et al., 2017). Such fusion can lead to a narrow and rigid set of behavioural responses: *given that* 'I will fail this exam' for example, there is little point in trying, or I should find a way to avoid it, etc. Through defusion, techniques are sought to help provide some psychological distance between the individual and the thought: seeing thoughts *as thoughts*. In so doing, the function of the thoughts can be altered, without addressing their content or getting caught up in questions about whether they are 'true'. The thought 'I will fail this exam' is no longer something definitive and demanding of all attention, or something that must guide behaviour in a narrow and rigid way. Rather than describing the world as it is, it is recognised as a product of the mind of the individual, a thought, and something which one can respond to in myriad different ways.

Flexible attention to the present moment/inflexible attention to the present moment: Responding flexibly to situations requires an ability to engage with attention to the present

moment, and to acknowledge and pay attention to what is going on around and inside us, in an open and non-judgemental way. Everything takes place in the present moment, but through our capacity for language and higher order cognition, human beings spend large amounts of time in 'mental time travel' (Flaxman et al., 2019), worrying about imagined futures and ruminating about remembered pasts. As with everything in ACT, such mental time travel is not inherently bad (our capacity to plan ahead, to imagine things that don't yet exist, or to replay things from the past are central to our ability to be creative, to invent, to tell stories, and to plan for the future etc.). However, frequently, such cognitive activity *is* unhelpful, in the sense that it interferes with values-based action by leading to narrow and rigid behavioural responses and taking us away from contact with the actual present moment. When caught up in imaginings about the future, or going over things from the past, behavioural responses become governed by conditioned responses or what has happened previously (Luoma et al., 2017). When elsewhere in our minds, we lose contact with the present moment, becoming less aware of our experience of the here and now. We also then lose contact with the contingencies of in-moment experience. The trainee who is entering a recorded clinical session with a patient whilst caught up in worries about an imagined future in which their work is failed, is less aware of their present moment experience. They are less able to connect with how they feel in the moment or the way in which that is influencing what they are doing. Similarly, they are less aware of even what the patient in front of them is saying. Their behaviour in the moment then becomes less directed by present moment experience (the words of the patient, the experience of the trainee in that moment) and more by a drive to fulfil some future goal or to avoid some imagined and aversive future outcome.

Self-as-context/attachment to a conceptualised self: As we grow and develop, we inevitably develop stories about ourselves, to describe and account for who we are. 'I am a hard-working

person', or 'I am shy' are descriptions we can give to ourselves (or pick up from others) that appear to describe the *content* of who we are. 'I am a hard worker because my mother was' or 'I've always been a perfectionist because I picked it up from my father' also give an account for *why* we are as and who we are. Society requires us to give reasons for our behaviour and to act in relatively predictable ways, and so these stories about the content of who we are can clearly be helpful in certain situations (Bennett & Oliver, 2019). Such stories support us being consistent, predictable and knowable to ourselves and others; they can give us an important sense of self. In keeping with ACT's pragmatic stance however, their utility is contextually dependent and such self-stories can – and often do – also have a limiting and unhelpful effect. When fusing with a conceptualised self, an individual can feel compelled to act in ways to maintain the consistency of that self-story, even when doing so is unhelpful (Hayes et al., 2012). When saying that *I am* (e.g.) shy, an individual limits themselves, closing off particular forms of behaviour in a variety of contexts (e.g. speaking up in a social situation, even when it would be in their best interests to do so). By equating 'I' with 'shy', an individual sets the limits of what they would or could do in any circumstances, limits outlined by the notion of shyness. As such, from an ACT perspective, self-stories are best held 'lightly', in a flexible and responsive way (Bennett & Oliver, 2019). Importantly of course, people also hold innumerable stories about themselves, and the way an individual might answer the question 'tell me a little about yourself' would differ drastically depending on who is asking the question and under what context (Hayes et al., 2012). Such observations helpfully demonstrate how much of the time, we do indeed hold multiple self-stories in a flexible or contextual way (at work I am hard-working and polite, with friends I am adventurous, with my children I am playful, and when playing football I am creative or a good team player, etc.). As against a rigid attachment to a conceptualised self, ACT encourages the development of the awareness of what it calls self-as-context. This self-as-context perspective enables us to see ourselves as the context – or 'container' – within which our thoughts, feelings, memories and urges take place. Rather than

being solely what my thoughts, experiences, urges and memories say, I am *the context or container in which these thoughts, feeling and memories are experienced*; the 'sky' across which the clouds play out (Hayes et al., 2012).

Values/disruption of values: Contact with values is a central feature of the ACT model, and something which distinguishes it from many other therapeutic approaches (including approaches within the cognitive-behavioural tradition) (Hayes et al., 2012). As such, significant efforts are given both to clarifying personal values, and identifying ways in which values-driven action can be increased. Values are variously defined, but in ACT terms are usually considered things you can *do* (Harris, 2008), and things which are *constructed* by the individual (rather than 'discovered' as though they were always there in waiting) (Hayes et al., 2012). Whilst culture and upbringing inevitably have a significant influence on an individual's values, ACT is interested in establishing what matters to a particular individual, rather than what a society or culture suggests *should* be important. In keeping with these features, values in ACT have recently been defined as 'personally meaningful qualities that an individual expresses in their daily behaviour' (Flaxman et al., 2019). Connection with and embodiment of such values is considered to be central to a full and vibrant life.

Committed action/inaction, impulsivity, persistent avoidance: Without values-driven action, values risk being simply abstract words on a page, or ideas of little significance. A full and vibrant life requires bringing values to life through our actions, and this requires behavioural activation and committed action. Committed action has been described as the 'antidote to the repertoire-narrowing effects of cognitive fusion and experiential avoidance' (Hayes et al., 2012). It is the commitment to live out and embody a set of freely chosen values, contacting

those values through present moment behaviour. As the opposite to committed action, 'inaction, impulsivity and persistent avoidance' describe the consequences of behaviour regulated by experiential avoidance, cognitive fusion, inflexible attention to the present moment, lack of clarity about values and rigid attachment to a conceptualised self. In such instances, behaviour designed to maintain a coherent self-story or avoid discomfort for example can predominate, significantly narrowing the range of behavioural responses considered. The trainee determined to avoid feelings or thoughts experienced as aversive, or to maintain the self-story 'I am a competent person' for example, comes to regulate their behaviour in the service of these ends, rather than seeking to move towards their values (Luoma et al., 2017). To minimise or avoid unpleasant feelings of anxiety, and to seek to protect that self-story of competence, avoiding opportunities to be observed working clinically by a supervisor may be a logical course of action. However, such behaviour is highly likely to take the individual away from the values (perhaps of learning, helping others, or personal development) that may have attracted them to the profession in the first place. Committed action then requires taking positive steps towards and alongside one's values, even in the face of difficult internal content.

It is worth reiterating that in the model of psychological flexibility described above, all processes are ultimately considered to be in the service of increasing values-based action. This is important, as it emphasises that defusion, acceptance, contact with the present moment, and self-as-context are not seen as ends in themselves; ACT does not propose defusing from difficult thoughts or adopting an accepting attitude towards them simply for the sake of it. All such action is undertaken in order to increase values-based action. In keeping with ACT's pragmatic stance and its philosophy of functional contextualism, it is also noteworthy that the processes underpinning psychological flexibility are not considered inherently 'good' regardless of context (and neither are the processes underpinning

psychological inflexibility considered inherently 'bad' in the abstract either). When writing an essay or completing a complicated puzzle for example, fusion is helpful. Hayes and colleagues give an example of an emergency nurse working in a busy A&E department where experiential avoidance too enables an individual to prevent the emotions of a situation interfering with their ability to do what is needed in a moment of urgency (Hayes et al., 2012). Similar such examples can easily be brought to mind for a psychological therapy trainee too (e.g. when working with a client in an acute moment of distress).

The same can be said for all the processes in the model; the function and context will determine their utility, and whilst the processes of psychological flexibility are generally considered essential to the effective living of a full and valued life, this does not mean that there will never be moments or instances in which any one or other of the inflexibility approaches may also help to serve the purpose of living in accordance with ones values.

As can be seen therefore in the account given above, ACT presents a model of psychological functioning that emphasises values-driven action, that makes room for the inevitable existence of difficult or unpleasant thoughts and feelings when living a full and valued life, and which encourages both present moment awareness and a broader conceptualisation of the self. Following from the findings of the qualitative interview study reported in this thesis, these features of the ACT model render it well suited for supporting trainee wellbeing. As described more fully in Chapter 4, trainees described the experience of wellbeing as being centrally concerned with feeling connected to important personal values, and to moving towards such values at the same time as acknowledging the inherent challenges associated with some aspects of their roles. Trainees described some of the challenges (self-doubt, worry, imposter syndrome and so on) that they experience in their roles, and spoke in detail about how connecting with their values and pursuing things of meaning to them defined their experience of wellbeing in the role. Whilst some of the external and inherent

challenges of training as a psychological professional will obviously remain unchanged by any psychological intervention, ACT provides a framework for increasing the extent to which trainees may feel able to move towards their values a little more often in that challenging context.

In the final section of this chapter, I conclude with a consideration of the evidence-base for ACT.

The evidence-base for ACT

On the basis of extensive meta-analytic evidence, ACT appears to be an effective treatment for a range of psychological and behavioural difficulties (Gloster et al., 2020). Existing evidence suggests that it is superior to inactive controls and most active controls, and that it performs at least as well as CBT in regards to a range of psychological difficulties such as depression and anxiety, as well as regarding transdiagnostic difficulties (Gloster et al., 2020).

In keeping with ACT's focus on improving positive functioning (over and above the simple removal of negative symptoms of distress (Hayes et al., 2012)) ACT has also been found to be effective at increasing positive wellbeing (van Agteren et al., 2021). This latter finding is important, and is in keeping with the theoretical underpinnings of the ACT model. Whilst in the large meta-analysis referred to above (van Agteren et al., 2021) CBT was found to be effective only at improving wellbeing in clinical populations (a finding which aligns well with the disorder-specific and symptom-removal based foundations of CBT), ACT was found to improve positive wellbeing consistently across both clinical and non-clinical populations.

Whilst these findings are promising, it is important to acknowledge a number of important criticisms about the existing ACT literature, and to keep in mind that further well controlled and high-quality studies are still required to develop the evidence base further. Whilst many of the central criticisms levelled at ACT (e.g. an over-reliance on the output of researchers aligned with ACT, a conceptually loose use of key terminology, and a large number of underpowered trials) are not unique to ACT, they nonetheless represent important issues for consideration by future ACT researchers. Several

authors have noted for example how despite the relatively advanced state of some aspects of the ACT literature, many of the central ACT processes and terms remain poorly defined (O'Donohue, 2023). The poor conceptual clarity of processes such as acceptance, psychological flexibility or values for example mean that measurement of these constructs can be considered unreliable, and some of the measures used most commonly in earlier iterations of ACT research (e.g. the Acceptance and Action Questionnaire (AAQ) and the Acceptance and Action Questionnaire – II (AAQ-II)) have been criticised on these grounds (O'Donohue, 2023). Further, given the significant emphasis on function and context in ACT, others have argued that the reliance on static, self-report measures (e.g. regarding the way that one typically acts or responds to unpleasant feelings) which by definition do not capture context and function, may be problematic (Kashdan & Rottenberg, 2010). Despite such criticisms, the ACT literature continues to expand and develop, and researchers in the field are seeking new and further ways to render the ACT evidence-base more robust. One of the ways that researchers have sought to do this is through the introduction of new measures for assessing psychological flexibility, such as the CompACT (Francis et al., 2016) and the Multidimensional Psychological Flexibility Inventory (MPFI) (Rolffs et al., 2018)). The contribution made to the literature by the MPFI may be especially important, for the way that it has drawn attention to important issues regarding the conceptualisation and measurement of ACT processes. Across three related studies, Rolffs and colleagues identified evidence to suggest that flexibility and inflexibility are related but distinct constructs (Rolffs et al., 2018). They found only modest correlations and relatively small proportions of shared variance for example between the sets of flexibility and inflexibility subscales, suggesting that flexibility and inflexibility are not (as they have sometimes been conceptualised as being) simply the opposing ends of a continuum, but rather two distinct but related continua (Rolffs et al., 2018). In the CompACT for example, psychological flexibility is inferred by reverse scoring negatively valanced items (Francis et al., 2016), but the findings of the work undertaken in developing the MPFI caution against this. The MPFI therefore has important implications for how psychological flexibility is understood, and also how the effects of ACT interventions should be

assessed. According to the findings of Rolffs and colleagues, an individual may be low on fusion for example, without necessarily being high on defusion. Similarly, an intervention that succeeds in reducing experiential avoidance in an individual, should not simply be assumed to have automatically increased acceptance (Rolffs et al., 2018). These are important conceptual distinctions and developments which evidence an evolving and increasingly advanced understanding of key ACT processes and which will therefore support the development of the ACT evidence-base for the future.

Applications of ACT in occupational and educational settings

In recent years, ACT has been used in a range of workplace and educational settings, including those based in healthcare and higher education. A 2019 review published in the *Journal of Happiness Studies* found that whilst further work was needed to understand the effects of ACT on the wellbeing of undergraduate students in more detail and with greater confidence, existing evidence does indicate that ACT can perform well to support wellbeing in this population (Howell & Passmore, 2019)). In workplace settings, several recent systematic reviews have found support for the value and effectiveness of ACT interventions for supporting workplace wellbeing, and reducing staff burnout and psychological distress (Prudenzi et al., 2021; Towey-Swift et al., 2023; Unruh et al., 2022). Notably, across these reviews, findings appeared to suggest that whilst ACT interventions appear useful for those working in the health and social care field (Towey-Swift et al., 2023), the findings regarding ACT's effectiveness appear more robust for those working in office-based roles (Unruh et al., 2022)), a finding which the authors suggested may relate to the often objectively challenging circumstances that health and social care workers operate within. As such, researchers in the field have suggested that ACT interventions designed for those working in health and social care may benefit from being longer and more intensive than the 3-session model commonly used in workplace settings (Unruh et al., 2022), a finding that was carefully considered in the design of the intervention at the heart of this PhD.

Chapter 6: Developing a psychological wellbeing intervention for psychological therapy trainees: a collaborative and theory-informed intervention development process

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Abstract

Background: There is recognition of the need to design wellbeing interventions in contextually sensitive ways, and report systematic, theory-driven approaches to intervention development. However, many intervention studies in the burgeoning literature on psychological professional trainee wellbeing do not include information on processes or theory surrounding the development of interventions tested.

Methods: This theory- and stakeholder-informed intervention development study was guided by the MRC framework for developing and evaluating complex interventions (Skivington et al., 2021) and underpinned by the COM-B model of behaviour change (Michie et al., 2011). Evidence and theory were used to support an initial intervention outline. Meetings were subsequently held to gather stakeholder perspectives, to address unknowns of intervention design, and to support development of a theory of change.

Results: Stakeholder (trainees and professional training staff) perspectives and relevant theory were used to inform the design of an Acceptance and Commitment Therapy (ACT) based intervention, to address key stressors experienced by trainees. The intervention was delivered in a group setting, over the course of 4 sessions spaced 1-3 weeks apart. Collaboratively constructed COM-B analyses identified target behaviours and shaped intervention design. A comprehensive theory of change was developed, outlining key assumptions and setting out hypothesised pathways of change.

Conclusions: An evidence-informed ACT-based intervention for psychological professional trainee wellbeing has been developed with key stakeholder collaboration. An acceptability and feasibility evaluation of this intervention is underway.

Keywords: Behaviour change, Intervention development, Wellbeing, Psychological Professional Trainees

Key Learning Aims:

1. To understand the processes through which a tailored wellbeing intervention for psychological professional trainees was developed in collaboration with key stakeholders
2. To consider how an Acceptance and Commitment Therapy (ACT) based intervention was adapted to address specific challenges encountered by psychological professional trainees
3. To understand the pathways through which an adapted ACT intervention is anticipated to support trainee wellbeing

Introduction

Psychological professional trainees (PFTs) frequently report poor wellbeing during training, with evidence suggesting that many experience burnout even before entering the qualified workforce (Owen et al., 2021; Pakenham & Stafford-Brown, 2012). Excessive stress and burnout impact negatively on several outcomes relevant to PFTs, including academic learning (Pascoe et al., 2020), clinical effectiveness (Delgadillo et al., 2018), and both professional and academic conduct (Barnett et al., 2007; Tindall et al., 2021).

In the UK, recent years have seen significant expansion both in the number of psychological professionals in the workforce, and the number of distinct psychological professional roles (Kell & Self, 2024). Psychological professions in England are classified into a taxonomy of 21 roles, comprised of psychologist (e.g. Clinical Psychologist), psychological therapist (e.g. Cognitive Behavioural Therapist), psychological practitioner (e.g. Psychological Wellbeing Practitioner), and associate or assistant (e.g. Clinical Associate in Psychology) roles (Whittington, 2024). Psychological professional trainees undertake a wide variety of work. Whilst many are trained to work primarily according to a Cognitive Behaviour Therapy (CBT) framework with regards to their clinical work, there is significant variation between the expectations and responsibilities of the different groups, and the requirements of their training. Psychological Wellbeing Practitioners for example are typically employed in a single service throughout their training, and are trained to deliver a relatively circumscribed set of low-intensity CBT interventions in NHS Talking Therapies services (NHS England, 2025). Clinical psychologists on the other hand receive a broader training across a range of therapeutic modalities, move between multiple placements across the training period, and are also trained in developing skills in leadership and research (Rosairo et al., 2023). Nonetheless, a range of evidence indicates significant overlap across psychological professions when considering the challenges faced in training. For example, challenges associated with self-doubt or imposter syndrome, the responsibility of clinical work, or holding dual roles as a student and mental health

practitioner concurrently have been reported in trainees across psychologist, therapist and practitioner roles (e.g. Owen et al., 2021; Pakenham Stafford-Brown 2012, Richardson 2020).

Psychological professional trainees are often in a first professional role and are typically young, with over half of the psychological professional workforce aged under 40 (Whittington, 2024) and over half of applicants to Clinical Psychology doctoral training programmes aged between 25 and 29 (Applicants & Acceptances, 2021). Importantly, poor wellbeing during training and beyond has been associated with high staff turnover (National Collaborating Centre for Mental Health, 2018) and an increased intention to leave the NHS amongst psychological professionals (Summers et al., 2021). Therefore, interventions to support trainee wellbeing and encourage flexible, adaptive approaches to work have the potential to be of significant value.

In a recent systematic review, we evidenced that interventions and teaching strategies for supporting trainee wellbeing can be effective and are valued by trainees themselves (Owen et al., 2025). However, studies in the field were heterogeneous and of mixed-quality. Few studies had a clear theoretical underpinning or rationale for why and how the intervention would be effective in the given population, and few outlined how the intervention had been tailored for the population of interest. These are important short-comings, with several researchers cautioning against attempts to improve wellbeing without first considering what it means to the target population (Annas, 2004; Fave et al., 2016), or designing interventions without consideration of how they might function in the specific context (Hamling et al., 2020; Skivington et al., 2021). In this paper we develop a stakeholder and theory-informed intervention with a clearly articulated theory of change, to fill an important gap in the literature.

The COM-B model (Michie et al., 2011) provided the underpinning theory of behaviour and behaviour change, and key stakeholders (psychological professional trainees and professional trainers) were involved throughout. The intervention development process built on findings of earlier research led by the current research team and others, and conducted with trainees across multiple

psychologist, psychological therapist and psychological practitioner professions. The wider literature regarding the nature and causes of poor wellbeing during training (e.g. 'imposter syndrome' and perfectionism (Jones et al., 2017; Richardson et al., 2020)) was also carefully considered, to ensure that the intervention could be designed to address known challenges experienced by trainees.

Careful consideration was given to understanding how the intervention would function in the context for which it was designed. In keeping with findings from the systematic review (in which lack of adaptation of interventions to the trainee context functioned as a barrier to intervention success (Owen et al., 2025)) consideration was given to what trainees would know, what they might want or need from an intervention, and how this would fit in alongside their wider training in a hybrid clinical/university setting. Finally, in keeping with relevant guidance and recommendations (Skivington et al., 2021) a programme theory for the intervention was articulated early in intervention development, and refined throughout the intervention development process.

Study objectives

The objectives of this study were to design a psychological intervention intended to support wellbeing in psychological professional trainees, using an underpinning theory that matched PFTs experiences of wellbeing.

Key research questions addressed throughout the study process were:

1. How to design an intervention that builds on existing evidence and supports the wellbeing of PFTs?
2. What do key stakeholders (current trainees, and professional trainers working on training programmes) consider most important in intervention design?
3. What would be the theory of change for an intervention designed for this purpose?

Method

Ethical approval

Ethical approval for this study was sought and obtained via the Faculty Research Ethics Committee (REC) at the primary researcher's employing institution.

Design

This theory and stakeholder-informed intervention development study was guided by the MRC framework for developing and evaluating complex interventions (Skivington et al., 2021). The research was underpinned by a worldview of pragmatism (Gillespie, 2024), with an emphasis on 'doing what works' to answer the questions of the research in a practically useful manner (Creswell & Plano Clark, 2018). The study proceeded in a pre-determined manner set out in a study protocol.

Intervention development and design

Drawing on findings from our research regarding interventions designed to support trainee wellbeing (Owen et al., 2025) and how psychological professionals thrive in their roles (Vivolo et al., 2024), a decision was made by the primary researcher to base the intervention on Acceptance and Commitment Therapy (ACT) prior to stakeholder involvement (Hayes et al., 2012). Although some evidence of effectiveness was found for interventions based on a range of therapeutic approaches including Mindfulness, Wellness Plans, CBT, Stress-Management workshops, ACT and more (Owen et al., 2025), ACT was selected for this study to establish a strong theoretical rationale for the intervention and close alignment between how wellbeing is conceptualised by the intervention approach and the target population. In several of our earlier studies with psychological professional trainees and qualified staff, connecting with and embodying personal values has been described as central to wellbeing and positive functioning in the role (Vivolo et al., 2024). Additionally, trainees

and professionals across the psychological professions have described how 'imposter syndrome' (Owen et al., 2021), perfectionism (Richardson et al., 2020) and self-criticism (Jones et al., 2017) are barriers to enjoying and performing fully in their roles. Since ACT emphasises moving towards what people value even in the face of difficult internal thoughts and feelings, and takes a normalising and non-pathologizing stance towards such thoughts and feelings (Hayes et al., 2012), ACT was considered to be a strong fit for this population, and a therapeutic approach for which there was a strong theoretical rationale. We also decided to incorporate some elements of Compassion-based approaches, since compassion-based ideas had also shown some evidence of effectiveness in our review, and appeared well-suited to supplementing efforts to address the common trainee issues of self-criticism and perfectionism (Jones et al., 2017; Richardson et al., 2020). Further, drawing from our systematic review, it was also decided that the intervention would include choice for trainees, that it would be experiential, delivered in a group format, and tailored specifically to the context of PFTs, given the ways in which these features had been identified as facilitators of intervention success (Owen et al., 2025). As an inherently experiential approach, with a wide-range of techniques that would facilitate options and choice for trainees, ACT was considered a useful model for the intervention.

Whilst these theory and evidence-informed decisions provided the guiding structure for the intervention design, the detail and form of the intervention was shaped throughout subsequent stakeholder meetings. To ensure that stakeholder time was used most effectively, stakeholders were involved early, but after the decision to use ACT had been taken. This decision was based on the findings of our review which had suggested that whilst multiple therapeutic approaches could be effective in this population, intervention implementation issues were central to their efficacy. Given the strong theoretical rationale for selecting ACT described above, stakeholder input was prioritised for informing the important contextual details (such as where and when to offer the intervention, intervention length, and how particular ACT tasks might be received) that the review had identified

as influential for intervention effectiveness. An outline of this process is presented in Figure 1. In keeping with MRC guidance, a programme theory for the intervention was outlined early in intervention development, and subsequently refined throughout through stakeholder input (Skivington et al., 2021). Details of how the stakeholders were involved are outlined below.

Theory of behaviour

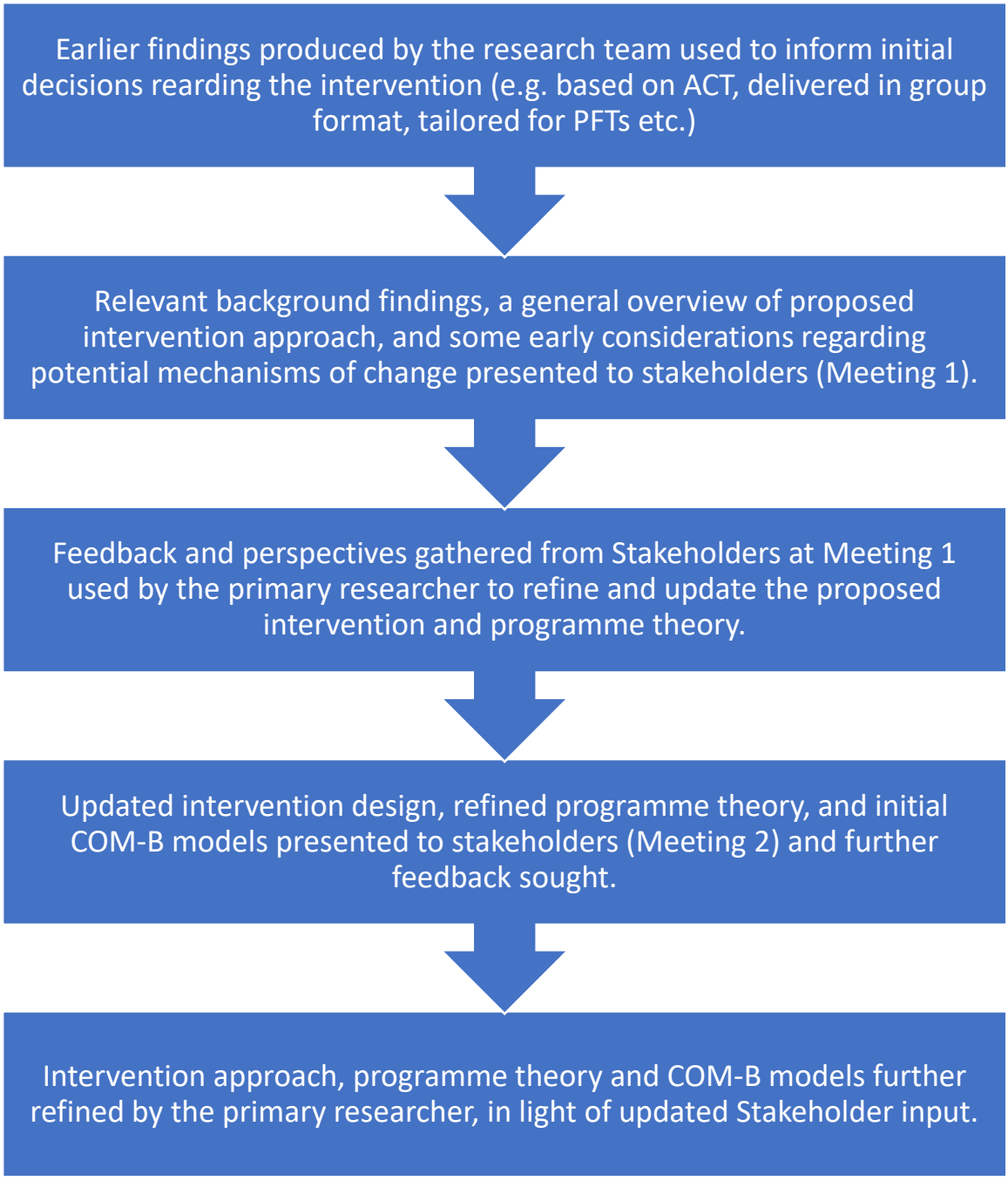
The COM-B model (Michie et al., 2011) was used to provide an underpinning theory of behaviour and behaviour change for this study. The model describes how behaviour (B) is the result of an adequate combination of capability (C), opportunity (O), and motivation (M) to perform that given behaviour. In the model, capability, opportunity and motivation can be further divided into two. *Capability* includes both *physical* and *psychological* (knowledge and understanding) capability to perform a particular behaviour. *Opportunity* refers to anything external which facilitates, impedes, prompts or makes the behaviour possible. Opportunity is conceptualised as being comprised of both *physical opportunity* (e.g. the environment in which one operates) and *social opportunity* (e.g. the social and cultural context which constrains or facilitates behaviour). *Motivation*, defined by Michie and colleagues as 'brain processes that energise and direct behaviour' (Michie et al., 2011, p.4) encompasses both *automatic motivation* (e.g. impulses, habits, and emotionally driven behaviour) and *reflective motivation* (e.g. conscious volition, choice and intention).

Michie and colleagues have noted how behaviour change interventions are frequently designed without paying sufficient attention to the target behaviour, the target population, or the context in which the intervention will be delivered (Michie et al., 2011). During intervention development, the COM-B model was used as an underpinning model of behaviour, and conceptual framework for thinking about the factors that might impede or facilitate the desired behavioural change.

To minimise requirements on participants (trainees and professional trainers) contributing to the co-production of this intervention, participants were not required or expected to be familiar with COM-B before joining the study, and the model was not used to constrain or actively direct discussions. However, the primary researcher was consistently using this model to organise and systematically shape thinking about how the intervention should function. In practice, this included writing detailed notes following each intervention development meeting regarding ideas that had been discussed relevant to future participants' capability, opportunity and motivation to enact the target behaviours. It also meant discussing with stakeholders about what target behaviours needed to be.

Throughout intervention development, the COM-B model was also used to identify potential barriers to implementing an intervention, and to map factors that might facilitate or impede the behaviour change necessary for such an intervention to work. Consequently, the COM-B model in this study was used in a deliberate and contained manner, promoting a systematic and theoretically-underpinned approach to the design of the intervention, but without relying on the extensive resources or range of choices that the associated Behaviour Change Wheel has been criticised for requiring (Webb et al., 2016).

Figure 1. Overview of then intervention development process



Setting

The research was conducted at a university in England with a well-established portfolio of applied training programmes in clinical psychology and psychological therapies.

Participants and recruitment

A group was convened using purposive sampling from current psychological professional trainees, and professional trainers employed to teach on psychological professional training programmes at the primary researcher's employing institution. Staff from a departmental wellbeing interest group were invited, given their interest and experience in the area. Student reps from across all five different psychological professions trained at the participating university were invited, to promote gathering of a diversity of perspectives that covered training pathways and academic levels. A total of ten participants were invited and agreed to participate. Two trainees (one PWP trainee and one High-Intensity CBT trainee) withdrew shortly before beginning due to clashes with academic workload, meaning a total of 8 participants took part in the two meetings. For both meetings, 3 participants were current trainees, and 5 were professional trainers. Participants included 6 females and 2 males, aged between 26-35 (n=2), 36-45 (n=3), 46-55 (n=2), and 56-65 (n=1). Participants described their ethnicity in terms aligned to the Office for National Statistics (ONS) categories of Asian/Asian-British, Black/African/Caribbean/Black-British, Mixed/Multiple Ethnic Groups, and White. A total of two participants reported following a religion, and seven reported having no disability. Participants were associated with a range of psychological professions (as either trainees or staff), including Clinical Psychology (n=3), Clinical Associates in Psychology (n=2), High Intensity Therapy (n=1), and Psychological Wellbeing Practitioners (n=2). For pragmatic reasons, meetings were hosted by the primary researcher, a Programme Director for a psychological practitioner training programme running in the university in which the research was carried out. In recognition of

the dual roles played by the primary researcher (as staff member, researcher, and intervention lead) efforts were made throughout all stages of the research (including in recruitment materials and during intervention development meetings) to promote an environment which facilitated open discussion and reduced power imbalances. Participants were encouraged to speak freely and were reminded that there were no particular answers being looked or hoped for.

Meetings

Following the Intervention Development protocol, two rounds of meetings (each 2-hours) were held. To maximise stakeholder input, meeting 1 was planned in the early stages of formulating ideas about the intervention. Meeting 2 took place approximately two months after Meeting 1. This was deliberate to allow the primary researcher time to work-up ideas following Meeting 1, building from stakeholder's earlier involvement. To facilitate involvement from busy and full-time employed staff and trainees, multiple time slots were offered for each round of meetings. Three iterations of Meeting 1 were held (attended by two or three participants each time), and 2 iterations of Meeting 2 were held (with five participants attending the first iteration, and three the second).

The purpose of meetings was to gather stakeholder perspectives on intervention design. Where contrasting perspectives were presented these were explored through discussion where possible, and the primary researcher balanced multiple perspectives against wider literature during intervention design. The primary researcher made extensive use of note-taking and reflection, and immediately after each meeting, wrote out and reflected on ideas raised, examining how ideas put forward related to each other, and to wider published literature. A record of notes was maintained to promote transparency of process.

Meeting 1

What was done	**Why this was done**	**Details of how this was done**
Primary researcher presented earlier findings, and a broad sketch for an intervention that aligned with these.	To provide participants with context for what was being proposed.	Brief verbal outline given of earlier research findings used to inform initial ideas for the intervention.
Pre-determined list of questions was used in a flexible way to gather feedback on: - The research presented, and the general outline for a proposed intervention. - What participants would want from an intervention designed to support trainee wellbeing, how it could be designed to appeal most strongly to trainees, and how it could be developed to accurately meet their needs. - Participant views regarding what the target behaviours of the intervention should be, and what might impede or facilitate success with these behaviours (COM-B).	To ensure that stakeholder perspectives were gathered in a systematic and structured way, in relation to a range of matters relevant to the intervention design.	The questions used to structure this information gathering can be found in Supplementary Material 1 – Questions and activities used for Meeting 1.

The proposed (and at this stage, under-developed) programme theory and logic model was described to participants, and views on this were gathered. Throughout, the primary researcher used the COM-B model as a conceptual framework for thinking about the views shared by participants.	To ensure stakeholder perspectives on the proposed theory of change were sought, and incorporated into future iterations of this.	Initial ideas regarding a proposed theory of change were presented verbally and visually.

Meeting 2

What was done	**Why this was done**	**Details of how this was done**
A comprehensive description of the challenges the intervention was intended to address (i.e. the known stressors identified in the literature) and an account of how and why this proposed intervention would address each challenge was presented to participants.	To provide participants with a detailed overview of the specific challenges the intervention was expecting to address, and the rationale for how the intervention was expected to address them; helping to support the rationale of the proposed theory of change.	A brief review of the literature on trainee wellbeing was presented, detailing identified trainee stressors, and hypothesised ways of addressing them.

For each target behaviour, a COM-B analysis constructed by the primary researcher to reflect the views shared by stakeholders in Meeting 1 was presented to participants.	To present and gather feedback on ideas regarding what might influence trainees' capability, opportunity and motivation to carry out core intervention behaviours.	Summaries of content described in Meeting 1 as relevant to trainee capability, opportunity and motivation were presented and discussed with stakeholders.
Examples of resources (e.g. ACT-based handouts, activities and the recruitment flyer) were shared with participants, with views and feedback sought.	To seek feedback on specific materials that had been designed for the intervention, and increase the chance that finalised resources were then acceptable and engaging for the target population.	Examples of these resources are included in Supplementary Material 2A (Adapted Passengers on the bus handout) and 2B (Therapist Self-criticism handout).
Pre-defined questions and small group discussions were used in a flexible way to encourage participants to reflect on what had been shared, feedback on it, and help to further refine the ideas presented.	To ensure that stakeholder perspectives were gathered in a systematic and structured way, in relation to a range of matters relevant to the intervention design.	The questions used to structure this information gathering can be found in Supplementary Material 3.

Results

As a result of the systematic and theory-informed process described above, an ACT-based group intervention for psychological professional trainees was developed in collaboration with key stakeholders. Key target behaviours were identified in collaboration with stakeholders, and a COM-B analysis formulated.

COM-B

In the tables below, the COM-B analyses developed over the course of the two meetings are presented. Through discussion with stakeholders, two separate target behaviours were identified: (1) attend the ACT-based wellbeing workshop, and (2) engage with between-session practice of ACT techniques, and factors that may influence capability, opportunity and motivation to carry them out were outlined. These factors reflect the contributions of stakeholders, and were generated through discussions in the intervention development meetings. As examples, participants spoke about the need for interventions to be developed in ways that were accessible in the context of busy training schedules, and suggested that offering sessions to professions individually would increase the acceptability and feasibility of the intervention. COM-B was used by the primary researcher as an organising framework for making sense of such findings, considering for example how profession-specific delivery was described as making trainees feel more comfortable with the prospect of attending and sharing openly (impacting 'Motivation') and making it easier to offer sessions at times that better suited the needs of all intended participants (enhancing 'Opportunity'). Features of how the COM-B analyses generated here shaped the finished intervention (e.g. regarding session length, intervention duration, online and profession-specific delivery, and trainee-adapted content) can be identified throughout the Intervention Outline and Theory of Change sections below.

Table 1. COM-B analysis for the target behaviour of attending an ACT-based wellbeing workshop

Target behaviour: Attend an ACT-based wellbeing workshop		
Factors that may influence Capability	**Factors that may influence Opportunity**	**Factors that may influence Motivation**
Trainees are busy and frequently receiving updates and new information throughout their training. To promote capability to attend this intervention, information about it needs to be clear and accessible, and registration needs to be straight forward. Offering sessions directly after long days of lectures will likely reduce capability to meaningfully engage due to fatigue or mental exhaustion/information overload.	Scheduling sessions will need careful consideration. This may be easier if offered to single professions at a time. Course curricula don't have lots of flexibility to incorporate many additional hours for this intervention, but offering sessions outside of course hours will mean some trainees (e.g. those with caring responsibilities) may not be able to attend. Keeping number and duration of sessions to the minimum needed to have a meaningful effect will help offset this. Using features of the social environment (e.g. course staff and discussions about the workshops in teaching) to identify the potential benefits of attendance may nudge people towards attending.	The content may be appealing to many trainees because of the nature of the intervention and their profession. However, trainees may feel less motivated to attend if the course is offered at inaccessible times (appearing tokenistic). Conversely, running intervention sessions directly before or after lectures may decrease motivation to attend due to fatigue. Mandatory attendance during course hours would also likely reduce motivation to attend as trainees would not feel self-determining. Framing the intervention as relevant to personal as well as professional development may help to increase motivation to attend. Similarly, emphasising the collaborative nature of the groups may increase motivation to attend. As such, both these should be emphasised in recruitment materials.

Table 2. COM-B analysis for the target behaviour of engaging with between-session practice of ACT techniques

Target behaviour: Engage with between-session practice of ACT techniques		
Factors that may influence Capability	**Factors that may influence Opportunity**	**Factors that may influence Motivation**
Trainees will have a good level of prior knowledge and understanding (e.g. about psychological processes, group workshops etc.) that mean they will be well positioned to understand content well. However, they will have limited cognitive resources (due to this being delivered at a time they are also already learning lots of new information and ideas). Presenting information in an accessible way and minimising the requirements for academic learning are likely to be helpful. Presentation of practical ideas should be demonstrated and discussed in sessions, so that trainees feel better prepared to also try things out between sessions.	Trainees are in an environment and period of their life that is nudging them towards progress and planning. Their schedules are busy, workloads high, and many will have a perception that they don't have time to invest in practice of extra techniques between sessions. Given this, techniques that fit into trainees' days without requiring lots of additional time are likely to be beneficial. Additionally, using the discussions in the intervention and the attitude of the facilitator to shape the social/cultural environment in a way that facilitates engagement and practice may be helpful (e.g. facilitator giving examples of using techniques in a similar context, a normalising approach, and an encouragement to give things a go and see).	Many trainees may be motivated to try out ideas and techniques that are new to them, or which have been presented as likely to be helpful to their context. However, at the same time, feelings of stress or overwhelm, and a sense that trainees have lots of other competing demands may reduce motivation through increased avoidance or procrastination processes. Trainees are busy, and so selecting techniques that can be carried out briefly and which quite quickly put trainees in touch (experientially) with their value will likely increase motivation to further practice. The facilitator should also work through the intervention as well, and discuss their between-session practice with the group too, in an effort to promote a shared sense of trying this together.

Intervention content

The intervention was carefully designed to address commonly reported stressors in the literature on PFT wellbeing (see Table 3), and to support wellbeing in terms aligned with how psychological professionals and trainees describe positive functioning in their roles (Vivolo et al., 2024). Both stakeholder feedback and relevant research were used to inform decisions about all details of the intervention. As an example, earlier research has highlighted how connecting with values through work is important for psychological professional wellbeing (Vivolo et al., 2024) and has drawn attention to the ways in which work and training (in preparation) feature as important avenues through which values are embodied. At the same time, wider research in the field and stakeholder input to this study suggests that self-doubt and self-criticism in the role can often render efforts to connect with those values difficult (e.g. Owen et al., 2022). In this context, a range of techniques identified as helpful for getting psychological distance for challenging thoughts (e.g. cognitive defusion techniques) and moving towards values even in the face of such thoughts (e.g. the ACT Matrix) were drawn upon. To help inform the theory of change, explicit consideration was also given by intervention stakeholders to how such techniques were expected to bring about change, and how such change would be assessed.

Stakeholders reviewed multiple aspects of the developed intervention at two separate time points, including reviewing several handouts and slides in their finalised form, reviewing the proposed theory of change at both meetings, and informing discussions regarding where, when and for how long the intervention should run. The resultant intervention draws on features of existing ACT protocols (Flaxman et al., 2019), established ACT techniques (Harris, 2008), and elements of compassion-focussed approaches (Gilbert, 2009), whilst also creating new resources and materials specifically for the PFT context. All examples and techniques have been adapted for the specific PFT context (e.g. PFT specific examples).

Table 3. Literature-informed review of stressors reported by trainees, and proposed ways of addressing them

The content of this table reflects the prominent stressors and challenges reported by trainees identified in the published literature. For each set of stressors, hypothetical examples of the types of thoughts or behaviours associated with them are provided to help give a context to what may be being addressed. The techniques considered helpful for addressing these challenges, the ways in which change was expected to be brought about, and the plans developed for assessing such change are also detailed in an effort to support the development and refinement of the theory of change. This content was refined through discussion with stakeholders.

Note: references provided for all techniques. However, techniques have been adapted and presented in specific ways tailored to the context and challenges of PFTs in particular. Examples of adapted resources are presented in Supplementary Material 2A (adapted Passengers on the bus handout) and 2B (Therapist self-criticism handout).

Reported stressors	**Hypothetical examples of unworkable thoughts or behaviours**	**ACT or non-ACT specific techniques or approaches to address unworkable thoughts/behaviours**	**Expected change**	**Plans for evaluating change**
Self-doubt and self-criticism Professional self-doubt, negatively comparing oneself to peers, or 'imposter syndrome'	**Unworkable thoughts**: 'I'm not good enough at this', **Unworkable behaviours**:	**ACT techniques** **Defusion techniques** (e.g. 'I'm having the thought that…' (Harris, 2008). **Passengers on the bus metaphor** (Hayes et al., 2012). **Self-compassion and acceptance techniques**	Changed relationship with unhelpful thoughts and feelings, minimising the extent to which such thoughts (a) cause significant distress and (b) interfere with valued living.	Use of standardised psychometric measures for resilience, wellbeing and psychological flexibility at pre, post and follow up. Focussed post-intervention interviews to explore

(Cushway, 1992; Jones & Thompson, 2017; Lloyd-Peck et al., 2024; Owen et al., 2022).	avoidance-type behaviours (e.g. avoiding taking part in role-play activities or supervision etc.), OR excessive and perfectionistic work behaviours.	**Therapist self-criticism and self-compassion** (Kjelgaard, 2014). **<u>Delivery methods</u>** Using facilitator style to normalise self-critical and unhelpful thoughts, framing them as both common and a feature of how our minds have evolved to function. Encouraging an attitude of acceptance and self-compassion through appropriate facilitator self-disclosure and delivery style, and through skilled use of peer group-based discussion and reflection activities.	Self-compassion when working towards values but encountering challenges or set-backs (as will be common in training). Increased sense of peer-to-peer support and connection, normalising feelings of anxiety or stress, and encouraging a more workable response to this.	participant perceptions regarding what (if anything) was perceived as helpful from the intervention. Direct questioning in interviews about the extent to which included techniques and intervention style/format were perceived to meaningfully address the challenges they experience on the training.
<u>Academic and clinical evaluation/feedback</u> Dealing with frequent feedback, evaluation and need for skill development (Pakenham & Stafford-Brown, 2012; Skovholt & Ronnestad, 2003).	**Unworkable thoughts**: 'If I get feedback/criticism it means I've done badly', **Unworkable behaviours**: Interpreting constructive feedback negatively. Avoiding aspects of the course (e.g. role-plays, or opportunities for	**<u>ACT techniques</u>** **Values-clarification techniques** (e.g. Values-sort exercise, and compass metaphor (Flaxman et al., 2019). **'Towards moves' planning** (Flaxman et al., 2019). **Passengers on the bus metaphor** (Hayes et al., 2012). **Two sheets of paper** (Flaxman et al., 2019). **<u>Self-compassion and acceptance techniques</u>** **'I am…' activity** (Gilbert, 2010, p.386; Kemp, 2021).	Changed relationship with thoughts and feelings regarding evaluation and learning during training. Increased ability to move towards values (e.g. of developing and learning) even in the face of unhelpful thoughts or feelings (e.g. feeling stressed about being evaluated).	As above.

	feedback etc.) OR, unproductive and excessive over-preparation.	**<u>Delivery methods</u>** Using group discussions and appropriate facilitator self-disclosure to normalise some anxiety around frequent evaluation, but to encourage an open and flexible response to this. Encouraging an attitude of acceptance and self-compassion through appropriate facilitator self-disclosure and through skilled use of peer-group based discussion and reflection activities.		
<u>Challenge to self-concept</u> Having aspects of personal narrative challenged through the training (e.g. sense of self as competent being challenged by receiving negative feedback or a fail grade etc.) (Richardson et al., 2020a).	**Unworkable thoughts**: 'If I can't do this then I'm a failure'. **Unworkable behaviours**: Avoidance of situations in which feedback is given, unproductive and excessive over-preparation.	**<u>ACT techniques</u>** **Passengers on the bus metaphor** (Hayes et al., 2012) . **<u>Self-compassion and acceptance techniques</u>** **'I am…' activity** (Kemp, 2021; Gilbert, 2009, p.386).	Less rigid holding to self-concepts, enabling trainees to be more flexible, accepting, and able to continue moving towards values even when obstacles are encountered.	As above.
<u>Uncertainty and ambiguity</u>	**Unworkable thoughts**:	**<u>Delivery methods</u>**	Trainees will feel more connected to and supported by	As above.

Tolerating the uncertainty inherent in a clinical role (Jones & Thompson, 2017; Lloyd-Peck et al., 2024; Pica, 1998), 1998).	'I don't know what to expect from the role' **Unworkable behaviours**: Seeking excessive reassurance (e.g. from course or clinical supervisors).	Using group discussions and appropriate facilitator self-disclosure to acknowledge the inherent uncertainty and ambiguity in a clinical training, and to normalise some anxiety or stress about this, whilst encouraging and modelling a more open and flexible response to such feelings.	peers, and have feelings of stress normalised in a helpful and positive way.	
<u>High work demands</u> Holding dual roles as university student and mental health professional (Owen et al., 2021, 2022), and high clinical workload and competing demands (Lloyd-Peck et al., 2024; Owen et al., 2022).	**Unworkable thoughts**: 'I can't ever stop or rest as there's just too much to do'. **Unworkable behaviours**: Procrastinating (e.g. neglecting course work at expense of clinical work or vice-versa).	**<u>ACT techniques</u>** **Defusion techniques** (e.g. 'I'm having the thought that…' (Harris, 2008). **Mindfulness and noticing techniques** (e.g. 3-step breathing space (Williams & Penman, 2011). **ACT Matrix** (Polk & Schoendorf, 2014). **<u>Delivery methods</u>** Acknowledgement of the genuine challenge and complexity of the training role/period. Appropriate self-disclosure and skilled group-discussions to normalise some feeling of stress in the face of external challenges.	Notice and gain distance from unhelpful or debilitating thoughts, unhooking from thoughts that can threaten to make helpful action appear futile. Trainees will feel more connected to and supported by peers, and have feelings of stress normalised in a helpful and positive way.	As above.

<u>Perfectionism and personal qualities</u> Having a background of 'overachieving' (Pica, 1998) perfectionism (Richardson et al., 2020b) or anxiety (Barnett et al., 2007).	**Unworkable thoughts**: 'I can't submit this work unless it is perfect'. **Unworkable behaviours**: setting unrealistic expectations, unproductive and excessive preparation on aspects of work.	**<u>ACT techniques</u>** **Defusion techniques** (e.g. 'Giving your mind a playful nickname' (Flaxman et al., 2019)). **ACT Matrix** (Polk & Schoendorf, 2014). **<u>Self-compassion and acceptance techniques</u>** **'I am…' activity** (Kemp, 2021; Gilbert, 2009, p.386).	Increased ability to move towards values in the presence of unhelpful or perfectionistic thoughts. More flexible responding through flexible holding of self-stories.	As above.
<u>Values clashes or the challenges of embodying competing values</u> Experiencing 'values clashes' through work (e.g. being required to work in a way to pass the course that doesn't align with how individuals want to) (Owen	**Unworkable thoughts**: 'I'm letting others down if I'm not always present in all areas'. **Unworkable behaviours**: Withdrawing from other important life areas, putting unrealistic pressures and	**<u>ACT techniques</u>** **Values-clarification techniques** (e.g. Values-sort exercise (Flaxman et al., 2019)). **'Towards moves' planning** (Flaxman et al., 2019). **ACT Matrix** (Polk & Schoendorf, 2014). **Passengers on the bus metaphor** (Hayes et al., 2012). **Two sheets of paper** (Flaxman et al., 2019).	Increased clarity regarding personal values and how to move more proactively towards them (even if in small ways). The delivery approach is also expected to help with feelings of unease and challenge associated with the impossibility of always embodying all of our values fully and at the same time.	As above.

et al., ongoing) and time management and competing life domain issues (e.g. being pulled between spending time on the course, and spending time with family) (Lloyd-Peck et al., 2024).	expectations on self to be perfect in all ways (i.e. must still be the ideal mum, partner, friend and trainee).	**<u>Delivery methods</u>** Acknowledgement throughout of the genuine challenge and complexity of the training role/period. Appropriate self-disclosure and skilled group-discussions to normalise some feeling of stress in the face of external challenges.		

Note:

Passengers on the bus metaphor: a complete ACT metaphor combing all 6 key ACT processes, including 1. Separating the unhelpful thoughts from the person having them (defusion), 2. Learning that we're more than our unhelpful thoughts (self-as-context), 3. Learning to tune into our own responding (present moment awareness), 4. Identifying what's important for us down the road (values clarification), 5. Taking steps towards our values even in the face of unhelpful thoughts etc. (committed action), 6. Learning to make some room for unhelpful thoughts and feelings (acceptance).

Therapist self-criticism and self-compassion (Kjelgaard, 2014) video and discussion point aimed at normalising self-critical thoughts and encouraging self-compassion in therapists.

Defusion techniques (e.g. 'I'm having the thought that…' (Harris, 2008) or 'giving the mind a playful nickname' (Flaxman et al., 2019) cognitive techniques to achieve psychological distance from content of the mind).

Mindfulness and noticing techniques (e.g. 3-step breathing space (Williams & Penman, 2011) experiential noticing techniques designed to support getting good at noticing the activity of the mind).

Values-clarification techniques : Values-sort exercise to clarify important personal values, and compass metaphor to support the idea of values as a behaviour guide (Flaxman et al., 2019).

‘Towards moves’ planning: (Flaxman et al., 2019) written plan to support trainees to make moves towards training related values.

ACT Matrix: (Polk & Schoendorf, 2014) written technique to support trainees in identifying when unhelpful thoughts/feelings might get in the way of acting in accordance with values, and to get more skilled at identifying ways to move towards values in the presence of such thoughts.

Two sheets of paper: (Flaxman et al., 2019) visual representation designed to encourage an approach of being driven more by values than unhelpful thoughts/feelings.

‘I am…’ activity (Kemp, 2021; Gilbert, 2009, p.386) designed to help people see the multiplicity of self-stories they have for themselves, and to hold onto self-stories 'lightly' without being unhelpfully constrained by them.

Intervention outline

In keeping with TIDieR guidelines (Hoffmann et al., 2014), comprehensive details regarding the planned intervention are outlined in this paper. 'Thriving in training: an Acceptance and Commitment Therapy (ACT) group wellbeing intervention for psychological professional trainees' is a psychological intervention designed to improve wellbeing in trainee psychological professionals. The intervention is underpinned by the COM-B model of behaviour change (Michie et al., 2011) and has been developed based on principles and techniques from ACT (Hayes et al., 2012). In smaller ways, ideas from Compassion-Focused Therapy (Gilbert, 2009) have also been drawn on. As demonstrated in Table 3, these approaches were selected due to the potential they have for addressing the specific stressors reported by trainees, and the way in which their underlying assumptions align with accounts of wellbeing and positive functioning in the role given by psychological professionals and trainees. The techniques used throughout the intervention and an overview of session content are described in Tables 3 and 4. Examples of study materials are provided in Supplementary Material 2A-B. The intervention is delivered remotely (via Teams) in order to be accessible to trainees over a large geographical region. It has been designed to be delivered over 4 sessions, each 2-hours in length, and each comprising facilitator-led content on ACT, experiential practice of ACT techniques, and group discussion. All 4 sessions are designed to take place over a period of approximately 6 weeks, with individual sessions typically scheduled between 1 and 3 weeks apart. It is designed to be delivered by one person, who may be a core member of staff on the training programme on which trainees are studying. It is assumed that group facilitators have a strong foundational knowledge of ACT, and experience delivering group-based interventions or psycho-educational workshops.

Table 4. Overview of intervention content by session

Session number	Outline of session content
Session 1	Introduction to key ACT processes Experiential practice of mindfulness techniques Values sort and Compass Metaphor Passengers on the bus metaphor
Session 2	Experiential practice of mindfulness techniques Reflection on home-practice ACT matrix Defusion techniques
Session 3	Experiential practice of mindfulness techniques Reflection on home-practice Self-criticism in training, self-compassion and acceptance techniques (e.g. 'self-critical passenger') Two sheets of paper exercise
Session 4	Reflection on home-practice Self, self-stories, and holding self-stories 'lightly' – 'I am…' activity Revisiting core content (e.g. acting out 'The passengers on the bus' metaphor)

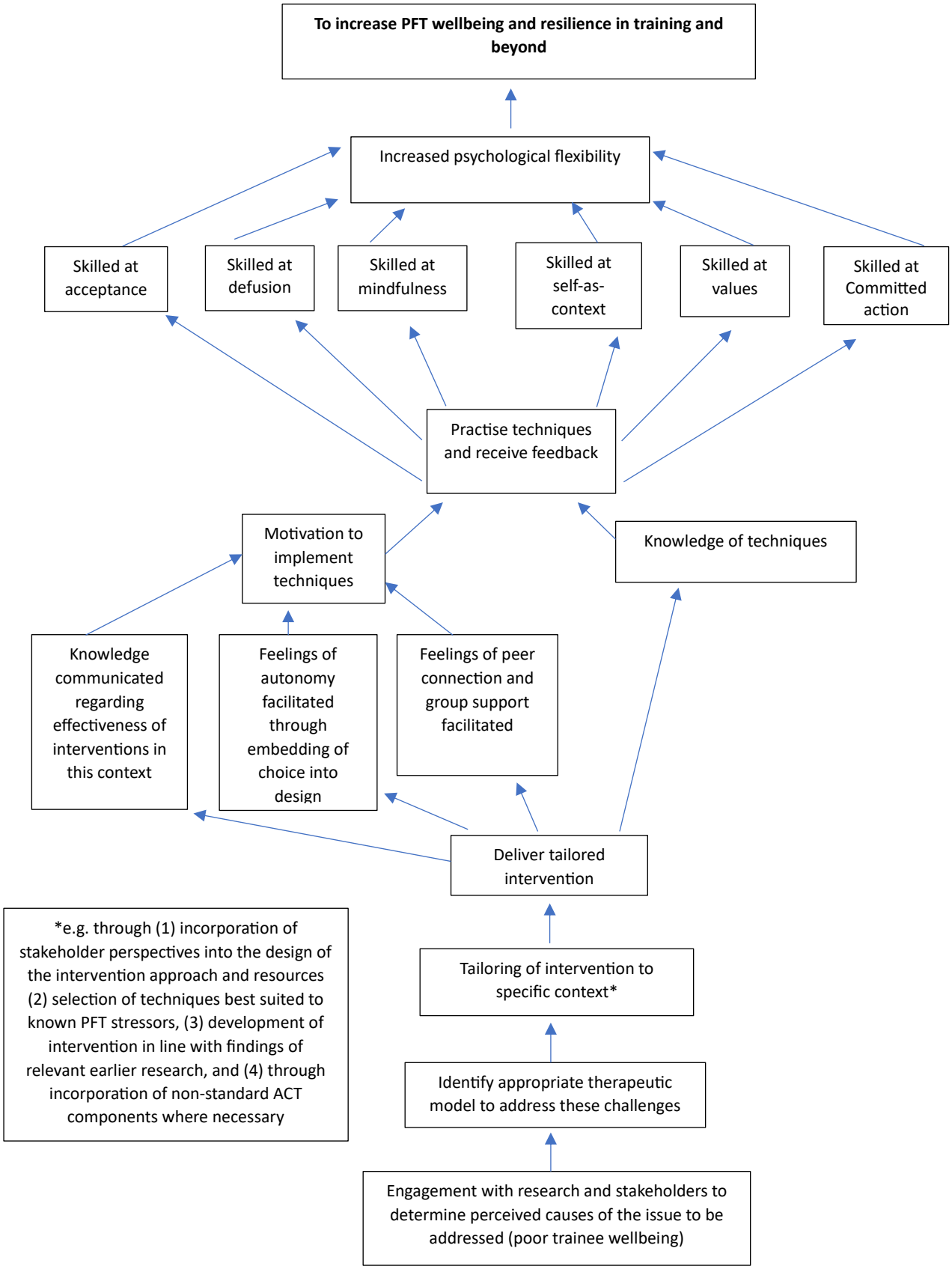
Theory of Change

A visual (Figure 2) and narrative account of the theory of change for the intervention are presented below. The process of establishing a theory of change supports the identification of key assumptions underpinning the approach, and visual depictions provide a succinct overview of intended pathways to change (Anderson, 2009). Whilst it has been acknowledged that visual representations of a theory of change necessarily simplify often complex processes (Morgan-Trimmer et al., 2018), they nonetheless provide a useful framework for defining testable expectations about how an intervention will function. Theories of change typically begin by establishing the intended outcome, and then working backwards to systematically set out the necessary pre-conditions and earlier outcomes for this to be achieved (Anderson, 2009). This process has been completed for the current intervention, and detailed below in Figure 2. A narrative description which expands this is then presented.

Assumptions of the Theory of Change

(1) that an adapted form of ACT is well suited to meeting the demands of trainees, (2) that an intervention tailored to individuals in this way can make meaningful differences to trainee wellbeing despite not altering the often objectively challenging circumstances within which they are working/training (3) that implementing techniques practically is necessary to bring the desired change, (4) that trainee motivation will be enhanced by the provision of some degree of choice/autonomy in features of the intervention, and by peer support and collaboration (5) that belief in the effectiveness of interventions for addressing PFT challenges is needed to engage in the intervention, (6) that given sufficient support and information, trainees will be willing to engage with the intervention and practice techniques, and (7) that increasing psychological flexibility will support improved wellbeing and resilience outcomes.

Figure 2. Theory of Change



Theory of change: narrative description

The intervention purpose is to improve wellbeing and resilience in PFTs. Based on the literature, it is assumed that using an adapted ACT-based intervention tailored to the PFT context will help to increase psychological flexibility in trainees, and that this will help to produce improved wellbeing and resilience. The main driver of outcomes therefore is assumed to be an increase in psychological flexibility. A range of important pre-conditions are assumed to be necessary to support this. Based on earlier literature, stakeholder perspectives gathered during the intervention development process, and anecdotal evidence from training, it is predicted that in order for trainees to engage fully with the intervention (and therefore to have the opportunity to benefit from it) they will need to feel supported by the course/organisation, have the opportunity to learn together with peers, feel some degree of choice or autonomy over features of the intervention, and have a realistic sense of hope or optimism about the potential for individual-level action to lead to change.

Implementing this intervention requires a range of resources, including staff/researcher time. In keeping with the delivery of many well-established features of training in this area (e.g. Self-Practice/Self-Reflection or reflective practice groups) it is expected that the intervention be delivered by core members of training staff where there are those with adequate understanding to do so. It will also require the investment of time and energy from trainees themselves (to attend the sessions, and to implement techniques in-between). On the basis of existing literature and the stakeholder meetings within this intervention development study, it is being assumed that trainees will have relatively little time and capacity to do so, so the intervention has been designed to be as brief as possible, whilst being sufficiently intense to be considered likely (according to relevant literature) to bring about a positive change. Techniques have also been selected that typically require little or no additional time in a trainees' day to practice (i.e. noticing a self-critical 'passenger' during daily activity, or identifying 'towards moves' in daily action).

All stages of the intervention will take place in a context in which trainees will be working clinically and receiving their clinical training, and the relationship between the intervention and context will likely be bi-directional and complex. Demands on trainee time due to academic and clinical workload for example might influence the extent to which trainees feel able to attend sessions or practice techniques. At the same time, the training context will provide multiple situations in which intervention ideas can be practised. Similarly, ideas and techniques learned in the intervention may influence trainees' experience of the training itself (i.e. increased flexibility and committed action as a result of the intervention may encourage trainees to periodically step back a little more from the demands of training, to give more time and space to self-care or other important life areas such as family).

Discussion

This paper outlines the process followed in the development of 'Thriving in training: an Acceptance and Commitment Therapy (ACT) group wellbeing intervention for psychological professional trainees'. As such, it contributes to the development and advancement of cognitive-behavioural theory and practice, by setting out the processes underpinning and the theoretical rationale for the development of this ACT-based intervention. It also responds to calls in the literature for more consistent reporting of intervention development processes (Hoddinot et al., 2015) and consideration of how interventions will be delivered and experienced in real-world training settings (Duncan et al., 2020). Guided by the MRC framework for developing and evaluating complex interventions (Skivington et al., 2021) and adhering to guidance regarding the reporting of intervention development studies (Duncan et al., 2020) and intervention details (Hoffman et al.,2014), the study reflects an effort to move the literature regarding PFT wellbeing interventions forward. Whilst a large number of earlier studies have reported outcome data, the field includes few attempts to detail the procedures followed when developing an intervention, or to theorise how an

intervention would be expected to function successfully in context. Similarly, little attention has been paid in prior work to understanding how trainees experience wellbeing (as a reduction in stress, or an increase in meaning for example), or to attempt to align interventions with this contextually-shaped outcome in mind. These are important gaps in the field that the current study seeks to address.

In keeping with findings of prior research indicating that many of the challenges and stresses experienced by PFTs are shared across multiple psychological professions (Owen et al., 2021; Pakenham Stafford Brown; Richardson 2020), the intervention was developed to be applicable for trainees across the psychological professions, including those who deliver CBT in various forms.

Whilst acknowledging the many and important differences between the training requirements of different psychological professions, the stakeholder input to this study, and much of the wider research drawn upon in its development indicate that there is much shared regarding what is experienced as challenging during the training period. In keeping with this, the process described here has drawn on research with trainees across a wide range of psychological professions to inform its development (e.g. Owen et al., 2025; Vivolo et al., 2024).

Notably, many training programmes across the psychological professions will already dedicate some of the curriculum to considering issues relating to self-care, personal practice, or reflection. Many of the existing approaches in this area will already draw on some of the delivery methods used in the current intervention and described in Table 3. In some specific ways therefore, the developed intervention may have at least some overlap with aspects of existing provision, and it could be used to supplement or replace existing practice, as considered appropriate by course staff. Whilst not intended to replace the educational benefits associated with some forms of personal practice such as Self-Practice/Self-Reflection (Bennett-Levy & Lee, 2014), the intervention does respond to a concern identified in some aspects of the literature that many of the existing offers on supporting personal

wellbeing during training are experienced by trainees as either too abstract or insufficiently practical (Owen et al., 2025).

With trainee wellbeing an important area of concern given the known influence of wellbeing on clinical effectiveness (Delgadillo et al., 2018), academic learning (Pascoe et al., 2020), and intention to stay in post (Summers et al., 2021), this theory-, evidence- and stakeholder-informed intervention has the potential to be an important and valuable addition to the literature.

Strengths and limitations

Stakeholder input was central to this study, and provided critical insight regarding how the intervention was expected to function in practice. This represents a key strength to this study. Stakeholders reflected a diversity of viewpoints, representing a range of professional backgrounds and demographic and ethnic characteristics. Despite this, an important limitation relates to the fact that explicit attempts were not made to explore in-depth the specific challenges experienced uniquely by trainees from ethnic minority backgrounds. Whilst the challenges the intervention seeks to address are drawn from literature including a wide-range of PFTs, and participants in this study fedback in detail both on how the identified challenges were reflective of their experience and the extent to which the intervention was considered well-suited to addressing them, wider evidence demonstrating that ethnic minorities experience a range of unique stressors both in study and work (Rhead et al., 2024; Stoll et al., 2022) suggest that this would be an important area for future work to focus on.

It is notable that the recruitment of trainees to the process was more challenging than the recruitment of staff. In total, 3 current trainees attended both meetings, with 2 further trainees having expressed an interest in taking part, but dropping out shortly before the meetings. The reason given by trainees for dropping out was that they didn't have enough time, or felt already too busy

with the demands of their training. This in itself was considered as an important piece of information that helped feed into and inform aspects of how the intervention was designed. The fact that trainees across two separate professions had been interested to take part, but found themselves unable to find the time to do so meant that careful consideration was given to how any intervention would sit around and be received in the context of such a busy and time-stretched training period. It also highlights an important limitation, in that only two professional training roles were represented by trainees (Clinical Psychology and Clinical Associates in Psychology) despite the intervention being developed with the intention of being appropriate for trainees across the psychological professions. The views and experiences of trainees across other professional training programmes will therefore need to be carefully considered and included in the evaluation of the intervention itself. Nonetheless, it is worth noting that professional staff represented views across five separate psychological professions. Additionally, we chose not to recruit workplace supervisors to take part as intervention stakeholders. This decision was driven in part by pragmatic considerations regarding the feasibility of finding suitable timeslots for stakeholders from multiple different settings within a limited timeframe, but also partly due to the fact that all of the included professional training staff were also current or past workplace supervisors. As such, it was considered that professional training staff would be able to offer perspectives that reflected considerations of both positions. Nonetheless, we acknowledge the important limitation of not having stakeholders included specifically for the perspective of workplace supervisors.

As noted already, participants for this study were recruited from trainees and professional staff, all of whom hold busy full-time academic/clinical posts. As such, efforts were made throughout to make participation as accessible as possible, by minimising demands for taking part (e.g. by keeping the number of intervention development meetings down to a minimum, minimising any requirements for preparation ahead of meetings, and using the COM-B model in a contained and focussed way). Whilst a further limitation therefore potentially relates to the more contained and focussed use of

the COM-B model (as opposed to the more comprehensive Behaviour Change Wheel (BCW)) it is noteworthy that this was considered likely to facilitate trainee and staff participation, by avoiding the extensive time and resource implications others in the field have noted that the BCW has required (Webb et al., 2016).

Plans for the evaluation of this intervention were determined in advance, with a focus on evaluating the acceptability and feasibility of the intervention, as well as testing the theory of change presented here. The intervention was recently delivered to trainees across five separate psychological professions (Education Mental Health Practitioners, Clinical Associates in Psychology, Clinical Psychologists, High-Intensity CBT Therapists, and Psychological Wellbeing Practitioners). A mixed-methods evaluation was used to explore factors relating to acceptability and feasibility (e.g. recruitment rates, retention, data completion, and trainee perspectives regarding how they experienced taking part in the context of real-world training), as well as to look for signals of efficacy by exploring change in outcomes of interest (e.g. psychological flexibility, wellbeing, stress, and resilience). Findings of this evaluation are currently under review for publication.

Conclusion

It has been noted that until recently, the processes and decision-making sitting behind the development of complex interventions has rarely been reported (Hoddinott, 2015). The current intervention development study has followed best-practice guidance on the processes and reporting of intervention development studies (Duncan et al., 2020), to describe in detail the steps followed in the development of 'Thriving in training: an Acceptance and Commitment Therapy (ACT) group wellbeing intervention for psychological professional trainees'. The acceptability and feasibility evaluation of this intervention has been written up in a separate paper currently under review.

Key Practice Points:

1. This paper has described the processes followed in developing an intervention to support wellbeing in psychological professional trainees
2. Stakeholder perspectives and a body of wider theory and research were used to design the intervention to be acceptable to trainees, and implementable in the context of real-world training, generating evidence and knowledge with practical implications for those involved in training psychological professionals
3. The COM-B model of behaviour was used to provide an overarching framework for understanding how to support effective behaviour change through the intervention
4. The developed intervention aims to fill important gaps in the trainee wellbeing literature, by detailing the processes followed in developing this intervention, and setting out a clear and testable theory of change

Supplementary Material

Supplementary Material 1 - Intervention development meeting1 – questions and activities

Meeting 1 (up to 2 hours)

Agenda

1. Welcome and thank you (Primary researcher to thank people for giving their time to the project, and to set the agenda for the session)
2. Primary researcher to deliver brief presentation summarising earlier findings from the PhD and outlining the planned intervention
3. Activity 1: discussion of earlier findings (Systematic review and qualitative interview study) and intervention outline (including COM-B analysis)
4. Full group feedback
5. Activity 2: TOC
6. Full group feedback
7. Close

Activity 1: discussion of earlier findings (25 mins)

- Participants will be asked to work in 3 small groups (max 3-4 people), to have an open discussion regarding their take on the findings that had been shared with them in advance (results of the Systematic Review and the qualitative interview study)
- Participants will be asked to reflect in those groups how they felt findings related to their own experience as a trainee or trainer, and what the would personally find useful or challenging in the findings
- **Prompt questions** will be shared to facilitate these small group discussions, including:
  1. How did the findings shared relate to your own experience as a trainee, or what you see as a trainer?
  2. Is there anything in the shared findings that seemed surprising or missing?

  3. What potential barriers do you see to trying to design or implement an intervention as outlined today (and that is in keeping with the earlier findings?)
  4. What would you find helpful from an intervention that aligned with these findings, or what could be done to make engaging with an intervention that reflected these findings easier or more appealing?
  5. What factors do you think might influence trainees' capability, opportunity or motivation to engage with the intervention?
  6. What do you think regarding some of the remaining unanswered questions (e.g. when in training? single or multi-profession? Online, in-person or both? How long? Etc.)

Full group feedback (25 mins)

- An opportunity will be provided for each group to feedback what they had discussed, and to collate ideas as a group

Activity 2: Theory of Change

- Participants will be asked to work in small groups to discuss the proposed TOC, and to make suggestions about how it should be refined

- **Prompt questions** will be shared to facilitate these discussions including:

  1. What do you think about the proposed TOC?
  2. What do you think is missing from or superfluous to the model?
  3. What would you expect to be the necessary and sufficient conditions needed to bring about the desired outcome?

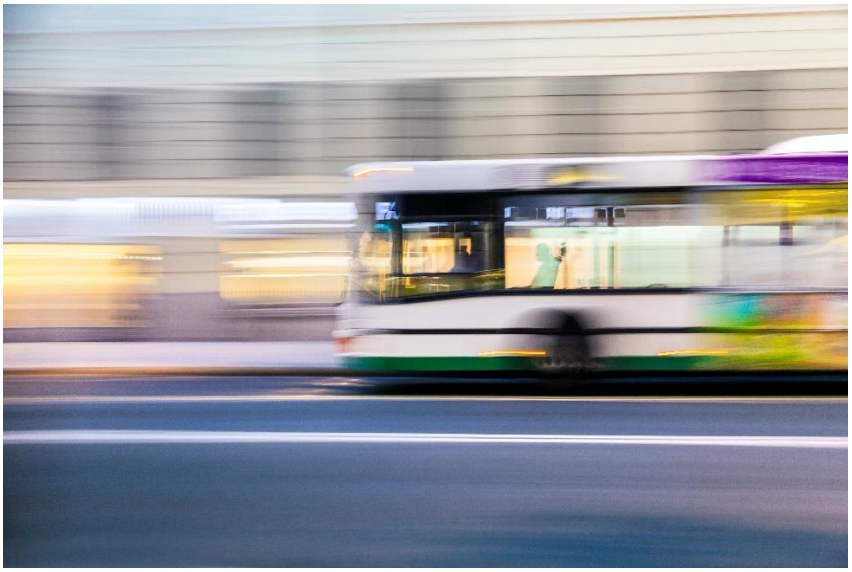
Full group feedback (25 mins)

- An opportunity will be provided for each group to feedback what they had discussed, and to collate ideas as a group

Supplementary Material 2 – Adapted Passengers on the bus

The Passengers on the bus: a complete ACT metaphor

The *Passengers on the Bus* metaphor (Hayes, Strosahl & Wilson, 2012) is one of the most well-known and widely used ACT techniques. It describes how the decisions we make in response to internal thoughts, feelings and emotions can either move us *towards* or *away from* the things we value. We'll revisit this technique on multiple occasions across this training.



Across training (and in life more generally!) it is common to experience difficult or unpleasant thoughts, emotions and feelings from time to time. One set of thoughts that seem to be very commonly experienced by trainee and qualified psychological professionals are those related to what can be called 'imposter syndrome'.

Many trainees experience self-doubt and self-critical thoughts, frequently experiencing thoughts or feelings relating to the idea that they are not good enough at their job, less competent than others around them, or insufficiently skilled or compassionate to succeed in their role. If we become entangled with thoughts like these, they can have a big influence on our behaviour. Thoughts about not being competent for example might lead someone to avoid role-plays or opportunities for being observed by their supervisor, for fear of being 'found out' or receiving negative feedback. That might be a helpful short-term strategy for avoiding the anxiety of putting themselves 'out there' in front of a supervisor or peer, or keeping quiet the thoughts telling them that they're not good enough. But it's also likely to be unhelpful in their attempt to move towards qualification or things they might value such as personal development.

Similarly, thoughts about a written piece of work not being good enough might lead someone to delay submitting it, to argue with themselves by reminding themselves that they've passed assignments before, or to spend many hours writing and re-writing it in an attempt to make it perfect. Again, these behaviours might help momentarily quieten the thoughts and feelings telling the person that the work isn't good enough, that it's bound to fail, or that it will expose them as a fraud. However, they're unlikely to help them move towards personal values associated with learning, or spending time with their family - because instead they're putting endless hours into trying to perfect their work in an attempt to quieten their own fears of failure.

The *Passengers on the Bus* metaphor helps illustrate another way of relating to such thoughts or feelings. Rather than arguing with the thoughts or taking steps to keep them quiet, we can instead choose to 'make room' for them, and bring them along with us. We can acknowledge difficult thoughts and feelings *and* move towards the things we value, rather than being constrained or directed by the thoughts and feelings.

The *Passengers on the Bus* metaphor (adapted from Hayes, Strosahl & Wilson, 2012)

"Imagine there's a bus and you're the driver. We'll call this your 'bus of life'. As you're the driver, you can drive it in a direction of your choice. On this bus you've got a bunch of passengers. The passengers are thoughts, feelings, bodily states, memories, and other aspects of experience. Some of them are pleasant, and they encourage you for going along in the direction you are. Some don't say much at all, whilst others provide a slightly negative and cautious message: 'I think you should drive a little slower, I don't feel like making this journey' and so on. Others still are mean, anxiety-provoking and downright unpleasant. They look intimidating and they can shout loudly. Some of these passengers pop up only at particular times with a specific message, like the one shouting 'You'll fail, you'll never get this right!' every time you try something new. Others are passengers you feel you've known a long time, and who repeat the same story at you over and over: 'You're not good enough, why do you even bother trying'.

What happens is this: you're driving along the road, and the passengers start making themselves heard. Again, some are reassuring, and some nothing worse than a little cautious. Others though are threatening you, telling you what you have to do, where you have to go: 'You've got to turn left,' 'You've got to go right,' etc. The threat that they have over you is that if you don't do what they say, they're going to come up from the back of the bus and surround you. You know that you're the driver of this bus, and you can decide where to go. But these passengers are loud and intimidating, and so you end up making a deal with them to keep them quiet. The deal is something like this: 'You sit in the back of the bus and sit down so that I can't see you very often, and I'll do what you say and drive where you want'. Once this deal is struck, the voices quieten. The passengers sit further towards the back, and the threat seems partly removed. But you're now no longer choosing where to drive your own bus. Instead of taking the turns you'd like to, towards the destinations you really want to reach, you stay on the same old road, to keep the passengers quiet.

Now, what if one day you get tired of that and say, 'I don't like this! I'm going to throw these people off the bus!' You stop the bus, and you go back to deal with the mean-looking passengers. Notice that the very first thing you had to do was stop. Notice how in fact, you're now no longer driving anywhere at all, you're just dealing with these passengers. Plus, these passengers are strong. They don't intend to leave, and you wrestle with them, but it just doesn't work as you hope. You quickly realise that you simply can't throw them off.

For a while then, you try drowning them out, cranking the music up loud on the bus, or putting your hands over your ears. But this doesn't seem to work well either. You recognise that you're having to put so much effort and attention into covering your ears and not focussing on what the passengers are shouting at you, that it's hard to really keep control of the bus at the same time.

Eventually then you go back to placating the passengers, to try and get them to sit in the back again where you can't see them. The problem with that deal though is that you again have to do what they ask. Pretty soon, they don't even have to tell you to 'Turn left' – you know as soon as you get near a left turn that certain passengers are going to be there, telling you to do it. Eventually you may get good enough that you can almost pretend that they're not on the bus at all. You just tell yourself that left is the only direction you even want to turn!

Now, here's the trick about this whole thing. The power that the passengers have over you is 100% based on this: 'If you don't do what we say, we're coming up and we're making you look at us.' That's it! It's true that when they come up, they look like they could do a whole lot more. They look menacing and threatening, and it feels like you could be destroyed. But in fact, they can't really do anything more than shout at and intimate you. Ultimately, the deal you made with them was to do what they'd say, just so that they'd do nothing more than stand close by and shout at you.

The driver (you) has control of the bus, but you trade away the control through those deals with the passengers. In other words, by trying to get control, you've actually given up control! Now notice that, even though your passengers claim they can destroy you if you don't turn left, it has never actually occurred. These passengers can't make you do something against your will.

So rather than focussing lots of energy on arguing with the passengers, stopping the bus to try and make them get off, or making deals with them to keep them quiet, you choose another way. You

realise that you can actually drive the bus where *you* want to *and* bring the passengers along with you. You don't always like what they're saying, and the passengers don't go away, but you 'make room' for them, acknowledging their presence, but reminding them that you're the driver of this bus, and you choose where it's going.

'Thanks for the advice' you say, to the passenger warning you you'll get stuck or break down if you take the path up the hill towards your chosen destination, 'but I'm the driver, and I'll decide'. This way, the passengers remain on the bus, and many may keep saying the same things. But you've now made room for them, recognised they can't actually do anything to hurt you, and resumed control of your own bus so that you can go towards the destinations that you choose.

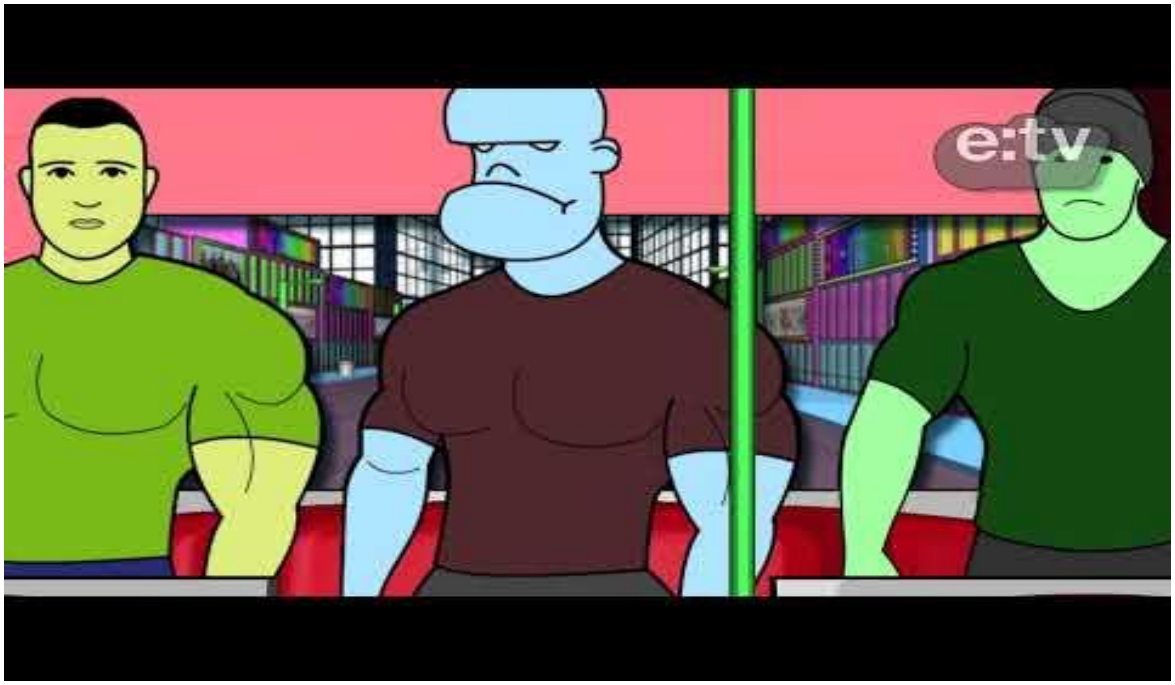
(text adapted from Hayes, Strosahl & Wilson, 2012)

In this metaphor, the unpleasant passengers represent the thoughts, feelings, memories and internal sensations we all have that try to steer us off course or take us away from things we value. Sometimes those passengers are loud and aggressive telling you to stop immediately or they'll make you crash the bus. Others are less threatening but just as forceful. 'This isn't worth it', 'Why even bother trying', or 'Maybe it would just be easier to stop trying' are all voices that can persuade us to stop moving in the direction that we might otherwise want to.

Remember though, these thoughts, feelings and emotions are really only that: thoughts, feelings and emotions. We can 'make room' for them, and bring them along for the ride. In other words, we can move towards the things we value, without letting unpleasant thoughts, feelings or sensations steer us off course.

Videos and online resources

You can find a number of helpful videos and animations of the Passengers on the Bus metaphor online, like this one produced by ACT trainer and psychologist Joe Oliver: https://www.youtube.com/watch?v=Z29ptSuoWRc



The well-known ACT author and trainer Russ Harris also created a slightly adapted version of this metaphor that he calls 'Monsters on a Boat'. You can watch an animation of that here: https://www.youtube.com/watch?v=vyxc889gQtY

Supplementary Material 3 Intervention Development - Meeting 2 Outline

Intro and welcomes – updates on what done since Meeting 1 (5 mins)

- Detailed planning regarding the nature of the problem the intervention is trying to address, and specific techniques and approaches designed to address them

Activity 1 – reviewing the common difficulties and techniques to address them document (40 mins)

- Talk through some examples (10 mins)
- Then give participants 10 mins to read through the other tabs independently
- Group discussion about the content of this (20 mins). Group discussion based around exploration of:
  ~ What do you think about the challenges outlined?
  ~ Are there challenges that seem missing?
  ~ Are some of the included challenges things you're surprised to see?

~ What do you think of the suggested techniques for addressing these?
~ What do you think of the proposed mechanisms of change? i.e. does my description of how these techniques will address the problems seem realistic?

Activity 2 – reviewing some examples of techniques/worksheets/resources (45 mins)

- Introduce some examples of resources to be used (5 mins)
- Give participants 20 mins to look through these example resources independently, including:
  ~ watch the common humanity YouTube clip (https://www.youtube.com/watch?v=HEghvn7We8w)
  ~ Adapted Passengers on the Bus metaphor
- Group discussion about the content of these resources (20 mins)

Activity 3 – recruitment and promotion (15 mins)

- Review the suggested titles
- Review the suggested recruitment flyer
- Gather feedback and views

Chapter 7: Thriving in training: a mixed-methods acceptability and feasibility study of a tailored Acceptance and Commitment Therapy (ACT) intervention to support trainee psychological practitioner wellbeing

This paper is presented in the form in which it has been submitted to the journal *Behavioural and Cognitive Psychotherapy*. The paper is currently under peer-review. The paper has recently been positively reviewed by peer reviewers, and invited for resubmission.

Owen, J., Biggart, L., Fisher, P., Kishita, N., & Sanderson, K. (under review). 'Thriving in training: An acceptability and feasibility study of a tailored Acceptance and Commitment Therapy (ACT) intervention to support trainee psychological practitioner wellbeing'. *Behavioural and Cognitive Psychotherapy*.

Abstract

Objectives: This study was designed to assess the acceptability and feasibility of a tailored Acceptance and Commitment Therapy wellbeing intervention for Psychological Therapy Trainees. The intervention was co-constructed with trainees, and designed to fill gaps in the literature by detailing a clear theory of change, and approaching wellbeing in trainees in a theoretically-informed manner.

Methods: A convergent-parallel, mixed-methods approach was used to assess the acceptability and feasibility of the intervention in one UK university and an online, extracurricular format. Quantitative data on recruitment, retention and data completion were considered alongside qualitative data from post-intervention interviews. To explore preliminary evidence of clinical utility, standardised

measures of psychological flexibility, stress, psychological distress, wellbeing and resilience were completed at three time points. Reliable change scores were calculated and effect sizes estimated.

Results: The intervention was highly acceptable to trainees. Pre-determined benchmarks of feasibility were partially met. Recruitment was strong (63 starters over 2-month period) and retention satisfactory (79%). Data collection fell below required thresholds (52.7% at T2 and 29.7% at T3). Tentative evidence was identified that this intervention may be useful in this population and setting, and that it may work through theorised pathways of change (supporting wellbeing through increasing psychological flexibility).

Conclusions: The intervention was found to be highly acceptable to trainees, and feasible to deliver in the setting of a UK university. Progression to further pilot testing to assess the feasibility of randomisation to different treatment arms is supported. Important learning was generated here to support the design of such testing.

Key words: acceptability, feasibility, wellbeing, Acceptance and Commitment Therapy (ACT), trainee, psychological therapy trainee

Background

The wellbeing of psychological therapy trainees (PTTs) is an important area of concern, with evidence to suggest that trainees frequently experience problematic levels of stress and burnout across their training (Jones et al., 2017; Pakenham & Stafford-Brown, 2012), including from the earliest stages (Owen et al., 2022). As mental-health professionals and university students concurrently, trainees experience a range of stressors relating to frequent practice and coursework evaluation, competing demands, and the need to quickly learn and implement new skills (Owen et al., 2021). Poor wellbeing or excessive stress have been found to be associated with a range of negative outcomes

relevant to this population, such as reduced clinical outcomes (Delgadillo et al., 2018), higher incidences of academic and professional misconduct (Barnett et al., 2007), increased intention to leave the workforce (Summers et al., 2021), lower academic attainment (Pascoe et al., 2020), and poor practitioner mental health (Vivolo et al., 2024). Given this, there is a strong clinical, academic and economic need for interventions designed to support trainee wellbeing.

A recent systematic review (Owen et al., 2025) found evidence to suggest that interventions designed for trainee psychological therapists and practitioners may be effective, and are frequently valued by trainees themselves. A wide range of intervention types have been trialled with this population, including those based on mindfulness, Cognitive Behavioural Therapy (CBT), stress-reduction programmes, Acceptance and Commitment Therapy (ACT) and many other approaches (Owen et al., 2025). Despite some limited support for the value of such interventions, the literature on this topic to date is heterogeneous and of mixed quality, with little consensus regarding the way that wellbeing in this population is conceptualised, or how an intervention designed to improve it should be implemented. As such, there is a pressing need for interventions designed to target the challenges commonly experienced in these roles, and to support wellbeing in ways consistent with how trainees experience it in their roles. Further, a need exists for the design of theoretically sound interventions with a clear pathway to improvement outlined, and an explicitly stated theory of change identified and tested.

The current study reports an acceptability and feasibility study of an ACT-based intervention designed to support PTT wellbeing. ACT is a therapeutic approach that considers values-driven action as central to positive psychological functioning (Hayes et al., 2012). The cornerstone of the ACT approach is the development of psychological flexibility; the ability to remain in contact with the present moment and to move towards personal values, even in the face of difficult internal thoughts or feelings (Bennett & Oliver, 2019). An ACT-based approach was selected given findings from the current research team to suggest that connecting with values is a central feature of how PTTs

experience wellbeing during training (in preparation). The intervention was also tailored to address the stressors commonly reported in the trainee literature (such as those associated with 'imposter syndrome' or perfectionism (Owen et al., 2022; Richardson et al., 2020)). The anticipated theory of change indicates that trainee wellbeing will be supported through increasing psychological flexibility, and supporting values-based action even in the presence of such stressors.

The current study is designed and reported in keeping with recently updated consolidated guidelines for pilot and feasibility studies (Lancaster & Thabane, 2019; Pfledderer et al., 2024), and was designed to address key uncertainties regarding the delivery and implementation of a wellbeing intervention for PTTs.

Study objectives

The objectives of this study were to assess the acceptability and feasibility of 'Thriving in training: An ACT intervention for psychological therapy trainee wellbeing', a four-session tailored ACT intervention designed to support wellbeing in PTTs.

Primary aims – acceptability and feasibility

1. To assess the acceptability and feasibility of a group ACT wellbeing intervention for PTTs

Secondary aims – clinical outcomes

1. To explore preliminary estimates of clinical effectiveness

Outcomes

Table 1. Methods of assessment for study aims

Primary Aims: Acceptability and Feasibility outcomes

Outcome	Method of Assessment
Recruitment	Proportion of eligible trainees who choose to take part. *Due to the unavailability of a suitable benchmark from the literature, no a priori level was set in advance.*
Retention	Number of participants who drop out during the intervention period. *Following expectations set by studies in a systematic review of wellbeing interventions for PTTs (Owen et al., 2025), a retention rate of 75% was established as indicating proceedable acceptability and feasibility.*
Data completion	Number of intervention participants who complete data outcomes at T1 (baseline), T2 (post-intervention) and T3 (3-week follow-up). *Following expectations set by studies in a systematic review of wellbeing interventions for PTTs (Owen et al., 2025), a data completion rate of 75% was established as indicating proceedable acceptability and feasibility.*
Acceptability of Intervention (AIM) score Feasibility of Intervention (FIM) score	Mean and SD participant scores on the AIM and FIM. *The AIM and FIM are 4-item measures, using a 5-point scale ranging from 1 (Completely disagree) to 5 (Completely agree). With no established cut-offs existing in the literature, consensus agreement was reached amongst the research team to define minimum levels of acceptability and feasibility. With scores of 12 or below indicating participants have not agreed with most or all statements, a score of 13 or above was selected as a minimum indicator of satisfactory acceptability and feasibility. A minimum of 85% of participants scoring 13 or above was established as the acceptability and feasibility thresholds.*

Participant accounts of intervention acceptability	Qualitative data generated through semi-structured, post-intervention interviews and analysed using Thematic Analysis.
Participant accounts of intervention feasibility	Qualitative data generated through semi-structured, post-intervention interviews and analysed using Thematic Analysis.
Secondary Aims: Clinical outcomes	
Outcome	**Method Assessment**
Preliminary indicators of clinical change	Change scores and Reliable Change Index (RCI) for clinical outcomes (CompACT, PSS-10, CD-RISC, WEMWBS, GHQ-12) from pre-to-post-intervention and follow-up.

Method

Ethics

Ethical approval for the study was secured via the Research Ethics Committee at the primary author's employing university.

Design

A convergent, parallel quant + qual design was used (Creswell & Plano Clark, 2018). In this design, quantitative and qualitative data are collected in the same phase of the research, with each data set analysed independently (using methods appropriate to the research questions and data) before being combined and integrated in an effort to provide a more comprehensive answer to the questions posed than could have been reached with quantitative or qualitative research alone (Creswell & Plano Clark, 2018). The current study was underpinned by a worldview of pragmatism

(Gillespie, 2024). From this perspective, the research question is considered of primary importance, and the focus is on doing 'what works', using multiple methods of data collection, and retaining a strong focus on the consequences of the research (Creswell & Plano Clark, 2018).

Quantitative analysis

Data regarding participant characteristics and attendance were summarised using frequencies, percentages, means and standard deviations as appropriate. As an acceptability and feasibility study, no formal statistical analyses were conducted, and the study was not designed to determine intervention effectiveness (Thabane et al., 2010). However, to identify potential indicators of effectiveness, change scores were calculated for pre- and post-intervention. These were averaged across all completers (with 95% confidence intervals also estimated). Cohen's *d* was subsequently estimated for effect sizes by subtracting the pre-intervention group mean from the post-intervention group mean, and dividing this by the pre-intervention standard deviation (Durlak, 2009).

In an effort to further explore change at an individual level, Reliable Change scores were calculated by dividing an individual's change score by the standard error of difference (S_{diff}) (Jacobson & Truax, 1991). The S_{diff} was estimated for each scale using standard deviation and Cronbach's alpha data from published norms using general population or non-clinical student samples. Full details of the studies selected for this purpose can be found in Supplementary Material 1. Following the recommendation of Jacobson & Truax (1991), RCI scores greater than ±1.96 are considered reliable improvement (+) or deterioration (-). Owing to the poor follow-up data completion, no attempts were made to include T3 data in any analysis.

Qualitative analysis

Thematic analysis as described by Braun and Clarke (2006; 2019) was used to analyse qualitative data generated through post-intervention interviews. Interviews were transcribed and read multiple

times, before being coded to identify 'chunks' of meaningful data relating to the research questions. Codes were then grouped into themes reflecting patterns of shared meaning generated by the primary researcher. The primary researcher kept a reflective journal to document reflections and considerations influencing the analysis. To support reliability and credibility, an audit trail of the analytic process was kept (Lincoln & Guba, 1985).

Participants and setting

Participants were recruited from across five separate psychological therapy/practitioner training programmes at one university in England, between 20th March and 17th May 2025. Trainees from Clinical Psychology (ClinPsyD), High Intensity CBT (HIT), Psychological Wellbeing Practitioner (PWP), Clinical Associate in Psychology (CAP), and Education Mental Health Practitioner (EMHP) programmes were invited to take part. Trainees were based over a large and diverse geographical region, working in a range of settings including primary care, secondary care, and schools. Eligibility criteria were:

- Currently enrolled on one of the university's formal psychological therapy/practitioner training programmes
- Not on a break in study

Information regarding the intervention and research was presented verbally to trainees during teaching sessions, and posted electronically via online learning portals. No incentives were offered for taking part and the intervention was designed to take place in addition to the core curriculum. In keeping with conventional recommendations for sample size in feasibility studies (Teare et al., 2014; Whitehead et al., 2016), a minimum of 30 participants were sought. To ensure all trainees who wanted to participate were able to, no maximum number was placed on recruitment. In keeping with guidelines for a study of this size, 12-15 participants were sought for post-intervention interview (Braun & Clarke, 2013). Interview participants were recruited from trainees who had registered for

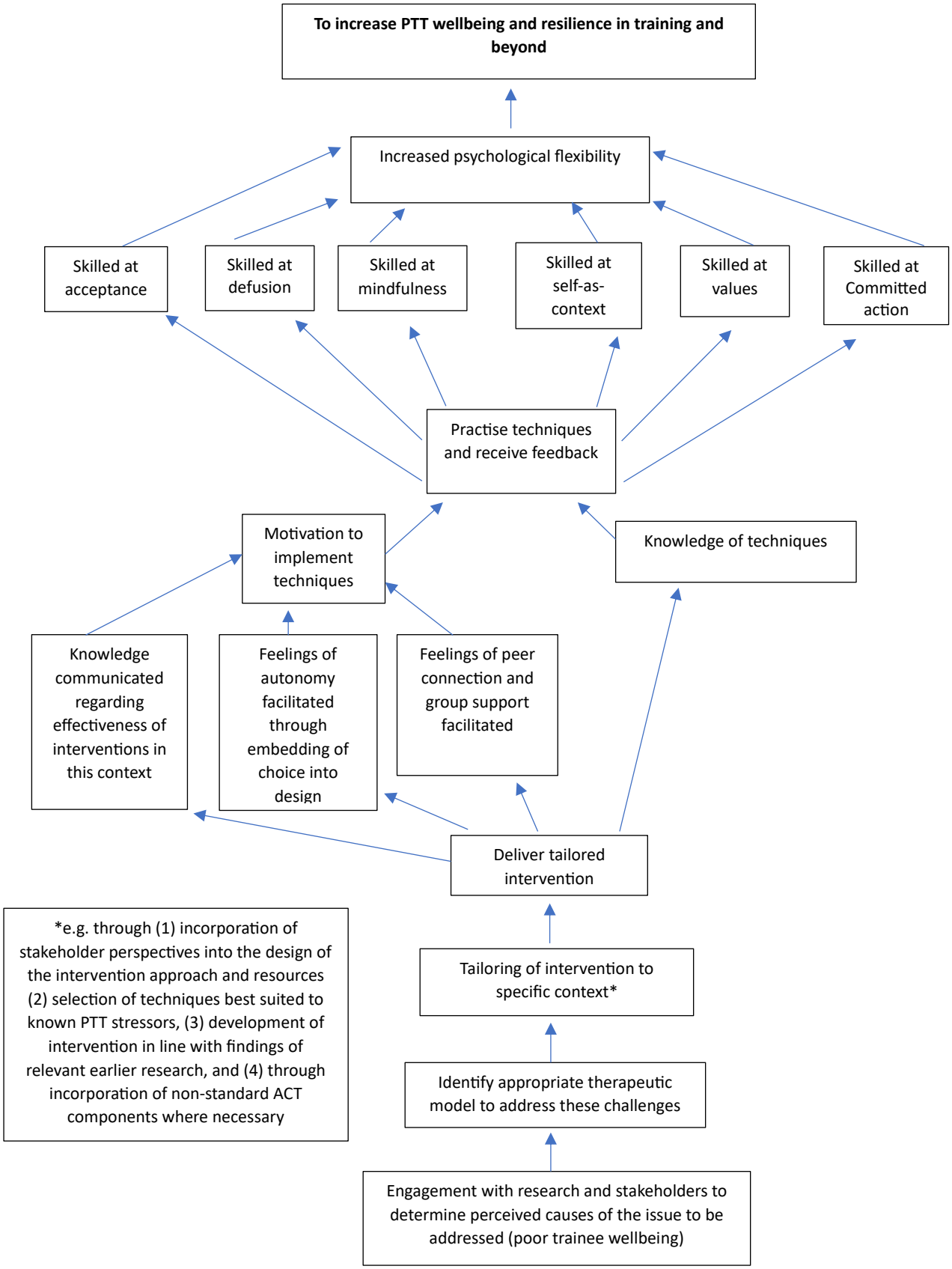
the study, and active attempts were made to recruit participants who had dropped out as well as intervention completers.

Intervention

'Thriving in training: a group ACT intervention for psychological therapy trainee wellbeing' is an intervention based on principles of Acceptance and Commitment Therapy (ACT). The intervention is designed to enhance psychological flexibility, and to address stressors identified in the psychological practitioner and trainee literature (e.g. 'imposter syndrome' (Jones et al., 2017; Owen et al., 2022)). The intervention was informed by an existing ACT protocol for workplace wellbeing (Flaxman et al., 2019) and established ACT techniques and exercises (Harris, 2008; Hayes et al., 2012), whilst also incorporating ideas and techniques from self-compassion approaches (Gilbert, 2009). All content was adapted and tailored specifically for PTTs, and co-constructed with trainees and clinical academics in response to detailed qualitative exploration of how trainees experienced wellbeing in their roles (under review).

A visual representation of the proposed theory of change is presented below. Further details of the theory of change are presented in the intervention development paper reporting the process of developing this intervention in full (under review).

Figure 1. Theory of Change



Intervention delivery

The intervention was delivered remotely via Teams, in a group setting, and over the course of four, two-hour sessions each 1-3 weeks apart. Group numbers ranged from 2 to 31. To accommodate the different schedules of each professional grouping, intervention sessions were delivered separately for each profession. HIT and EMHP trainees were offered the sessions on weekday evenings (6.30pm-8.30pm). ClinPsyD, PWP, and CAP trainees were offered sessions during working hours, but without additional time being allocated to attendance (e.g. attending meant taking time out of a clinical or study day). Attendance to all sessions was optional. All sessions were delivered by the primary researcher, a qualified Psychological Wellbeing Practitioner (PWP) and academic with eight years' experience training psychological professionals. The primary researcher has extensive experience teaching about trainee wellbeing and delivering psycho-educational groups in the United Kingdom's National Health Service (NHS), has undertaken comprehensive training in ACT, and received clinical-style supervision from Clinical Psychologist members of the research team, throughout the intervention period.

Table 2. Overview of intervention content (examples of intervention resources are available in Supplementary Material 2.1 – 2.2).

Session	Session objectives	Outline of content	Between Session tasks set
Session 1	Introduce key components of the ACT model. Begin some experiential 'noticing' practice. Introduce values, and identify important personal values.	Introduction to key ACT processes Experiential practice of mindfulness techniques – 'The Pen' (Flaxman et al., 2019)) Values sort and Compass Metaphor (Flaxman et al., 2019) Introduction to tailored adaptation of 'Passengers on the bus metaphor' (Hayes et al., 2012)	Practice bringing present moment attention to a routine activity. Notice 'towards moves' in relation to personally relevant values.
Session 2	To gain practical experience 'noticing' bodily sensations and the activity of the mind. To use real-life experience to explore the influence of thoughts and feelings on behaviour. To explore how to move towards values even in the face of difficult internal content. To practice getting psychological distance from unhelpful thoughts related to training.	Reflection/discussion on home practice Experiential practice of mindfulness techniques - (Mind, Body, Breath – (M. Williams & Penman, 2011)) Introduction to the ACT matrix (Polk & Schoendorff, 2014) Introduction to acceptance and defusion, including multiple defusion techniques (e.g. 'I'm having the thought that…' (Harris, 2008))	Practice of mind, body and breath guided meditation Practice 'noticing thoughts as thoughts' in real life (e.g. 'I'm having the thought that…' in real time). Use of ACT Matrix principles to notice how unhelpful thoughts and feelings can interfere with towards moves.
Session 3	To explore the nature of self-critical thinking from an ACT perspective.	Reflection/discussion on home-practice	Guided mindfulness practice (3 minute breathing space)

	To explore self-criticism in therapy training. To introduce ideas of self-compassion in therapy training.	Experiential practice of mindfulness techniques (3 minutes breathing space – (Williams & Penman, 2011)) Self-criticism in therapy training, self-compassion and acceptance techniques (e.g. 'Our common humanity' video (Kjelgaard, 2014) and introducing the 'self-critical passenger' (Kemp, 2021)) Two sheets of paper exercise (Flaxman et al., 2019)	Practice noticing the 'self-critical passenger' in real life, using defusion techniques and self-compassion. Use of ACT Matrix principles to notice how unhelpful thoughts and feelings can interfere with towards moves.
Session 4	To further explore notions of self-criticism and self-compassion in the training context. To introduce the notion of flexible perspective taking and flexible self-stories. To further embed the core ACT ideas through acting out the POTB metaphor.	Reflection/discussion on home-practice Holding self-stories 'lightly' – 'I am…' (Bennett & Oliver, 2019; Gilbert, 2009) Revisiting core content (e.g. acting out 'The passengers on the bus' metaphor) Further reflection on taking ideas out 'into real life'	Invitation to continue using any ideas covered in the sessions that were found useful.

Measures

Information was gathered regarding demographics (course of study, age, gender, disability status, and ethnicity). Additionally, the following measures were completed at Time 1 (within one week of starting the intervention), Time 2 (up to 1 week from the final session) and Time 3 (3-4 weeks after the final session).

Acceptability of Intervention Measure (AIM) (Weiner et al., 2017): A 4-item measure of intervention acceptability with promising psychometric properties. It uses a 1-5 Likert scale with higher scores indicating greater acceptability.

Feasibility of Intervention Measure (FIM) (Weiner et al., 2017): A 4-item measure of intervention feasibility with promising psychometric properties. It uses a 1-5 Likert scale with higher scores indicating greater feasibility.

Perceived Stress Scale (PSS-10): A validated and widely-used instrument for measuring perceived stress (Cohen et al., 1983). Comprised of 10 self-report questions scored on a 0-4 Likert scale rating, higher scores indicate higher perceived stress.

Connor-Davidson Resilience Scale (CD-RISC-25): A validated and widely-used instrument for measuring resilience (Connor & Davidson, 2003). Comprised of 25 self-report questions scored on a 0-4 Likert scale rating, higher scores indicate higher resilience.

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): A validated and widely-used instrument for measuring mental wellbeing. Comprised of 14 self-report questions scored on a 1-5 Likert scale, higher scores indicate higher mental wellbeing.

Comprehensive Assessment of ACT processes (CompACT): A validated and increasingly widely-used measure of psychological flexibility (Francis et al., 2016). Comprised of 23 self-report questions scored on a 0-6 likert scale, higher scores indicate higher psychological flexibility. The measure includes 3 sub-scales: Openness to Experience (range 0-60), Behavioural Awareness (range 0-30), and

Valued Action (range 0-48). Scores can be presented as a total, and/or for each of the three sub-scales independently.

General-Health-Questionnaire (GHQ-12): A validated and widely-used instrument for measuring psychological distress (Goldberg, 1972). Comprised of 12 self-report questions scored on a 0-3 Likert scale rating, higher scores indicate higher distress.

Results

Participant characteristics at T1 (baseline)

Variable	**N (%)**
Age	18-25 *n*=13 (18%) 26-35 *n*=43 (58%) 36-45 *n*=13 (18%) 46-55 *n*=4 (5%) 56-65 *n*=1 (1%)
Gender	Female *n*=63 (85%) Male *n*=8 (11%) Non-binary *n*=1 (1%)
Disability	Yes *n*=12 (16%) No *n*=57 (77%) Unsure *n*=2 (3%) Prefer not to say *n*=3 (4%)
Ethnicity (Using Office for National Statistics (ONS) groupings)	**Asian/Asian British** Indian *n*=2 (3%) Pakistani *n*=0 Bangladeshi *n*=1 (1%) Chinese *n*=0 Any other Asian background *n*=4 (6%)

	Black/African/Caribbean/Black British African *n*=1 (1%) Caribbean *n*=0 Any other Black/African/Caribbean background *n*=0 **Mixed/Multiple ethnic groups** White and Black Caribbean *n*=0 White and Black African *n*=0 White and Asian *n*=1 (1%) Any other Mixed/Multiple ethnic background *n*=4 (5%) **Other ethnic group** Arab *n*=1 (1%) Any other ethnic group *n*=1 (1%) **White** English/Welsh/Scottish/Northern Irish/British *n*=52 (70%) Irish *n*=1 (1%) Gypsy or Irish Traveller *n*=0 Any other White background *n*=5 (6%) Prefer not to say *n*=1 (1%)
Professional Training Programme	ClinPsyD *n*=37 (50%) CAP *n*=8 (11%) PWP *n*=11 (15%) HIT *n*=3 (4%) EMHP *n*=15 (20%)

The demographic makeup of the sample was broadly reflective of the UK psychological professions workforce (Whittington, 2024). However, this sample was slightly younger, and under-represented by those identifying as Black or Black British.

Interview participants

Post-intervention interviews were conducted with trainees who had completed the intervention in full (n=12) or registered but subsequently only attended one or two sessions (n=2). Interview participants included 3 PWPs, 3 EMHPs, 3 Clinical Psychology trainees, 2 CAPs and 2 HITs, and were aged 18-25 (n=4), 26-35 (n=6), and 36-45 (n=4). Participants included 1 male and 13 females and described their ethnicity as Arab (n=1), Latino (n=1), Indian (n=1), and White or White British (n=11).

Acceptability and feasibility outcomes

Recruitment, retention and data completion

A total of 277 trainees were eligible to participate and were offered the intervention. Of these, 91 (33%) registered to take part. In total, 74 (27%) subsequently completed the T1 measures, and 63 (23%) actually commenced the intervention by attending Session 1. Reasons given by those who registered but did not eventually take part were clashes with clinical or academic commitments (n=9), deciding they didn't have enough time (n=2), or deciding they were already going to be familiar with the content covered (n=1). 50 participants attended session 4. This reflects a completion rate of 55% for those who registered to take part (n=91), and a retention rate of 79% of those who actually commenced the intervention (n=63).

Regarding data completion, of the 74 participants who completed the T1 measures, 39 also completed the T2 measures (52.7%) and 22 (29.7%) at Time 3.

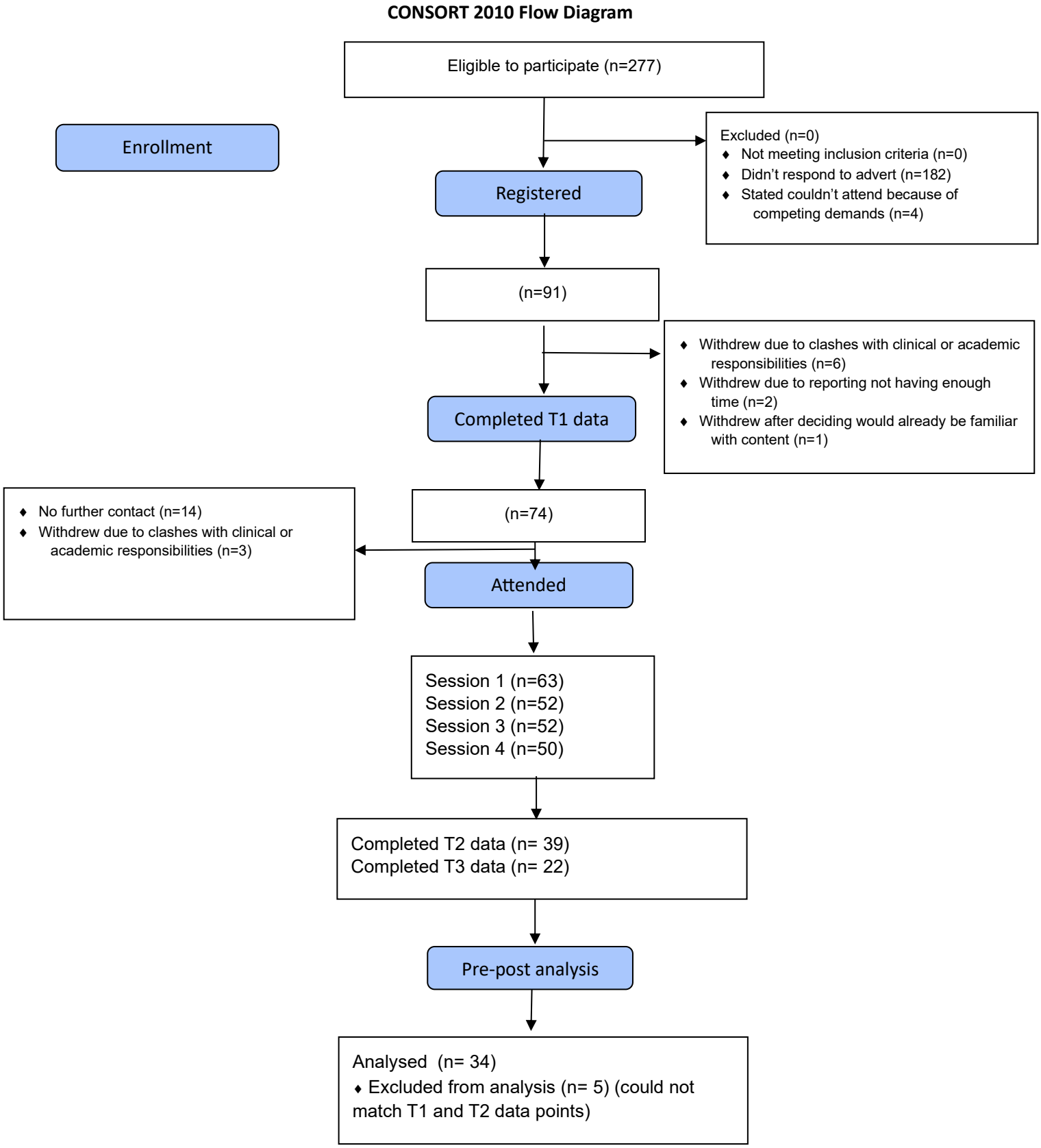
Table 3. Recruitment, attendance and retention data by professional group

Column no.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Professional group	**No. advertised to**	**No. registered (% of 1)**	**No. completing T1 data (% of 2)**	**No. attending Session 1 (% of 3)**	**No. attending Session 2 (% of 3)**	**No. attending Session 3 (% of 3)**	**No. attending Session 4 (% of 3)**	**No. completing T2 data (% of 3)**	**No. completing T3 data (% of 3)**
PWP	21	11 (52.38%)	11 (100.00%)	11 (100.00%)	9 (81.82%)	11 (100.00%)	11 (100.00%)	9 (81.82%)	5 (45.45%)
CAP	26	10 (38.46%)	8 (80.00%)	8 (100.00%)	6 (75.00%)	7 (87.50%)	6 (75.00%)	5 (62.50%)	3 (37.50%)
ClinPsyD	150	45 (30.00%)	37 (82.22%)	31 (83.78%)	27 (72.97%)	25 (67.57%)	25 (67.57%)	19 (51.35%)	11 (29.73%)
EMHP	54	21 (38.89%)	15 (71.43%)	11 (73.33%)	7 (46.67%)	6 (40.00%)	6 (40.00%)	3 (20.00%)	2 (13.33%)
HIT	26	4 (15.38%)	3 (75.00%)	2 (66.67%)	3 (100.00%)	3 (100.00%)	3 (100.00%)	3 (100.00%)	1 (33.33%)
Total	**277**	**91 (32.85%)**	**74 (81.32%)**	**63 (85.14%)**	**52 (70.27%)**	**52 (70.27%)**	**50 (67.57%)**	**39 (52.70%)**	**22**

									(29.73%)

Note: % relates to column number indicated in column header.

Figure 1. CONSORT Flow Diagram showing participant pathways through the study



Acceptability and Feasibility Measures

Both the AIM and FIM have a range of 4-20, with higher scores indicating greater acceptability and feasibility respectively. Mean scores at post-intervention (T2) were 17.82 (SD = 3.30) on the AIM and 18.38 (SD = 1.88) on the FIM, with both measures displaying strong negative skews, and scores for this sample clustered at the top of the scale. Across the sample, 100% of all respondents scored at or above the threshold marker of 13 for the FIM, and 94% scored at or above 13 for the AIM, meaning established thresholds indicating acceptability and feasibility were met.

Qualitative data

Qualitative data was generated through participant interviews designed to explore the perceived acceptability and feasibility of the intervention.

Acceptability findings

1. **'It helped to keep the sessions engaging': The interactive and experiential nature of the intervention was key**

This theme describes how the engaging, interactive and practical nature of the intervention was key to its perceived acceptability. Participants across the sample spoke positively of the group environment and experiential format, describing the group as 'normalising' (P8) and 'very collaborative' (P7). The opportunity to try techniques out in session was also valued, helping 'it to feel less like another lecture to go and sit through' (P9). Whilst completing activities in session occasionally felt quite 'vulnerable' (P6), several participants described how working with peers and friends had made it easier to 'get straight into trying techniques out and sharing openly' (P12), something which appeared central to the positive way the intervention was experienced. Relatedly,

the input and approach of others in the group was described as important to how sessions were received. Whilst several trainees described what they considered an optimum group size, for others, the effectiveness of the sessions were 'maybe not so much about the size, but more the fact that it seemed like everybody contributed' (P5). Together, these findings suggest that the interactive, open, collaborative and experiential nature of intervention sessions was central to the perceived acceptability.

2. **'It's helpful in a work way, an academic way, and a personal way': the intervention was experienced as highly relevant to the trainee context**

This theme describes how participants experienced the intervention as highly relevant to their trainee context. The intervention was considered helpful for addressing some of the key challenges encountered during training, such as those relating to 'self-doubt and imposter syndrome' (P1). Whilst other wellbeing supports offered during training were described as 'disappointing' (P4) for the way they offered little that was new or practical, this intervention was experienced as filling a gap by providing meaningfully-tailored and practical techniques that 'really made a difference' (P3). Notably, trainees also reported that the benefit and appeal of the training was 'both professional and personal' (P14). Trainees described how 'the opportunity to learn about ACT' (P14) had been appealing, and a strong sense ran throughout participant responses that the intervention was experienced as acceptable both for the ways it supported personal wellbeing, but also for how it provided an important opportunity for professional development.

3. **'Having choice made me more motivated': feeling autonomous regarding the intervention increased acceptability**

This theme captures how feeling autonomous and having a degree of choice over multiple components of the intervention helped increase its acceptability. Whilst there was evidence that some participants thought the intervention should be embedded formally into the training curriculum, several trainees described how the fact they had *chosen* to take part led them to feel more motivated than they would have done if they had 'felt that it was mandatory' (P7). The busy nature of their roles was raised, and participants described how they 'would have dropped out' (P2) or 'felt like [they were] failing' (P1) if they were given mandatory tasks they subsequently felt unable to complete, indicating that the choice trainees were given regarding how much of the between-session tasks to complete was also important. Throughout the accounts of trainees, there was also a strong sense that the choice and variation of techniques to which they were introduced was valued. Participants spoke of how there were 'so many different concepts that were helpful' (P1), and described how although they connected with some techniques more than others, the array of included techniques meant you could 'take what you love and leave what you don't like' (P4).

Feasibility findings

4. **'It's definitely hard to fit it in': managing attendance alongside the core requirements of training**

This theme captures how the positioning and structure of the intervention alongside core course requirements was central to its perceived feasibility. A perception that trainees were busy and managing multiple competing demands ran throughout much of what participants described. There was a strong sense that offering the intervention too early in training (when trainees are receiving high volumes of teaching regarding the fundamentals of the job) would have been unhelpful. Trainees described how this would have been 'too much like information overload' (P9) and would have inadvertently risked them feeling 'more stressed' (P11).

Practical matters relating to the intervention were also central to its perceived feasibility. The online nature of the intervention was received positively, with several trainees reporting that they 'wouldn't have been able to take part' (P5) if they had been required to travel to an in-person location. Several trainees also described valuing the fact that sessions had been limited to 'just four sessions' (P4) and that between-session tasks had been designed to be 'unintrusive' to their schedules (P2). It was apparent throughout much of what was described that high levels of motivation and a feeling of 'really wanting to take part' (P5) had been necessary for trainees to carve out or hold the time needed to attend. Multiple participants described how it was 'hard to fit in' (P6), and both interview participants who dropped out described having done so because of the challenges of taking part around core course demands. Several participants reported believing that the intervention should be offered during protected university time, as 'part of the curriculum' (P3), suggesting that doing so would have increased uptake. Taken together these findings indicate that attending an intervention as an additional extra during a busy training period is feasible but difficult, and requires high levels of motivation from trainees.

Secondary (clinical) outcomes

In Table 3, pre- and post-intervention group means for all measures are displayed, with average change scores and effect sizes estimated. Using Cohen's (1988) conventional thresholds, effect sizes of large or medium magnitude were identified across all outcomes. In Table 4, reliable change scores are presented. At least 18% (n=6) of participants reliably improved on all outcomes, with rates of reliable improvement approaching or at 50% of participants on multiple outcomes. Minimal numbers of participants reliably deteriorated on any measure. Reliable deterioration rates ranged from 0 (0%) to 4 (12%).

Table 4. Mean scores for T1 and T2 completers, with averaged change score and estimates of Cohen's *d*

Measure	**T1 Mean (SD)** *n*=34	**T2 Mean (SD)** *n*=34	**Average Change** *(95% CI)*	**Cohen's *d*** Small = 0.2 Medium = 0.5 Large = 0.8
Total CompACT *Mean (SD)* Scale Range: 0-138	76.74 (18.97)	97.47 (14.54)	20.74 *(15.34 – 26.14)*	1.09
Openness to Experience (CompACT subscale) Scale Range: 0-60	31.18 (10.85)	42.29 (7.00)	11.12 *(7.94 – 14.30)*	1.02
Behavioural Awareness (CompACT subscale) Scale Range: 0-30	11.06 (5.48)	16.53 (6.23)	5.47 *(3.33 – 7.61)*	1.00
Valued Action (CompACT subscale) Scale Range: 0-48	34.50 (6.06)	38.64 (5.24)	4.15 *(2.85 – 5.45)*	0.68
PSS-10 *Mean (SD)* Scale Range: 0-40	19.85 (6.56)	16.21 (5.30)	-3.65 *(-5.46 – -1.84)*	-0.55
GHQ-12 *Mean (SD)*	15.32 (6.24)	9.24 (4.91)	-6.09 *(-8.53 – -3.64)*	-0.97

Scale Range: 0-36				
WEMWBS *Mean (SD)* Scale Range: 14-70	43.82 (7.19)	47.21 (5.79)	3.38 *(0.49 – 6.27)*	0.48
CD-RISC *Mean (SD)* Scale Range: 0-100	63.12 (9.83)	68.06 (9.38)	4.94 *(2.18 – 7.70)*	0.50

Note: Wellbeing (WEMWBS), Stress (PSS-10), Psychological Distress (GHQ-12), Resilience (CD-RISC), Psychological Flexibility (CompACT).

Note. Despite having 39 data entries from T2, 5 entries could not be matched to a T1 entry, and so were excluded from the analysis.

Table 5. Reliable Change pre-post intervention (n=34)

Outcome Measure	**Reliable Deterioration**	**No reliable change**	**Reliable Improvement**
CompACT (total)	0	18	16
Openness to Experience (CompACT subscale)	0	20	14
Behavioural Awareness (CompACT subscale)	0	22	12
Valued Action (CompACT subscale)	0	27	7
PSS-10	2	25	7
CD-RISC	1	27	6
WEMWBS	4	16	14

GHQ-12	1	15	18

Discussion

This study was designed to assess the acceptability and feasibility of a tailored ACT intervention for psychological therapy trainees. Findings suggest that the intervention was highly acceptable to trainees, and feasibility benchmarks were partially met. However, several important considerations regarding intervention feasibility were identified. Data collection levels fell below the pre-determined benchmark and as such, significant adjustments would be required to this aspect of the research before a larger trial. Information was not collected specifically on the process of data completion in the current study, and therefore this should be a key component of future studies before advancing to a full-scale trial.

With the intervention offered to trainees as an optional extra during what is frequently experienced as a busy and stressful training period (Owen et al., 2021; Pakenham & Stafford-Brown, 2012), a recruitment rate of almost one-third (32.85%, or 91 from 277 trainees) was considered to represent a high level of interest in participation, and recruitment strategies appeared to work effectively. In a recent systematic review of interventions designed to support trainee wellbeing (Owen et al., 2025), it was observed that data on the rate of recruitment or the numbers of trainees offered the chance to participate were not routinely or reliably reported. As such, no *a priori* goals were set regarding recruitment, and this information presents important preliminary evidence regarding the feasibility of recruiting participants to a study of this kind. Whilst the recruitment of approximately one in three trainees across the department was considered an encouraging level of interest, this does nonetheless indicate potential limits to the reach of interventions such as the one developed here. Further, whilst 91 trainees registered to take part, only 74 (81.31%) completed the T1 data collection and 63 (69.23%) subsequently attended the first session, figures which can be helpfully understood in reference to aspects of the qualitative data. Interview participants frequently described the

challenge of making time to attend whilst also maintaining other course requirements, and both interview participants who had dropped out before the end of the intervention described having done so due to this challenge. As reported above, and in keeping with literature elsewhere highlighting the high workloads and multiple demands of trainees (Jones et al., 2017; Pakenham & Stafford-Brown, 2012), the most common reason cited by those who withdrew before the intervention began was also clashes with clinical or academic responsibilities, suggesting that the drop in numbers between registration and Session 1 reflect feasibility concerns. Whilst overall, recruitment and retention to the study were acceptable, consideration of methods to make attending more accessible to trainees may help increase confidence of appropriate recruitment ahead of a future trial. Deliberate efforts to better understand the reasons for not registering at all are perhaps especially important, and may be required to help more fully understand the true acceptability and feasibility of the intervention.

Several interview participants described how attending would have been easier if time had been formally held in the teaching curriculum, and evidence gathered across the study suggests that holding space in this way would have notably increased recruitment, retention and data completion. Importantly however, and as noted above, several trainees described how choice and autonomy were important features of intervention acceptability. These findings align closely with those reported in a recent systematic review of wellbeing interventions for PTTs, in which choice and autonomy were identified as important facilitators of intervention success (Owen et al., 2025). They also align with the large body of evidence relating to self-determination theory (SDT), in which feeling autonomous is described as a basic psychological need (Ryan & Deci, 2017). The findings of the present study therefore suggest that actions designed to increase feasibility (such as holding time in the teaching curriculum to run the intervention as a mandatory component of training) could inadvertently effect intervention acceptability if not carefully planned. In future studies, embedding sessions into protected teaching time may be helpful, with attendance encouraged but not obliged,

and with sessions delivered in a way that retains as much as possible feelings of choice and autonomy over engagement with the intervention. Before progressing to a full-scale trial, future pilot testing should consider trialling the acceptability and feasibility of multiple modes of delivery, with optional attendance, mandatory attendance, and no intervention, compared.

Once into the intervention period, a retention rate of 79% of intervention starters was achieved. This level slightly exceeds the benchmark established for this study to indicate intervention feasibility. This appears likely to be connected to the high levels of satisfaction and acceptability reported with the intervention. Interview participants reported high levels of satisfaction with the intervention, a sentiment echoed in the AIM scores, and reflected in the positive retention rates that withstood the acknowledged challenge identified by participants of finding time to take part. Notably, despite widely varying group numbers, acceptability was high across all groups, with evidence to suggest that acceptability was influenced less by group size, and more by a sense that group-peers were engaging actively. Very small group numbers may however influence intervention feasibility in terms of delivery costs for a low reach. The specific acceptability and feasibility of differing group sizes should therefore be considered in future testing.

As an intervention designed to support trainee wellbeing, and also an opportunity to learn about and experience a third-wave therapeutic approach, participants described having dual motivations to attend, and interview participants described both personal and professional benefits from taking part. These findings align closely with research into the notion of 'personal practice', in which the self-practice of therapy techniques by psychological professionals has been found to support both personal and professional development (Bennett-Levy & Finlay-Jones, 2018). In the current study, the opportunity to learn skills relevant to their roles whilst also paying attention to their own wellbeing appears to have increased intervention acceptability, and was likely important in attracting and retaining the numbers reached.

The secondary (clinical) outcome findings reported in this study provide tentative and preliminary evidence regarding the potential effectiveness of this intervention. As an acceptability and feasibility study, this study was not designed to assess intervention effectiveness (Thabane et al., 2010) and no formal statistical analyses were conducted. However, reliable change scores provide some tentative evidence of the potential for this intervention to be effective in this population and setting. The number of participants reporting reliable improvement on all measures and subscales over the intervention period were encouraging. Using Cohen's (1988) conventional benchmarks, improvements of a large magnitude were identified on all outcomes except resilience, psychological wellbeing, stress and valued action – all of which improved with a medium or medium-large effect. A small number of participants experienced reliable deterioration on measures of wellbeing (n=4), stress (n=2), resilience (n=1) and psychological distress (n=1), numbers that are comparable with other feasibility studies of ACT-based interventions (Kishita et al., 2022). Quantitative data on secondary outcomes also lends some provisional support to the hypothesised theory of change. The large effect sizes and encouraging number of reliable improvements identified on the CompACT indicate that the intervention has potential for increasing psychological flexibility in trainees. Psychological flexibility is considered important for wellbeing, resilience and psychological health (Doorley et al., 2020; Kashdan & Rottenberg, 2010) and is the principal pathway through which trainee wellbeing is hypothesised to be improved through this intervention. The particularly large effect size and high number of reliable improvements on the 'Openness to Experience' subscale indicates that the intervention may be especially well-suited to addressing some of the known cognitive stressors experienced by trainees (e.g. 'imposter syndrome' and perfectionistic or self-critical thoughts (Jones et al., 2017; Richardson et al., 2020)). Study findings therefore largely support the proposed theory of change, but indicate potential refinements through an increased emphasis on 'Openness to experience' as the component of psychological flexibility most important to this population. The differential contributions of the three psychological flexibility subscales should be further explored in subsequent testing with this population.

Limitations

Despite the encouraging signals, the findings reported here should be interpreted cautiously and the study has a number of important limitations. Without a control group for example, it is unclear to what extent identified effects are attributable to the intervention itself. Whilst across the sample, trainees were at varying stages of their training, the fluctuating demands of training across the year could have potentially influenced outcomes on all variables. Additionally, intervention completers are over-represented in both the quantitative and qualitative components of this study, an important limitation that should be borne in mind when interpreting the results presented here. Whilst efforts were made to recruit as many non-completers as possible to interview, only two agreed. As such, the qualitative perspectives provided regarding intervention acceptability and feasibility primarily reflect the views of those who had completed the intervention in full, participants who by definition could be considered likely to have experienced the intervention as more acceptable and feasible than those who dropped out or never registered at all. With regard to the quantitative data, a complete case analysis approach was used. The intentions of this study with regards to the secondary (clinical) outcomes were exploratory in nature, designed to explore potential signals of effect amongst trainees who received the intervention, and to therefore contribute to the refinement of the theory of change. However, it is important to note explicitly that complete-case analysis may lead to biased results if data are 'missing not at random' (Chaplin & Dwan, 2024) and the results identified here should therefore be interpreted cautiously, with the over-representation of intervention completers in mind. Additionally, all analysed results across quantitative and qualitative findings are drawn from a self-selecting sample of trainees who had volunteered to take part in the intervention. The absence of efforts to understand the reasons for not registering at all is an important further limitation, which potentially limits the understanding developed regarding the true overall acceptability and feasibility of the intervention.

Although participating trainees included those training in five separate psychological professions and working across a wide geographical and clinical area, trainees were all recruited from the same university, meaning features specific to the experience of trainees at that one university may have influenced findings, and the extent to which the methods and approach used here will generalise to other university settings is unknown. The acceptability and feasibility of recruiting and retaining trainees from other institutions therefore remains as a key uncertainty to be considered before a trial. The under-representation of Black or Black British participants also represents an important limitation to this study.

Whilst drawing on established features of the implementation literature (e.g. Proctor et al., 2011) and using validated and purpose-designed instruments (Weiner et al., 2017), the means through which acceptability and feasibility were measured in this study also reflects a potentially important limitation. Recent developments in the field have drawn attention to the multifaceted nature of constructs such as acceptability and feasibility (Sekhon et al., 2017; Sekhon et al., 2022). In their Theoretical Framework of Acceptability (TFA) for example, Sekhon and colleagues define acceptability as a multifaceted construct comprising seven component parts: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy (Sekhon et al., 2017; Sekhon et al., 2022). By measuring acceptability via the AIM, an instrument which captures information primarily related to affective attitude, important wider features of the construct of acceptability may have therefore been missed. This is important, as it could lead to overestimating the acceptability of the intervention, through neglecting to consider acceptability issues relating to opportunity costs, burden, or perceived effectiveness for example. Additionally, in the widely cited Consolidated Framework for Implementation Research (CFIR), multiple determinants of acceptability and feasibility are identified (Damschroder et al., 2009), highlighting how these constructs should be considered from multiple perspectives. The CFIR highlights how the feasibility of an intervention may be influenced by matters relating to Intervention

Cost, Adaptability or Complexity for example (Damschroder et al., 2009) in a way that cautions against efforts to reduce feasibility to a singular construct. Whilst efforts to consider both acceptability and feasibility broadly in this study were made (e.g. through the AIM and FIM, records of recruitment and retention, and qualitative interview data), the absence of important determinants of feasibility (such as those relating to cost highlighted above) represents an important further limitation.

A further limitation relates to the use of the CompACT measure to assess changes in psychological flexibility. Whilst the CompACT was designed to address several key shortcomings of earlier measures of psychological flexibility (Francis et al., 2016) it is not capable of explicitly capturing the independence of flexibility and inflexibility processes in the way that the MPFI does (Rolffs et al., 2018). Its use here therefore is an important limitation, meaning that the changes identified via the CompACT may reflect only part of the picture. Future research in this area would benefit from the more comprehensive and nuanced account the MPFI may afford. Finally, it is important to note that the GHQ-12 had originally been administered with incorrect scores attributed to the item descriptors (e.g. 'Not at all', 'No more than usual' etc.). Whilst the qualitative descriptors were accurate throughout, the scale had been set up using a 1-4 Likert scale, where it should have been 0-3. Scores have therefore been subsequently amended to be brought into line with the 0-3 scale. Whilst the consistency of the qualitative descriptors and number of levels (i.e. 0-3 vs 1-4) means this would not be expected to impact the way participants scored, it is theoretically possible that it could have done.

Conclusion

This paper reports findings from a mixed-methods acceptability and feasibility study of a tailored ACT wellbeing intervention for PTTs. Recruitment to the study was strong and pre-determined benchmarks for retention were met, however data completion benchmarks were missed, indicating the need for further exploration of ways to increase this in future studies. Preliminary evidence lent

tentative support to the notion that the intervention has the potential to be effective, and that the anticipated pathway of change (supporting wellbeing through targeting psychological flexibility in training) may be supported. Both quantitative and qualitative data supported the notion that the intervention was experienced as highly acceptable to trainees. Whilst support for feasibility was largely achieved, the research identified several challenges – most notably those associated with taking part as an additional task in the context of a training perceived to be busy – that should be addressed before a subsequent trial. On the basis of these encouraging results, next steps would include developing further pilot testing including recruitment from multiple sites, adjusted data collection strategies, comparing different modes of delivery, and randomisation to these different modes, all of which will need consideration before proceeding to a full trial.

Supplementary Material 1- Norm scores for Reliable Change Calculations

Reliable Change scores in this study were calculated by dividing an individual's change score by the standard error of difference (S_{diff}) (Jacobson & Truax, 1991). The S_{diff} was estimated for each scale using standard deviation and Cronbach's alpha data from published norms using general population or non-clinical student samples. Details of the source studies are presented below.

Comprehensive Assessment of Acceptance and Commitment processes (CompACT)

The development and validation of the Comprehensive assessment of Acceptance and Commitment Therapy processes (CompACT)

Reference: Francis, A. W., Dawson, D. L., & Golijani-Moghaddam, N. (2016). The development and validation of the Comprehensive assessment of Acceptance and Commitment Therapy processes (CompACT). *Journal of Contextual Behavioral Science*, *5*(3), 134-145. http://dx.doi.org/10.1016/j.jcbs.2016.05.003

Mean score: 86.83 (SD = 20.94)

Cronbach α = 0.91

Perceived Stress Scale (PSS-10)

Evaluating the Perceived Stress Scale among UK university students: implications for stress measurement and management

Reference: Denovan, A., Dagnall, N., Dhingra, K., & Grogan, S. (2019). Evaluating the Perceived Stress Scale among UK university students: Implications for stress measurement and management. *Studies in Higher Education, 44*(1), 120–133. https://doi.org/10.1080/03075079.2017.1340445

Mean score = 19.79 (SD = 6.37)

Cronbach α = 0.86

General Health Questionnaire (GHQ-12)

The reliability of the twelve-item general health questionnaire (GHQ-12) under realistic assumptions | BMC Public Health | Full Text

Reference: Hankins, M. (2008). The reliability of the twelve-item general health questionnaire (GHQ-12) under realistic assumptions. *BMC Public Health, 8*, 355. https://doi.org/10.1186/1471-2458-8-355

Mean score: 10.6 (SD = 4.9)

Cronbach α = 0.9

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation | Health and Quality of Life Outcomes | Full Text

Reference: Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes, 5*, 63. https://doi.org/10.1186/1477-7525-5-63

Mean score: 51.0 (SD = 7)

Cronbach α = 0.91

Connor-Davidson Resilience Scale (CDRISC-25)

Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC)

Reference: Connor, K. & Davidson, J. (2003) Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*, 76-82. DOI: 10.1002/da.10113

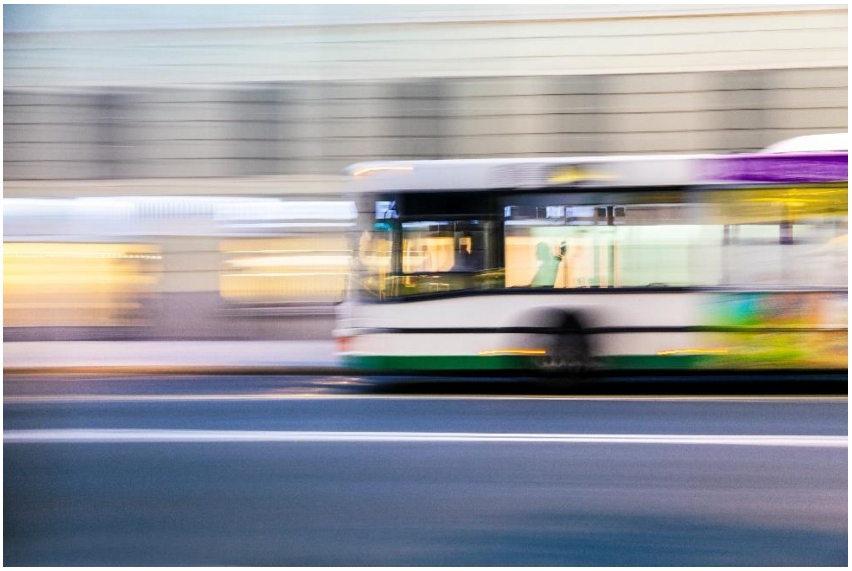
Mean score: 80.4 (SD = 12.8)

Cronbach α = 0.89

Supplementary Material 2.1 - adapted Passengers on the bus metaphor

The Passengers on the bus: a complete ACT metaphor

The *Passengers on the Bus* metaphor (Hayes, Strosahl & Wilson, 2012) is one of the most well-known and widely used ACT techniques. It describes how the decisions we make in response to internal thoughts, feelings and emotions can either move us *towards* or *away from* the things we value. We'll revisit this technique on multiple occasions across this training.



Across training (and in life more generally!) it is common to experience difficult or unpleasant thoughts, emotions and feelings from time to time. One set of thoughts that seem to be very commonly experienced by trainee and qualified psychological professionals are those related to what can be called 'imposter syndrome'.

Many trainees experience self-doubt and self-critical thoughts, frequently experiencing thoughts or feelings relating to the idea that they are not good enough at their job, less competent than others around them, or insufficiently skilled or compassionate to succeed in their role. If we become entangled with thoughts like these, they can have a big influence on our behaviour. Thoughts about not being competent for example might lead someone to avoid role-plays or opportunities for being observed by their supervisor, for fear of being 'found out' or receiving negative feedback. That might be a helpful short-term strategy for avoiding the anxiety of putting themselves 'out there' in front of a supervisor or peer, or keeping quiet the thoughts telling them that they're not good enough. But it's also likely to be unhelpful in their attempt to move towards qualification or things they might value such as personal development.

Similarly, thoughts about a written piece of work not being good enough might lead someone to delay submitting it, to argue with themselves by reminding themselves that they've passed assignments before, or to spend many hours writing and re-writing it in an attempt to make it perfect. Again, these behaviours might help momentarily quieten the thoughts and feelings telling the person that the work isn't good enough, that it's bound to fail, or that it will expose them as a fraud. However, they're unlikely to help them move towards personal values associated with

learning, or spending time with their family - because instead they're putting endless hours into trying to perfect their work in an attempt to quieten their own fears of failure.

The *Passengers on the Bus* metaphor helps illustrate another way of relating to such thoughts or feelings. Rather than arguing with the thoughts or taking steps to keep them quiet, we can instead choose to 'make room' for them, and bring them along with us. We can acknowledge difficult thoughts and feelings *and* move towards the things we value, rather than being constrained or directed by the thoughts and feelings.

The *Passengers on the Bus* metaphor (adapted from Hayes, Strosahl & Wilson, 2012)

"Imagine there's a bus and you're the driver. We'll call this your 'bus of life'. As you're the driver, you can drive it in a direction of your choice. On this bus you've got a bunch of passengers. The passengers are thoughts, feelings, bodily states, memories, and other aspects of experience. Some of them are pleasant, and they encourage you for going along in the direction you are. Some don't say much at all, whilst others provide a slightly negative and cautious message: 'I think you should drive a little slower, I don't feel like making this journey' and so on. Others still are mean, anxiety-provoking and downright unpleasant. They look intimidating and they can shout loudly. Some of these passengers pop up only at particular times with a specific message, like the one shouting 'You'll fail, you'll never get this right!' every time you try something new. Others are passengers you feel you've known a long time, and who repeat the same story at you over and over: 'You're not good enough, why do you even bother trying'.

What happens is this: you're driving along the road, and the passengers start making themselves heard. Again, some are reassuring, and some nothing worse than a little cautious. Others though are threatening you, telling you what you have to do, where you have to go: 'You've got to turn left,' 'You've got to go right,' etc. The threat that they have over you is that if you don't do what they say,

they're going to come up from the back of the bus and surround you. You know that you're the driver of this bus, and you can decide where to go. But these passengers are loud and intimidating, and so you end up making a deal with them to keep them quiet. The deal is something like this: 'You sit in the back of the bus and sit down so that I can't see you very often, and I'll do what you say and drive where you want'. Once this deal is struck, the voices quieten. The passengers sit further towards the back, and the threat seems partly removed. But you're now no longer choosing where to drive your own bus. Instead of taking the turns you'd like to, towards the destinations you really want to reach, you stay on the same old road, to keep the passengers quiet.

Now, what if one day you get tired of that and say, 'I don't like this! I'm going to throw these people off the bus!' You stop the bus, and you go back to deal with the mean-looking passengers. Notice that the very first thing you had to do was stop. Notice how in fact, you're now no longer driving anywhere at all, you're just dealing with these passengers. Plus, these passengers are strong. They don't intend to leave, and you wrestle with them, but it just doesn't work as you hope. You quickly realise that you simply can't throw them off.

For a while then, you try drowning them out, cranking the music up loud on the bus, or putting your hands over your ears. But this doesn't seem to work well either. You recognise that you're having to put so much effort and attention into covering your ears and not focussing on what the passengers are shouting at you, that it's hard to really keep control of the bus at the same time.

Eventually then you go back to placating the passengers, to try and get them to sit in the back again where you can't see them. The problem with that deal though is that you again have to do what they ask. Pretty soon, they don't even have to tell you to 'Turn left' – you know as soon as you get near a left turn that certain passengers are going to be there, telling you to do it. Eventually you may get good enough that you can almost pretend that they're not on the bus at all. You just tell yourself that left is the only direction you even want to turn!

Now, here's the trick about this whole thing. The power that the passengers have over you is 100% based on this: 'If you don't do what we say, we're coming up and we're making you look at us.' That's it! It's true that when they come up, they look like they could do a whole lot more. They look

menacing and threatening, and it feels like you could be destroyed. But in fact, they can't really do anything more than shout at and intimate you. Ultimately, the deal you made with them was to do what they'd say, just so that they'd do nothing more than stand close by and shout at you.

The driver (you) has control of the bus, but you trade away the control through those deals with the passengers. In other words, by trying to get control, you've actually given up control! Now notice that, even though your passengers claim they can destroy you if you don't turn left, it has never actually occurred. These passengers can't make you do something against your will.

So rather than focussing lots of energy on arguing with the passengers, stopping the bus to try and make them get off, or making deals with them to keep them quiet, you choose another way. You realise that you can actually drive the bus where *you* want to *and* bring the passengers along with you. You don't always like what they're saying, and the passengers don't go away, but you 'make room' for them, acknowledging their presence, but reminding them that you're the driver of this bus, and you choose where it's going.

'Thanks for the advice' you say, to the passenger warning you you'll get stuck or break down if you take the path up the hill towards your chosen destination, 'but I'm the driver, and I'll decide'. This way, the passengers remain on the bus, and many may keep saying the same things. But you've now made room for them, recognised they can't actually do anything to hurt you, and resumed control of your own bus so that you can go towards the destinations that you choose.

(text adapted from Hayes, Strosahl & Wilson, 2012)

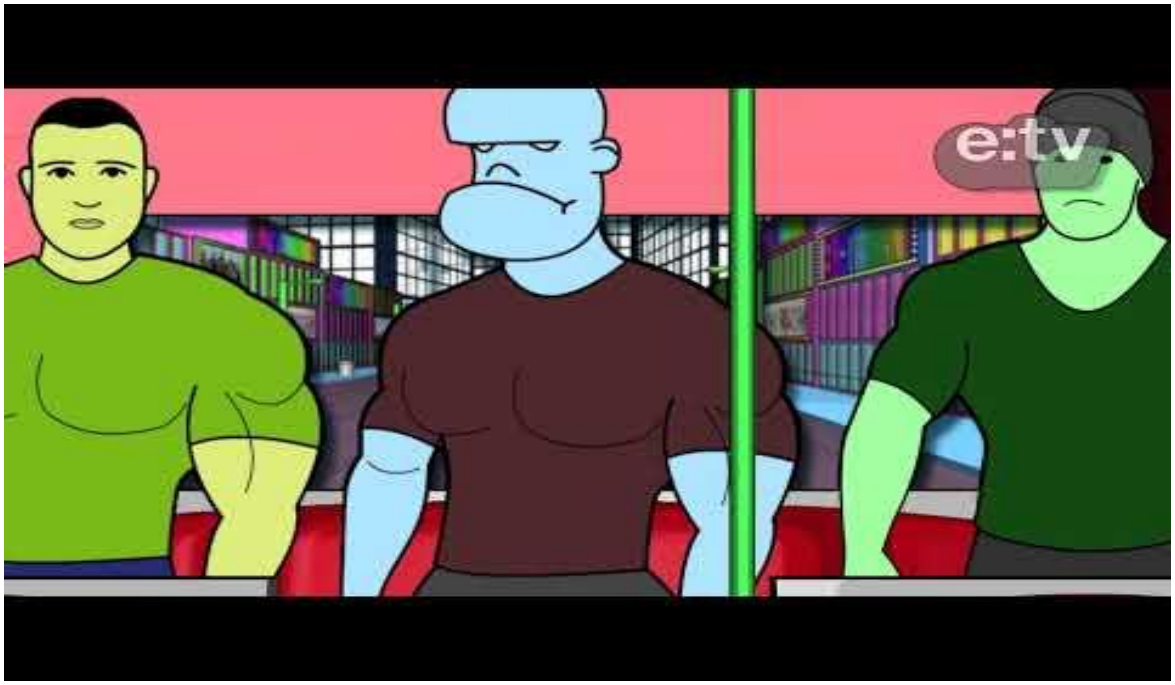
In this metaphor, the unpleasant passengers represent the thoughts, feelings, memories and internal sensations we all have that try to steer us off course or take us away from things we value. Sometimes those passengers are loud and aggressive telling you to stop immediately or they'll make

you crash the bus. Others are less threatening but just as forceful. ‘This isn’t worth it’, ‘Why even bother trying’, or ‘Maybe it would just be easier to stop trying’ are all voices that can persuade us to stop moving in the direction that we might otherwise want to.

Remember though, these thoughts, feelings and emotions are really only that: thoughts, feelings and emotions. We can ‘make room’ for them, and bring them along for the ride. In other words, we can move towards the things we value, without letting unpleasant thoughts, feelings or sensations steer us off course.

Videos and online resources

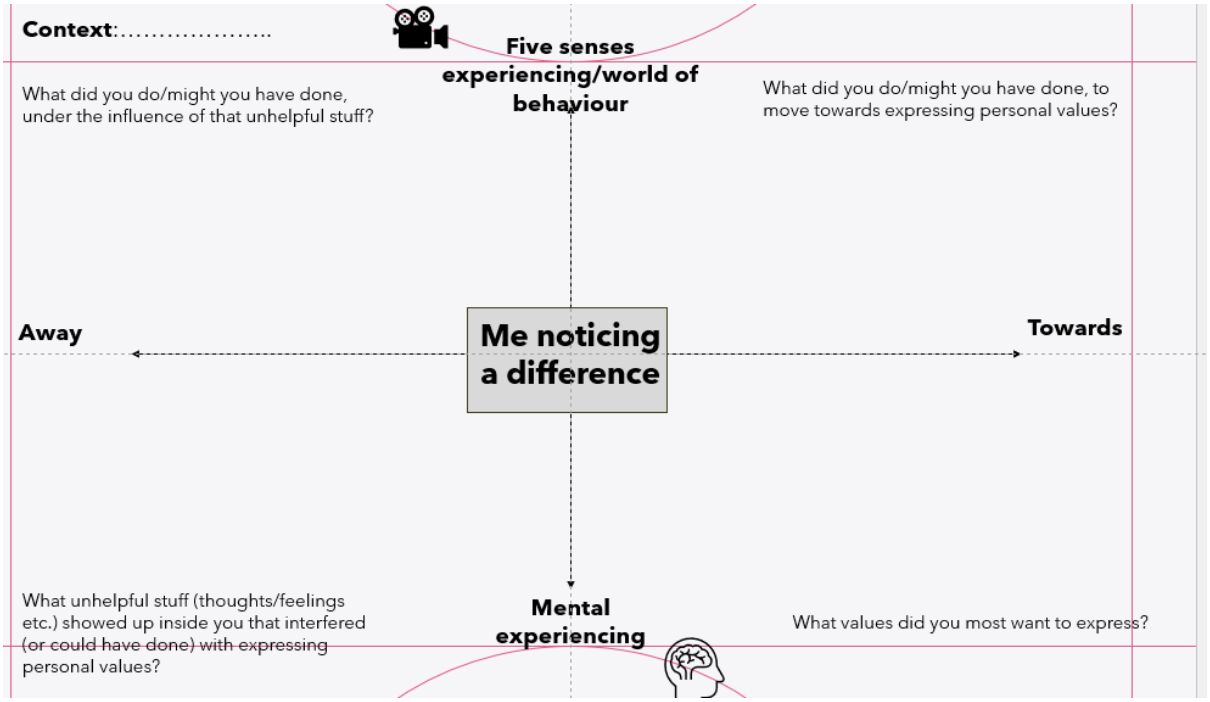
You can find a number of helpful videos and animations of the Passengers on the Bus metaphor online, like this one produced by ACT trainer and psychologist Joe Oliver: https://www.youtube.com/watch?v=Z29ptSuoWRc



The well-known ACT author and trainer Russ Harris also created a slightly adapted version of this metaphor that he calls ‘Monsters on a Boat’. You can watch an animation of that here: https://www.youtube.com/watch?v=vyxc889gQtY

Monsters on a Boat
Written and narrated by
Dr Russ Harris
www.TheHappinessTrap.com

Supplementary Material 2.2 – Blank ACT Matrix



Chapter 8: Summary and Discussion of Findings

The purpose of this thesis was to explore wellbeing in psychological therapy trainees (PTTs), and to design an intervention to support it. To this end, three studies were conducted to better understand the nature of the existing literature in the area, and to work with trainees themselves to better understand how they experience wellbeing in their roles, and what they would want from an intervention designed to support it. Finally, a fourth study was completed in which the developed wellbeing intervention was acceptability and feasibility tested.

As a mixed-methods thesis, this thesis has integrated findings from quantitative and qualitative work, in order to arrive at a comprehensive response to the overarching questions of the thesis. A defining feature of mixed-methods research is the way that quantitative and qualitative findings are integrated, considered in relation to each other, and used together to go beyond what could have been achieved simply by having separate quantitative and qualitative features (Creswell and Plano Clare, 2018). The thesis started with a systematic review of interventions to improve trainee wellbeing (Chapter 3), before moving through an in-depth qualitative exploration of wellbeing with trainees (Chapter 4), and feeding into the construction in collaboration with stakeholders of an intervention designed to support trainee wellbeing (Chapter 6). The context-setting and introductory chapters (such as Chapters 1, 2 and 5) have been added to situate the empirical studies in context, and to demonstrate a theoretical understanding of both the ideas introduced and the setting in which they are being explored or applied. As the research progressed across the duration of the PhD, each later study was built on the foundations laid by the earlier studies (as well as relevant aspects of the wider literature). The acceptability and feasibility study reported in Chapter 7 therefore built on the findings of all earlier chapters. Following the mixed-methods systematic review in which heterogeneity was identified regarding how wellbeing was conceptualised, qualitative exploration of wellbeing was undertaken, and later stages of the PhD focussed on mixed-methods evaluation of the intervention developed in keeping with these findings. As such, the approach used across the

entirety of the thesis aligns broadly with the ethos of an exploratory sequential mixed-methods approach (Creswell and Plano Clarke, 2018) where an exploratory, qualitative approach to a topic is subsequently followed, tested or built on by quantitative examination of the matter. Importantly, and in keeping with the mixed-methods approach utilised, quantitative and qualitative streams were integrated and used to make sense of each other, both within individual chapters where appropriate, and across the thesis as a whole. As examples, qualitative findings regarding the way attending the intervention in the context of a busy training was experienced are used in Chapter 7 to offer a deeper understanding of the meaning behind the numbers of trainees who completed or dropped out of the intervention. Similarly, quantitative data on the numbers of trainees who registered to take part were used to enhance the extent to which qualitative reports provided by interview participants regarding the appeal of the intervention may be considered to be generalisable to a greater breadth of trainees. Separately, by integrating findings from across chapters in the thesis Discussion that follows (e.g. by considering how qualitative findings in Chapter 4 regarding the way that wellbeing was experienced in the role relate to the mixed quantitative findings reported in Chapter 2), attempts are made to integrate quantitative and qualitative findings from across the thesis as a whole, and in ways that goes beyond what could have been reached through distinct and unrelated quantitative and qualitative streams.

The purpose of this general discussion and summary of findings is to consider the results of each study in relation to each other, and to reflect on the findings and implications of the thesis as a whole. To do so, an outline is first provided of the conclusions of each primary research study, with consideration of the remaining uncertainties from each study, and the way that subsequent chapters build on what has preceded them. Following this, consideration is given to several novel findings of this thesis regarding the nature of wellbeing for trainees, and the manner in which it is assessed, measured and supported. The chapter subsequently considers the strengths and limitations of the

thesis as a whole, before outlining a number of recommendations that can be made in light of its findings.

Primary study conclusions and remaining uncertainties: how findings built across the thesis

Systematic review

Study conclusions: In Chapter 3, I reported a systematic review of psychological interventions to improve wellbeing in psychological therapy trainees. The review synthesised a large (n=70) and diverse literature, exploring the impact of a wide array of psychological interventions on trainee wellbeing. Interventions based on Mindfulness, Compassion, Wellness Plans, Stress-Management, Acceptance and Commitment Therapy and a theoretically diverse Mixed/Other category, were included. Drawing on both quantitative and qualitative findings, the review cautiously indicates that wellbeing interventions across these categories can be effective with this population, and that they are frequently valued by trainees. Qualitatively, trainees described benefits from interventions, including increased positive mood, reduced stress, and feeling better able to manage unhelpful cognitive processes such as self-criticism or rumination. Exploration of the direction of effect for study outcomes also found that a large majority of outcomes improved across the study period. This finding was consistent across intervention types and suggests there may be reason to be cautiously optimistic about the potential for wellbeing interventions to be effective with this population. Whilst presented in only a small sub-set of studies, effect sizes also indicated that the magnitude of identified changes was often large. However, GRADE and GRADE-CERQual assessments resulted in a judgement that the quality or certainty of effectiveness findings was very low, and the confidence in qualitative findings moderate. Reviewed studies included many with notable methodological limitations; with small samples, lack of control groups, absence of follow-up, and lack of clarity regarding what the primary outcomes of the study were intended to be, all common. Given this, a number of important questions remain unanswered.

Remaining uncertainties and next steps: To answer questions regarding the effectiveness of wellbeing interventions with psychological therapy trainees, larger, adequately powered, and well-designed randomised controlled trials are needed. Such studies will help to develop the evidence base further, and improve the very low certainty and quality of existing evidence in the field. Importantly, the review also highlights uncertainties regarding the outcome(s) at which such interventions should aim. Studies in this review conceptualised wellbeing broadly, measuring constructs such as stress, burnout, depression, anxiety, or life satisfaction without clearly articulating why or how particular outcomes were expected to change, or why they should be selected as primary targets for the intervention with this population. On the basis of this review, it was determined that further work exploring how trainees themselves experience wellbeing was needed, to develop knowledge in the area, and to support attempts to address trainee wellbeing in terms reflective of how it is experienced in the role.

Chapter 4

Study conclusions: In Chapter 4, I reported on a qualitative study in which I conducted individual semi-structured interviews with current trainees, to explore the experience of wellbeing in their roles. Underpinned by a phenomenological worldview, the study sought to explore the experience of wellbeing in depth, and to generate new findings that would facilitate efforts to support wellbeing in this population. Interviews were conducted with fifteen trainees across five separate psychological professions. Trainees described wellbeing as centrally concerned with connecting to important personal values. One over-arching theme and four themes were generated. The overarching theme 'Connecting with and embodying personal values is at the heart of wellbeing in the role' provided an overarching and organising structure to the analysis. The themes 'It's for the greater good', 'I like to feel that I'm doing well', 'I don't think you'd get a bond like that anywhere else', and 'There's more to life than training' reflected how trainees described wellbeing not solely as an absence of stress or

anxiety, but as a sense of connection to personal values associated with contributing to something bigger than themselves, feeling competent, feeling connected to like-minded others, and to maintaining a wider sense of self and purpose outside of training. The findings generated contributed important new knowledge to the literature with significant implications for how trainee wellbeing should be conceptualised, and how efforts to support it should be developed. Whilst a majority of existing interventions in this field focus on reducing or removing negative correlates of wellbeing for example, the findings of Chapter 4 emphasise how wellbeing was experienced not as an absence (of stress, anxiety, burnout etc.), but as a *presence* (of connection with personal values, and of feelings of competence, connection and purpose).

Remaining uncertainties and next steps: In order to build on the findings generated here in practically useful ways, next steps were planned to explore how to design and implement a wellbeing intervention for trainees that was consistent with wellbeing as it had been described here. The findings of Chapter 4 offer important insights into how trainees experience wellbeing in their roles, and highlights how the focus of most interventions in this area on reducing or removing negative features of wellbeing may address only part of the problem. Subsequent work therefore requires efforts to develop and test interventions that approach wellbeing in this theoretically-informed manner. The remaining stages of this PhD sought to develop such an intervention and subsequently to undertake preliminary evaluations of it.

Further uncertainties related to the extent to which the findings generated here would be transferable to other contexts (such as those with greater ethnic or organisational diversity). In an effort to partially address such uncertainties, efforts were made in the intervention development and acceptability and feasibility evaluation studies that followed, to recruit ethnically diverse trainees, and through this, to explore the extent to which the findings generated here may be considered meaningful to a more diverse group of trainees.

Chapter 6

Study conclusions: In Chapter 6, I reported on an intervention development study through which a tailored wellbeing intervention was designed in collaboration with stakeholders (current trainees and training staff). A worldview of pragmatism underpinned the research, with a focus on doing what works to generate practically valuable findings. The COM-B model of behaviour change provided an overarching behaviour change theory, and target behaviours for trainees of (1) attending the intervention, and (2) implementing between-session tasks were identified.

Building on the findings generated in earlier stages of this PhD, decisions were taken in advance of stakeholder involvement to base the intervention on ACT and to design it to be experiential, group based, facilitative of choice, and tailored to the specific context of psychological therapy trainees. Stakeholders were subsequently involved at two separate points in the intervention development process, providing feedback and insight into emerging ideas for the target behaviours, intervention design, and its underlying theory of change. Building on the feedback and input of stakeholders, a four-part intervention comprised of 2-hour sessions delivered remotely and to trainees for specific psychological professions was developed. The intervention was informed by an existing ACT workplace wellbeing protocol, but adapted to address the specific challenges identified in the trainee literature.

Remaining uncertainties and next steps: Whilst the work of this chapter involved key stakeholders in trainees and training staff, several potentially important perspectives were absent from the process. Involving the perspectives of course directors or health economists for example could have helped better ensure the intervention was developed in ways that would be implementable and sustainable over the long term. Future work will be required in particular to assess the extent to which the intervention is cost-effective; an important matter for exploration given the financial challenges faced by training and service providers, but also the significant financial costs of poor staff wellbeing and turnover.

The work of this chapter culminated in the development of a theory and stakeholder-informed ACT wellbeing intervention for psychological therapy trainees. Next steps were planned to evaluate the acceptability and feasibility of the intervention for trainees, and to look for signals of effect that might support or challenge the developed theory of change. This work was an essential next step to better understand the extent to which the developed intervention may be acceptable and feasible in the contexts for which it was developed.

Chapter 7

Study conclusions: In Chapter 7, I reported on an acceptability and feasibility study of the intervention developed in Chapter 6. A mixed-methods approach was used to evaluate the acceptability and feasibility of the intervention, and also to look for signals of effect and evidence to support or challenge the developed theory of change.

Both quantitative and qualitative findings indicated that the intervention was acceptable to trainees, and feasibility benchmarks were partially met. Whilst some important feasibility concerns were identified regarding attending in the context of a busy training schedule, data on the numbers of trainees who remained in the intervention once beginning, qualitative accounts of participants, and the quantitative data gathered through the AIM and FIM strongly indicated that participants valued the intervention and considered it acceptable. Whilst not designed to evaluate the effectiveness of the intervention, Reliable Change scores and effect sizes identified tentative signals of effect, with evidence of reliable improvement for many trainees across the measured outcomes, and only a small number experiencing reliable deterioration on any measure over the study period. Given the absence of control group and the fact that the study was neither designed nor powered to evaluate effectiveness, it is important not to over-interpret these tentative indications. However, the signals were encouraging, and also leant some potential support to the proposed pathways of change. Importantly however, the relatively low numbers of trainees reached when considered against the

total number offered the intervention, and the UEA-centric nature of the evaluation means that caution is required when considering the extent to which findings may be considered robust and generalisable to other contexts. Further evaluation is required to answer these and other uncertainties. The findings of Chapter 7 also identified important challenges with data completion, suggesting that efforts to address the particularly low levels of data completion for follow-up are necessary before progressing to more comprehensive evaluation.

Remaining uncertainties and next steps: To build on the early but promising findings generated here, further evaluation is required. Remaining uncertainties relate to questions regarding whether the existing recruitment and retention strategies can be effective across multiple sites, whether protecting time in the taught curriculum for the intervention can further increase feasibility (of attendance and of data collection) without negatively effecting acceptability, whether randomisation is acceptable and feasible, and whether the intervention can be delivered at scale in a cost-effective manner. Next steps are discussed in detail in the Research Recommendations section of this Thesis Discussion.

Wellbeing in PTTs: novel findings regarding how wellbeing in this population should be conceptualised and supported

The wellbeing of PTTs has been identified as an important area of concern, and research attesting to this reaches back several decades (Cushway, 1992). Trainee wellbeing has important implications for trainee welfare and mental health, but also for the nature and quality of their professional work too (Barnett et al., 2007; Delgadillo et al., 2018). As evidenced by the large number (n=70) of studies identified in the systematic review undertaken at the beginning of this PhD, a sizeable intervention literature has developed to address this issue, and there appears to be widespread agreement that

trainees in this group of professions experience some challenge, and that addressing it is important (Posluns & Gall, 2020). However, it is notable how comparatively little attention has thus far been paid to exploring the nature of the issues and outcomes such interventions are trying to address. In many existing studies to date, it is often left unclear how wellbeing is being conceptualised or understood, and the relationship between how wellbeing is conceptualised in a study, how changes in it are measured, and how the specific intervention tested is anticipated to address it are often not stated explicitly. This represents an important shortcoming in the current literature, limiting the usefulness of existing studies in the field, since efforts to support wellbeing without paying sufficient attention to what it is, how it is experienced, or how an intervention designed to support it will function in a specific context are likely to be of limited value (Annas, 2004; Hamling et al., 2020; Skivington et al., 2021).

Notably, and as identified in the systematic review of Chapter 3, many existing studies in the trainee literature have tested interventions without a clear theoretical account of how or why that intervention was expected to address the specific challenges faced by trainees. Further, terms such as wellbeing, stress, mental health and burnout are often used with a degree of overlap in the existing literature, with studies designed to assess the impact of interventions on trainee 'wellbeing' for example assessed through changes on measures of stress or anxiety (e.g. Hopkins & Proeve, 2013; Scott et al., 2021).

The lack of conceptual clarity regarding trainee wellbeing and the absence of clearly articulated pathways of change for interventions hamper the utility of the existing literature (Skivington et al., 2021). In recent decades, several important advances have been made in the study of mental health, mental illness, and wellbeing, and these developments are an important context within which the findings of this PhD should be considered. A growing body of evidence has accrued for example to indicate that mental health and mental illness are not simply two opposing ends of a single continuum (Keyes, 2005; Westerhof & Keyes, 2010). A range of evidence suggests instead that

mental health and mental illness can be best conceptualised as two separate, related but distinct continuums, suggesting that measuring the effectiveness of wellbeing interventions for trainees by looking solely at the reduction of stress or anxiety for example may be capturing only part of the picture. A growing body of research has shown how an individual may be low on negative affect for instance, without necessarily being high on positive affect. Similarly, people experiencing significant and longstanding mental illness, can nonetheless also experience high levels of purpose or meaning in life (Compton & Hoffman, 2023). In large scale population research, evidence has been found to suggest that significant numbers of us experience the subtle, nuanced, dynamic nature of psychological health, in which positive and negative affect, and psychological distress and wellbeing can be experienced concurrently (Compton & Hoffman, 2023; Keyes, 2005). Many of our greatest moments of joy and achievement are intertwined with stress or anxiety, and even in our lowest moments, we can retain feelings of connection with others or purpose. The findings of this thesis further add to this developing knowledge base, and make an important contribution by bringing the literature regarding psychological trainee wellbeing into step with recent developments from positive psychology and elsewhere regarding the nature of wellbeing and the design of interventions intended to support it.

As described in the section on Positive Psychology in Chapter 1, recent decades have also seen increasing recognition of the idea that the study of flourishing, happiness and thriving must also incorporate the study of difficulty, challenge and conventionally 'negative' attributes and experiences such as stress, discomfort, anxiety and so on (Lomas & Ivtzan, 2016). Indeed, it is difficult to imagine living a personally meaningful and wellbeing-rich life that does not also incorporate aspects of challenge, setbacks and periods of anxiousness or distress, as these are experiences that almost inevitably accompany the pursuit of personally meaningful and value-relevant actions (Hayes et al., 2012). The findings described in the qualitative interview study reported in Chapter 4 align closely

with and add to these ideas. Interview participants described wellbeing in their roles not as an absence of stress or anxiety, but as a feeling of purpose and connection with their values. Indeed, some of the clearest examples of wellbeing and enjoyment in their roles offered by trainees were also ones entangled with some degree of stress, anxiety or apprehension. The feeling of having supported a client with an intervention newly learned, or the sense of mastery described on successfully grappling with complex new ideas in a university lecture evidenced how wellbeing for these trainees was much more than a simple absence or relative paucity of stress or anxiety. In this regard, and as argued in Chapter 4, the account of wellbeing offered by trainees in the interview study provides evidence of the qualitative difference between hedonic and eudaimonic conceptions of wellbeing that researchers sceptical of the difference between hedonia and eudaimonia have suggested are absent from the literature (Kashdan et al., 2008).

Unsurprisingly, overwhelming or problematic levels of stress, distress or anxiety were experienced as aversive to trainees, but a clear sense was described to suggest that wellbeing was experienced primarily as a *presence* (of purpose, connection, fulfilment and so on) rather than an *absence* (of stress, anxiety or distress etc.). Indeed, in many ways, wellbeing in the role was described as a presence of these positives even whilst such challenge and stressors persisted, findings with important implications for the design and delivery of wellbeing focussed interventions for this population.

Importantly, this is of course not to say that any and all levels of stress or burnout were welcomed by trainees or considered irrelevant to their experience. In keeping with findings from the body of work on the Job Demands-Resources model (Bakker & Demerouti, 2007; Bakker & de Vries, 2021), several interview participants described the problematic effects of excessive levels of stress and feelings of burnout, being clear that such effects at their most extreme could detract from or overwhelm the more positive features of their roles. Supporting trainees therefore to manage excessive stresses may indeed be an important feature of attempts to support trainee wellbeing. The findings of this PhD

suggest however that a more comprehensive conceptualisation of mental health and wellbeing in the role – one that incorporates a dual continua perspective on mental health (Keyes, 2005), acknowledges the importance of meaning and purpose in wellbeing (Ryff, 1989), and recognises the unavoidability of some conventionally 'negative' experiences to value-driven behaviour (Hayes et al., 2012; Lomas & Ivtzan, 2016) – is required to support and enhance wellbeing in ways considered meaningful to trainees themselves.

Notably, in the systematic review reported in Chapter 3, interventions most commonly focussed on reducing 'negative' components of wellbeing or mental health such as stress, anxiety or burnout, and comparatively few included measures of positive wellbeing indicators such as meaning, purpose, or psychological wellbeing (Owen et al., 2025). These findings echoed those of an earlier review in which studies exploring burnout were almost three times as common as those exploring positive features of wellbeing in psychological practitioners (Van Hoy & Rzeszutek, 2022). Whilst the significant costs, implications and consequences of burnout in mental health staff (France & Rachel, 2022; Vivolo et al., 2024) mean a focus on reducing or eliminating these negative correlates appears at first glance to make intuitive sense, the findings of this PhD caution against an exclusive focus on this objective, without also paying sufficient attention to positive features of mental health and wellbeing. Importantly, findings of this thesis suggest that attempts to support wellbeing aimed primarily or exclusively at the reduction of stress, anxiety or burnout – as many studies included in the systematic review appeared to be – will be unlikely to succeed in any full or comprehensive sense. Reducing stress or anxiety may be desirable, but it will not necessarily increase positive features of mental health or wellbeing (Compton & Hoffman, 2023), and is unlikely to capture the essence of how trainees themselves described wellbeing or its absence in their roles (Chapter 4).

At a minimum, it seems therefore that measures of both positive and negative components of wellbeing are required. An intervention measuring success only in terms of reducing stress for example may miss important benefits of an intervention in terms of increased positive affect or

purpose. It is possible that the heavy reliance on measures of 'negative' features of wellbeing (e.g. stress, anxiety or burnout) account for some of the mixed or counter-intuitive findings identified in the systematic review. As discussed in that chapter, several mixed-methods studies reported no significant effect on the quantitative measures used, and yet participants described benefits and a belief that wellbeing had been improved. It is clear that there are a number of potential explanations for this. The measures and methods used for example may have been inadequate to detect relatively small changes, or perhaps interventions and measurement time-periods were too short to capture change that was quantitatively identifiable. Similarly however, it may have been a feature of the way that wellbeing was being conceptualised and measured in the study. By their very nature, trainee roles include some stressors, and it is possible that perceived stress or anxiety could remain relatively consistent even whilst feelings of purpose, enjoyment, mastery or pleasure could also be being increased. Indeed, the findings generated in the qualitative study reported in this thesis indicate this may be likely. This thesis then makes an important contribution to the literature on this point, encouraging researchers in the area to conceptualise wellbeing in the eudaimonic (Huta & Waterman, 2014) terms in which trainees themselves described it, and to hold in mind the importance of connection to values, meaning and purpose, as well as the reduction of stress or anxiety.

How should a wellbeing intervention for trainees be designed?

As well as having implications for the way that wellbeing is conceptualised and measured in this population, findings from across this PhD make an important contribution to issues relating to how wellbeing interventions for trainees could be better be designed and implemented. With evidence to suggest that interventions designed to eliminate mental distress do not necessarily also improve mental wellbeing (Compton & Hoffman, 2023), the combined findings of the studies reported here indicate not only that intervention success should be measured broadly, but that interventions

themselves should also be designed to target positive features of wellbeing in line with the way that wellbeing in the role was described by trainees (Chapter 4).

In the wider literature on positive psychology and wellbeing, an increased recognition has also recently developed regarding the importance of context (Hamling et al., 2020). Researchers are increasingly noting the ways in which successful wellbeing interventions need to be adapted and tailored for the context in which they are delivered and the ways in which different populations experience wellbeing (Hamling et al., 2015). The qualitative interview study (Chapter 4) and the intervention development study (Chapter 6), therefore advance the literature in the field and adhere to calls made by positive psychology researchers both to pay more attention to context (Hamling et al., 2020) and to build interventions around adequately developed understandings of wellbeing (Annas, 2004; Hamling et al., 2015).

The intervention development study presented in Chapter 6 reports on the efforts to design an intervention in collaboration with trainees and professional trainers that meaningfully addressed the core challenges of training, and was implementable in the real-world setting of practitioner training. Stakeholder input is considered critical for the effective design and development of complex interventions (Skivington et al., 2021), and in this study, stakeholder input was essential for helping to design the intervention in ways that would be appealing and useful to trainees working in the field. This also supported efforts to build on a key finding of the systematic review, that the perception that interventions had been tailored to the specific trainee context was a potential facilitator of intervention success (Owen et al., 2025).

In light of wider findings from the systematic review (in which tentative evidence was found for wellbeing interventions across a range of theoretical and therapeutic domains) and the qualitative interview study (in which wellbeing was described by trainees primarily in terms of feeling connected to personal values), a decision was taken early on in the intervention development process to base the intervention on principles of ACT. No single therapeutic approach had consistently outperformed

others in the review, and whilst there were only a small number of earlier attempts to support trainee wellbeing with ACT principles, a conscious decision was taken to try and align the intervention design with the findings of the qualitative study, in the belief that this would maximise its potential usefulness (Hamling et al., 2015). As described in Chapters 4 and 5, ACT aligns closely with wellbeing as it was described by trainees, placing a central importance on connecting with values, and encouraging continued values-based action even in the face of internal stresses and difficulties (Hayes et al., 2012). Further, having reviewed the primary reported sources of stress and challenge for trainees in the intervention development study reported in Chapter 6, ACT offered a set of principles and techniques that appeared well suited to addressing the key challenges described by trainees themselves.

The result of this process then was the development of an evidence-informed wellbeing intervention, designed in collaboration with trainees and trainers, on the basis of how wellbeing had been described by trainees. The intervention had been carefully designed in a manner intended to address what had been identified as key stressors during training. The comprehensive, systematic, and evidence-informed process followed throughout this process means the 'Thriving in training' intervention has the potential to be an important addition to the literature.

What works for supporting trainee wellbeing?

Together, the findings of this PhD make a number of important contributions to the literature on this topic. Trainee wellbeing interventions with this population appear best placed to succeed when they incorporate features of choice and autonomy into the intervention experience, when they are group-based and interactive, when they are designed collaboratively with trainees, and when they are designed to support wellbeing in terms that align with how trainees describe experiencing wellbeing in the role. Whilst as an acceptability and feasibility study, the work reported in Chapter 7 did not seek to assess the effectiveness of the intervention, there were tentative signs that the intervention

showed promise. The intervention was considered highly acceptable by trainees who attended, and showed promise in terms of feasibility. Notably, there was evidence that features of the intervention that had been shaped by earlier stages of this PhD were especially well received. Trainees reported connecting well with the ACT basis of the intervention, describing this as helping to meaningfully address the core challenges and stressors of their training (such as 'imposter syndrome' or evaluation related anxiety (Owen et al., 2022; Richardson et al., 2020)). The tailored nature of the intervention – designed and delivered in a way intended to meet the needs of trainees specifically – was valued, and the fact that the intervention was delivered in a way that supported feelings of autonomy was positively received. Together, the quantitative (reliable change scores) and qualitative (interview data) findings also lent tentative and preliminary support to the notion that the intervention may be of value, and that it may work along the anticipated pathways of change. The large effect identified for psychological flexibility change scores (especially the 'Openness to experience' subscale), and the reports of interview participants of how the intervention was helping them to connect with personal values during training even in the face of internal challenges, both provide preliminary support to the notion that the intervention may be of value, and indicates that it is worth proceeding to further and more comprehensive pilot testing.

To continue efforts to more comprehensively answer the question regarding what works for supporting trainee wellbeing, more research is however needed. The findings of this PhD provide an important framework on which future research in this area should be built. Given the disparate and heterogeneous nature of the intervention literature in this field to date, future research would benefit from using the key findings of this thesis to standardise efforts to support wellbeing in PTTs. Whilst there is insufficient evidence at this point to recommend that the 'Thriving in training' intervention trialled here be universally adopted, further evaluation of the intervention does appear warranted. Additionally, key learnings that went into its development should also be used to inform other attempts to support wellbeing using alternative approaches. More high-quality research,

trialled in real-world settings and designed to address the challenges faced by trainees is needed. To advance the literature productively, research in the field should routinely articulate the theory of change on which the intervention is built, and wellbeing should be conceptualised broadly, and in theory-consistent ways. Doing so will help to advance the field beyond its current state (as a literature that is large, but heterogeneous and comprised of studies in which theoretical issues regarding what the intervention is designed to address or how it is expected to work are often not sufficiently described) and towards one with an increasingly robust theoretical and empirical foundation. In keeping with calls from across the positive psychology literature (Hamling et al., 2020), evaluation of the effectiveness and value of interventions in this field should use mixed-methods approaches to generate comprehensive answers regarding whether and how the intervention works. Finally, and in light of the fact that feasibility was only partially supported in the study reported in Chapter 7, future research in this area should engage further with some of the challenges reported here. In order to maximise the potential reach of an intervention, and to engage trainees broadly, the questions left unanswered by this PhD regarding how to support higher rates of data completion, and whether to offer the intervention in or outside of the core curriculum require further investigation.

Strengths and limitations

This thesis has a number of important strengths that enhance the usefulness and value of its findings. Principal amongst these is the fact that the research is grounded in the actual experience of trainees and the context of real-world training. Across the thesis, current trainees have been worked with, ensuring the voices of trainees are heard and represented, and that the perspectives of those for whom the research is intended to benefit are considered, included and valued at all stages. As a Programme Director of a psychological practitioner training programme myself, I have sought throughout to remain close 'to the ground', considering how the research could be experienced and

used to benefit trainees, in the reality of their training position. As well as seeking trainee perspectives through the qualitative interview study (Chapter 4) and the collaboration with trainees of the intervention in Chapter 6, the notion of attempting to place trainee perspectives at the heart of the research can also be detected in the acceptability and feasibility study (Chapter 7). Such sentiments drove for example the attempts to deliver the intervention in accessible and feasible ways, that respected and acknowledged the challenges of adding something additional to an already busy training schedule.

As a Programme Director for a psychological practitioner programme, and someone closely involved in the reality of training psychological professionals, I have an in-depth knowledge of the training landscape, the challenge of delivering a training of this sort, and the needs of the services and workforce that trainees join. The design of this ACT-based intervention was therefore shaped to harness and develop some of the skills and characteristics that are known to be associated with positive outcomes in this population, such as reflection (Bennett-Levy, 2006) and resilience (Green et al., 2014).

Critically, I also have an in-depth understanding of the higher education context, and the practical realities of including an intervention such as the one developed here in an already busy training curriculum. Throughout, I have sought to use my own personal and professional knowledge, as well as the views and perspectives of trainees and colleagues to help ensure the research was designed and implemented robustly, and in ways that increased its possibility of success. Such efforts represent strengths of the thesis, and increase the extent to which the findings generated here can have real-world impacts. At all stages, this research has been conducted in the context of real-world training experiences, and I hope that its findings can shape those training experiences for the better in the future.

Further strengths include the careful attention paid throughout to relevant literature, the use of systematic and evidence-informed approaches to all features of the thesis, the effort to ensure

consistency in how wellbeing for trainees was conceptualised, measured and targeted, and the theory-informed development of the intervention at its heart. This thesis has brought together literature regarding the nature of wellbeing, the study of behaviour change, the experience of training in the psychological professions, and the development of complex interventions. The systematic progression through which the thesis has proceeded has resulted in the development of an evidence- and theory-informed intervention that addresses many of the gaps and shortcomings identified in the current literature in this field.

As a mixed-methods thesis, the research has also drawn upon a range of research methods, data collection techniques, and analytical procedures, seeking to draw on the strengths of qualitative and quantitative research to answer the specific questions posed at each stage (Creswell & Plano Clark, 2018). When taken as a whole therefore, the findings of this thesis offer a comprehensive account of wellbeing in PTTs and how it can be supported.

The thesis also has a number of important limitations. Whilst each individual study has considered its specific limitations, I consider here those limitations that can be applied to the thesis as a whole. I also use this opportunity to develop specific limitations in more detail, considering them in relation to relevant literature and guidelines.

Notably, all research within this thesis has been completed with trainees exclusively from UEA. Whilst participating trainees include those studying from five distinct training programmes, each of which is staffed differently, leads to a different qualification, and prepares trainees in different ways and for different roles, the UEA-centric nature of the thesis does place some important limitations on the research. Additionally, whilst efforts were made in all studies to recruit in a way that generated a plurality and diversity of views, several components of the thesis did not achieve this in all regards.

The importance of conducting research that embeds equality, diversity and inclusion into all stages of the research cycle is increasingly well acknowledged, though under-representation in research of

several groups, including people from ethnic minority backgrounds, persists (Hua et al., 2026). In recognition of the importance of promoting equality, diversity and inclusion through research, NIHR have recently published their first 'Research Inclusion Strategy', designed to promote inclusive research, tackle structural barriers to people contributing to and participating in research, and reduce health inequalities (NIHR, 2022). Such policies and documents reflect the fact that reducing health inequalities is an important ethical, clinical, and societal objective, and that to do so, diverse views and perspectives of people across communities are required. An important limitation to this thesis relates to the under-representation of participants from ethnic minority backgrounds in Chapters 4 and 7. The under-representation of ethnic minority perspectives in Chapter 4 is particularly important given that findings from this study played an important part in shaping later stages of the thesis. In the *Research Inclusion Strategy*, NIHR remark how for research to support the health and care of everyone, it must include everyone. The absence of ethnic minority perspectives therefore to a study seeking to explore how wellbeing is experienced by trainees, is an important shortcoming that perpetuates the under-representation of diverse perspectives in research. Whilst the qualitative, interpretative approach used in this study was not designed to produce knowledge that is generalisable in a statistical sense, the transferability of findings produced there to the settings for which it is intended (education providers, employing clinical services etc.,) is likely markedly reduced by the fact that findings were generated through analysis of the accounts of only White British or White European trainees.

In an effort to partially mitigate the effect that this had on the utility and inclusivity of later stages of the thesis, efforts were made in Chapter 6 to promote diverse participation in the Intervention Development Study, where efforts to explore with stakeholders to what extent earlier findings from the PhD resonated with their own experience were planned. Recruitment to this study included focussed attempts to invite participation from trainees from multiple ethnic backgrounds (by inviting a departmental Equality, Diversity and Inclusion (EDI) interest group to promote participation in the

research). In my future research, I will ensure that matters relating to inclusivity are embedded into all stages of my work, with consideration given at all stages to how to design and conduct research that reduces and tackles health inequalities, promotes inclusion, and values diversity.

In the overall Theory of Change for this thesis presented in Chapter 1, the importance of involving appropriate people with relevant experience for the research was identified. Firstly, finding ways to involve appropriate people with the experience needed for each stage of the research was identified as a key Moderating Factor, likely to influence the extent to which the research succeeded in its goals. Developing in-depth understanding of how a breadth of trainees experience wellbeing in the role and what they would hope for from a wellbeing intervention for example was also considered important for the causal pathways of the overall thesis. Through gaining the perspectives of a range of key stakeholders regarding how wellbeing is experienced in the role and how an intervention should function, it was anticipated that a more effective, acceptable, and feasible intervention would be designed and that such knowledge would therefore lead to better outcomes. Looking back now from the point of having completed the work of this thesis, it is apparent that across several studies, efforts in this regard were only partially successful. The under-representation of ethnic minority trainees in Chapter 4 for example has already been discussed. In Chapter 6 too, limitations can be identified regarding the recruited participants in the research. As noted in that chapter, two of the trainee participants who had originally agreed to take part withdrew shortly before the first meeting, citing lack of time as the reason for withdrawal. The loss of this additional trainee input, alongside the absence of other course director, commissioner, or economic perspectives, represents a further limitation to that study, lessening the extent to which the work aligned with best-practice guidance for public involvement in research (e.g. HRA, 2025).

This is important, since recent years have seen increasing recognition of the ways in which involving patients and members of the public in research can support better research that is more relevant to its intended beneficiaries (Karlson 2023; Locok 2019). In a recent systematic review for example,

Vargas and colleagues reported on how co-production has significant potential for enhancing the design and implementation of health research, but also acknowledged how widespread variation and inconsistencies in terminology renders empirical evaluation of its value challenging (Vargas et al., 2025). Importantly, they also noted variability regarding how and to what extent stakeholders are involved in work described as co-produced, with many examples of stakeholders taking on more peripheral roles through which information is 'extracted' from stakeholders, without meaningful attempts to empower stakeholders to take ownership of key features of the research or to generate findings together. In their *Guidance on Co-Producing a Research Project*, NIHR (2024) explicitly differentiate 'collaboration' or 'consultation' (in which members of the public are consulted on aspects of the research decided as important by researchers) from 'co-production', a meaningful effort to work with diverse individuals at all stages of the research cycle in a way that fosters joint responsibility for the research, values experiential as well as academic knowledge, and uses shared decision-making processes (NIHR, 2024).

To support researchers in conducting more meaningful and impactful PPIE, several organisations have produced guidelines or standards for public involvement. The NIHR *UK Standards for Public Involvement* for example emphasise how public involvement should be inclusive, collaborative, and communicated about clearly. The standards further note how public involvement should also offer opportunities for growth and learning of those involved, involve the public in research management and decision-making, and identify and share the difference that public involvement made to research (NIHR, 2019).

In an attempt to provide high-level, accessible, and practical guidelines for public involvement in research, the NHS Health Research Authority also recently produced a set of best-practice principles (HRA, 2025). These principles state that researchers should:

1. **Involve the right people**: when designing research, the lived experiences of people should be considered, and people with direct or highly relevant experience of the condition or experience being researched should be invited to be involved
2. **Involve enough people**: whilst the number of people needed will vary between projects, attempts to convene a group that ensures a diversity and breadth of experiences is important. Ideally, this breadth and diversity should reflect that seen in the target population for the research
3. **Involve those people enough**: people should be involved as much as is practical and feasible, including from the earliest stages of the research and across the research cycle. This means involving people when the research is being planned, whilst it is being conducted, and after it has been completed
4. **Describe how it helps**: researchers should describe how the public have been involved and what the impact of this was

The research conducted in this thesis aligns in several ways with the ethos and principles of the policies and documents described here. However, the work of this thesis sits firmly at the 'collaboration/consultation' end of the continuum, rather than co-production as described by NIHR (NIHR, 2024) and others. As such, it fails to benefit from the breadth of benefits considered to be associated with co-production (NIHR, 2024; Vargas et al., 2025). As examples, whilst stakeholders with relevant experience contributed to the intervention development work, their involvement was limited to the moments and domains selected as important by myself as the primary researcher and the supervisory panel. Core decisions regarding the focus of the intervention (e.g. to be based on ACT) were taken in advance of stakeholder engagement, and on the basis of my interpretation of the existing literature and earlier research findings. In this way, central features of the decision-making power were not shared, with stakeholder engagement limited to influencing important but

nonetheless smaller and later details of the intervention design. Had trainees been involved in establishing the focus of the research for example, it is possible that they may have seen changes to structural elements of training courses or service provision as higher priority than the development of a wellbeing intervention. Whilst the input of stakeholders was genuinely significant, and did meaningfully shape central aspects of the developed offer, the decision for me to lead on several core decisions in advance of stakeholder engagement, and to adopt a position in which I took responsibility for interpreting stakeholder input or resolving conflicting perspectives, implied a power imbalance in which researcher/academic knowledge was seen as more important. By prioritising researcher-led interpretations and academic knowledge over the experiential knowledge that trainees may have provided (e.g. regarding what approach may have been best suited to supporting wellbeing), the research approach tended strongly towards collaboration or consultation, rather than co-production. It also aligned less comprehensively with the HRA guidance to 'involve people enough' (HRA, 2025), reserving stakeholder contributions to the later stages of the research process only. Further, whilst the presence of trainees and academic training staff in the intervention development process meant that at least some of 'the right people' (HRA, 2025) were involved, the research was limited by the absence of other potentially important perspectives, such as those of commissioners, course leads, or health economists. Ideally, involving this wider breadth of perspectives in this stage of the research would have helped to provide more of the information needed to understand its suitability for real-world delivery. To ensure that I had 'enough' of the right people in the conversation too, planning the research process to facilitate trainee involvement (e.g. by running sessions on study days for example) may have also helped mitigate some of the challenges faced with trainees withdrawing from the process shortly before meetings due to having insufficient time.

The issue outlined here also connects to a related point regarding the extent to which the research of Chapter 6 aligned with the MRC framework for developing and evaluating complex interventions

(Skivington et al., 2021). As described in Chapter 2, the MRC framework outlines four phases of complex intervention research (developing or identifying an intervention, feasibility, evaluation, and implementation), each of which has a set of common core elements. These core elements cover the need to consider context, develop and refine programme theory, engage stakeholders, identify key uncertainties, refine the intervention, and consider economic matters (Skivington et al., 2021). Despite fulfilling features of several of these elements, the intervention development work presented in this thesis has a number of important limitations in this regard. Whilst trainees and professional training staff were engaged as stakeholders, and whilst attempts were made to consider with them the context in which the intervention was being delivered and the key uncertainties regarding how it should be developed, there was an absence of important perspectives which would have substantially strengthened the work and the conclusions that could be drawn from it. Most significantly perhaps, the intervention development process did not pay sufficient attention to economic matters. The MRC framework reports that economic evaluation 'should be a core component of all phases of intervention research' (Skivington et al., 2021, p. 6) and its absence therefore from the work presented in this thesis is an important limitation. With universities working in challenging financial contexts (Universities UK, 2025), the need to consider the costs and cost-effectiveness of introducing an intervention such as the one developed in this thesis is arguably critical. Relatedly, further limitations can be identified regarding the extent to which the context of the intervention was fully considered. The MRC framework notes how context is multi-dimensional, and can encapsulate cultural, organisational, economic, political and other dimensions (Skivington et al., 2021). In this light, and as indicated above, the perspectives of other course leaders, heads of department, or commissioners would likely have contributed usefully to the process. Commissioners (such as NHS England) for example would have contributed a detailed understanding of the political and financial context in which these programmes were commissioned and designed. This would have helped to better understand how – and indeed *whether* – additional space and time in curricula for including interventions such as the one being developed may have been possible. Other course leads

or heads of department would have contributed usefully regarding the organisational context in which the intervention was set to be delivered. Given that all of the research was conducted at UEA, and all stakeholders were also from UEA, including course leads or heads of department from universities elsewhere may have been especially important for understanding the wider organisational contexts in which a future version of this intervention could be implemented. Health economic perspectives would also have helped to ensure due consideration was given to whether the intervention was likely to be cost-effective, and would have supported further consideration of what the anticipated 'downstream' effects of the intervention were. All such perspectives would have contributed significantly to better understanding how attempts to scale up this intervention in future work could be possible.

As this demonstrates, whilst the focus of my work was primarily at the micro-level (individuals and their behaviour), complex interventions exist in and are influenced by multiple systems (Skivington et al., 2021), meaning that consideration of the meso and macro levels are also critical for implementation. The intervention developed here for example was delivered in a university training course (meso-level) which itself is influenced by policy and the wider healthcare and university context that shapes the commissioning and delivery of NHS training (macro-level). The design and implementation of interventions that are successful in real-world contexts must pay attention to all three of these levels, acknowledging the importance of each, and the relationship between each level. Whilst the intervention developed in this thesis primarily targets individual trainees, it does not take place in a vacuum, and its sustained success requires consideration of how it fits within and is influenced by the wider systems it operates within. The organisational context the intervention was designed for is key to its success for example. In order for this intervention to be scaled up in future work, organisations will require the time, resources, expertise, and willingness to offer the intervention to trainees, over and above existing curricula. The extent to which universities and training providers are able and motivated to do so is itself influenced by macro-level considerations

relating to the policy, financial, and political contexts within which training is provided. If the requirements of commissioners to deliver a set amount of content in a limited number of days, or the constraints placed on providers by financial constraints for example are such that implementing the intervention becomes impractical or unappealing, any efforts to consider the individual-level features of the intervention and how it will be received by trainees may be insufficient. The incorporation of stakeholder perspectives representing the meso (such as course leads or heads of department) and macro (such as NHS course commissioners) levels would therefore have helped to significantly strengthen confidence in developing the intervention in ways likely to support future scale up in other contexts, and may have helped to generate ideas about design and implementation that could have led to a more contextually-prepared intervention. The paucity of these perspectives from the intervention development and evaluation process reflects a position in which micro-level considerations about how individual trainees would receive the intervention took on too much precedence, and important organisational and systemic considerations were neglected. These are important limitations that constrain the value of the findings generated.

Together, the relative prioritisation of academic/researcher knowledge and the absence of key stakeholder perspectives means that the research produced here risks not being sufficiently grounded in the reality of the context for which it is designed, or the experience and expectations of all those affected by the research. This important limitation means that less of the necessary information required to understand how and whether to scale this intervention up in the future was gathered. Combined with the noted absence of economic considerations regarding the affordability or cost-effectiveness of the intervention, these are limitations which reduce certainty in the value of the developed intervention despite the relatively positive appraisal of it given by trainees in Chapter 7.

Further to the point about how and to what extent stakeholders were involved in the intervention development work, limitations can also be identified in regards to the transparency and rigour of the decision-making processes used in that study. In selecting ACT as an appropriate basis for the intervention for example, earlier evidence generated through the PhD and the wider literature on wellbeing were both considered. In making decisions regarding the form and content of the intervention (e.g. delivery mode, duration, specific ACT content etc.) stakeholder perspectives were also incorporated. Importantly however, such decision-making processes were relatively informal, relying on researcher interpretations of evidence and what was required. In this regard, my own interpretations as the primary researcher took precedence where decisions were required that necessitated the balancing of differing or opposing views. Whilst concerted efforts were made both here and throughout the thesis to ensure these decision-making processes were open and justifiable (e.g. by making frequent use of supervision, by relating my decisions explicitly to existing literature, and by using my reflective diary to consider how and why I was making the decisions I made) formal criteria such as APEASE (Michie et al., 2016) were not utilised. The APEASE criteria, developed for use alongside frameworks such as COM-B outlines six important criteria to consider when designing, choosing, or shaping an intervention. The criteria prompt consideration regarding the Affordability, Practicability, Effectiveness and cost-effectiveness, Acceptability, Side-effects/safety, and Equity of interventions (Michie et al., 2016). Using such criteria in this study would have significantly strengthened its rigour, ensured the decision-making process was more comprehensive, and provided a framework in relation to which the processes underpinning decisions could have been more clearly articulated. As an example, whilst many of the criteria outlined in APEASE were discussed with stakeholders in intervention development meetings, this was done in a relatively informal way. Although the focus of what was discussed was guided by my interpretation of the wider literature and my perspectives of what information was needed to help progress the research to subsequent stages for example, there was no clear framework utilised to relate this to. Meetings sought perspectives on whether an ACT intervention was likely to be considered acceptable for

example, whether delivering it in or outside of course time would enhance its practicability, and to what extent decisions regarding delivery duration, location, and timing would influence equity of access. However, the use of APEASE would have strengthened conduct in several important ways. Prompting a requirement to consider affordability for example – a key issue for the development of interventions that can be effective in real-world settings (Skivington et al., 2021) – may have led to broadening participation further to involve stakeholders able to contribute to consideration of this topic. Use of APEASE may have also ensured that consideration of issues such as equity were more explicitly covered in greater depth (e.g. considering whether the chosen approach might disadvantage trainees with particular learning styles or needs). Perhaps most significantly, use of criteria such as APEASE may have helped more generally with the transparency and rigour of the research conducted for the intervention development chapter. The criteria could have been used to help guide stakeholder discussions, justify decisions, and provide a reference point for documenting why particular issues were considered and how they were weighed against others (Michie et al., 2016).

Further limitations relate to the analysis approach used in the acceptability and feasibility study of Chapter 7. In this study, no control group was used and a complete-case analysis approach was employed to analyse quantitative data, where only outcomes for those participants with complete data were included. As discussed in the *Limitations* section of that chapter, this introduces the possibility that findings may be biased if data were 'missing not at random' (Chaplin & Dwan, 2024). Reasons for missing data were not systematically explored in this study, which is itself a further limitation, as it makes drawing conclusions regarding the effect of missing data difficult, and future research in this area would benefit from addressing this point explicitly. Available data (such as that from the two interview participants who did not complete the intervention) and features of the wider literature (e.g. Owen et al., 2021) provide tentative support to the idea that the drop out and

low data completion rates may be related to the busy nature of the training role, and limited time available that trainees had to take part in the intervention or complete data collection. These are important feasibility concerns which indicate that finding ways to increase the feasibility of attending may be necessary in order to realise the potential of the intervention. However, systematic exploration of this in future research is needed in order to understand this more fully.

Importantly, the sample of trainees who registered for the study were themselves only a subset of the trainees who were offered the chance to participate. Approximately two-thirds of the trainees offered the intervention did not register to take part, meaning that explicit considerations of the reasons for not registering are required in order to provide a fuller account of the true acceptability and feasibility of the intervention.

When drawing these considerations together then, it is important to note that the analysis reported across all outcomes in Chapter 7 relied on intervention completers who were themselves a sub-set of the trainees who had been offered the chance to take part. These trainees may be imagined to have experienced the intervention differently to those who did not undertake it or who dropped out. Whilst definitive conclusions cannot be drawn owing to the fact that reasons for non-participation or missing data were not comprehensively explored, it may be reasonable to assume that trainees who completed the intervention and data completion experienced the intervention more positively than those who did not. This introduces the possibility that outcomes relating to the acceptability and feasibility of the intervention, and those relating to secondary outcomes, may be inflated. This possibility should therefore be borne in mind when considering the magnitude of the effects identified and the extent to which the findings generated might generalise across the wider trainee population.

One approach that is commonly recommended in trials (Shrier et al., 2017) and which can minimise potential bias associated with analysing data only for intervention completers, is an Intention To Treat (ITT) analysis. Whilst ITT has itself been shown to be vulnerable to biases under certain contexts (Shrier et al., 2017), it is a method of analysis frequently used in trials to support researchers in providing unbiased estimates of the effect of an intervention (Detry & Lewis, 2014). Whilst inconsistencies in the definition of ITT have been noted, a recent Cochrane Tutorial paper highlights that ITT analysis has two defining principles. Firstly, in ITT, outcomes for all participants are reported or analysed according to the intervention arm to which they were originally randomised, irrespective of the dose or intervention they ultimately received (Chaplin & Dwan, 2024). Secondly, outcomes are measured for all participants, and if data is missing, efforts are made to account for this in some way (e.g. through the imputation of data) (Chaplin & Dwan, 2024). By reporting and analysing outcomes for all participants assigned to an intervention irrespective of how well they adhered to it or whether they received the intervention at all, ITT analysis accounts for the fact that the effect of an intervention reflects not only the active mechanisms of the intervention itself, but also factors relating to whether interventions are delivered as planned and how well patients are able to adhere to them (Detry & Lewis, 2014). Further, ITT analysis seeks to minimise bias that may be introduced from analysing participants only with complete data (Detry & Lewis, 2014). This makes ITT an appealing approach for much pragmatic and real-world research, where evidence regarding how interventions perform in real-world conditions is sought (Shrier et al., 2017). With only one treatment arm, participants in the acceptability and feasibility study reported in Chapter 7 were not truly 'assigned' to an intervention. However, drawing on the principles of ITT by reporting and analysing data for all participants who had registered for the intervention may have been well suited to the aims of this study (to evaluate the acceptability and feasibility of the intervention in real-world training contexts). It is possible that this may have provided a more informative account of the overall acceptability, feasibility and potential for clinical utility of the intervention if rolled out more widely to trainees. In future research designed to address remaining uncertainties before progressing

to a full trial, use of such methods should be considered. With regards to the research presented in Chapter 7 of this thesis, the potential biases introduced through the over-representation of intervention completers should be borne in mind when interpreting the findings for the acceptability and feasibility of the intervention, and also in regards to the signals of efficacy identified in the secondary outcomes.

As a final limitation, despite efforts to promote participation and to carefully consider power imbalances (described in more detail in relevant chapters) it is also notable that my role as a Programme Director on a training programme in the department in which the research was conducted may have had important impacts on who took part in all studies, and what those who did felt they were able to say. This is an important limitation, that should be borne in mind when making sense of the results presented across this thesis.

Reflexivity

Whilst an explicit section on reflexivity was included in the Methods chapter (Chapter 2) and the qualitative study reported in Chapter 4, I provide here some concluding reflections on my position as researcher across the whole thesis, giving consideration to how I have developed and changed as a person and a researcher throughout the project, and how my own characteristics have shaped and informed the research at all stages. Having been a trainee myself at an earlier stage of my career, and having spent the last 8 years training others to work in the psychological workforce, I am closely connected to the subject matter that I have been researching. I am conscious that my reasons for choosing to complete a PhD on this topic, the questions I have asked since starting, the way I have made sense of and thought about the findings, and my aspirations for what can be built on the

results are both a product of my personal and professional characteristics and interests, and also things which have themselves in turn shaped the way I think about my role as a professional trainer and educator. Throughout all stages of the PhD, I have tried to keep this dual position (as researcher on trainee wellbeing, and as educator of psychological trainees) in mind. I am grateful for the regular and reflective supervision I have received throughout the PhD and I believe that I have developed both as a researcher and a professional trainer through the journey that this PhD has taken me on. I have made regular use of reflective notes and journalling, and I have consistently sought to integrate my research into my teaching work. One of the notable satisfactions I have taken from my PhD experience has been using findings to support my teaching on trainee wellbeing, and using the feedback gathered from trainees in teaching to subsequently feed back into my research.

At multiple stages of my PhD journey, I have been conscious of the power imbalances inherent in some of the work I have been doing. Researching trainee wellbeing, and exploring the experience of trainees on courses in the department in which I am employed clearly carries with it some complexity. I have facilitated intervention development groups with trainees and colleagues exploring what trainees would want from wellbeing support (conversations which unsurprisingly sometimes also covered what trainees considered to be presently lacking in the university's provision). I have interviewed trainees about their experience of wellbeing during training, and have interviewed trainees to explore their experience of taking part in a wellbeing intervention that I had personally delivered. Within all of this, there has been ethical, methodological and analytical complexity, and a thoughtful and reflexive approach has been imperative. Across these varied contexts and circumstances, I have had to consider how my position as a staff member in the participants' department of study might influence who wants to take part, what those who do might feel able to say, and how I should make sense of what is reported. In some instances, the challenges posed by these issues were such that it was deemed necessary to remove myself from data collection processes (as when interviews with trainees on the programme I lead were conducted by a

colleague for the interview study reported in Chapter 4). In other instances I have taken different steps to acknowledge these power dynamics, and to minimise any negative effects they may have on the research (such as when trying to create a genuinely collaborative environment in the intervention development study meetings, or when doing all I could to support trainees to feel able to meaningfully describe their experience of the intervention whether positive or otherwise). Separately, I am also conscious of how some of my personal characteristics may have influenced the research. My ethnicity for example may potentially have acted as a barrier to participation for some participants from ethnic minority backgrounds, or may have influenced what ethnic minority participants who took part may have felt able to say. In all cases and at all moments, I have sought to take a reflective, considered, and ethically robust approach. The use of supervision, and the training received throughout this PhD have been notable supports in this regard, and I believe that I have succeeded in conducting the research in positive, collaborative and productive ways.

The ways in which I have developed over the course of this PhD then are many and varied. I have greatly improved my understanding of research design, data collection, and data analysis, all areas in which I had limited formal training prior to undertaking this doctorate. I believe I have improved as a communicator, and gained skills talking confidently about my research in varied settings. Other key insights for my development as a researcher have included the ways in which I have deepened my understanding of the need for research to be truly grounded in and informed by the views and perspectives of those for whom the research is designed. The revelation experienced during the intervention development study regarding how much trainee input benefitted the research was profound. Though it now feels naïve to have expected anything less, it was an extremely powerful moment for me to realise how much direct input from trainees and academic staff was needed, and how knowledge of the relevant literature or expertise in the research can only ever provide some of the information needed. Whilst trainee or stakeholder perspectives are of course themselves also situated in a particular context and emanate from particular viewpoints, I found it interesting to note

how much a diversity of inputs is needed to support impactful research. By incorporating the views of trainees, staff who deliver the training and understand the requirements of the role, and also the wider research literature on the topic, I felt I was able to arrive at a far better end point than I could have ever reached alone. I was also struck however by how active my role as researcher nonetheless remained, and how much sense-making was still required for bringing together the insights of these multiple perspectives in useful ways.

As both a researcher and an educator, I have also learnt a lot throughout this period of the need for research to be impactful, and for it to be grounded in real-world settings. Many of my early imaginings for later stages of the PhD (such as ideas regarding running large, in-person and multi-profession intervention group sessions) were simply unrealistic, or too far detached from the reality of real-world training settings. I believe these insights and learnings will greatly support my efforts to continue developing as a researcher into the future.

Recommendations

Several research, educational and policy recommendations can be devised on the basis of this thesis, and my hope is that the findings generated here can be used to support and enhance the training of psychological therapists and practitioners in a range of ways.

Educational Recommendations

First and foremost I hope that the research conducted in this thesis can support the effective and impactful delivery of psychological professional training. Drawing on the findings generated across this thesis, several recommendations can be made to education providers.

Recommendation 1: routinely include wellbeing interventions or teaching strategies in psychological practitioner training

Most broadly, and in keeping with the wider literature on this topic (Jones et al., 2017; Owen et al., 2021, 2022; Pakenham & Stafford-Brown, 2012), the findings of this PhD emphasise the importance of and need for wellbeing supports for this population. Participants in the qualitative interview study (Chapter 4), the intervention development study (Chapter 6), and the acceptability and feasibility study (Chapter 7) shared a conviction regarding the need for such interventions, and the scores returned on baseline measures for the intervention study echoed this. A primary recommendation of this research then is that wellbeing interventions or strategies are routinely included into training for the psychological professions.

Notably, trainees across multiple studies completed within this PhD commented how some space was already given in their taught curriculums to consideration of personal wellbeing, but that existing lectures and supports on this topic were typically considered superficial, surface-level, insufficiently practical, and minimally useful. Importantly, this indicates therefore that much of the time needed for an intervention such as the one feasibility and acceptability tested here is already available and being used, but that there is scope for such time to be used more effectively.

Recommendation 2: design interventions or teaching on this topic to be group-based, experiential, and facilitative of feelings of choice and autonomy

Given the availability of some space in the curriculum to deliver teaching or interventions on this topic, education providers are encouraged to consider ways to build practical, experiential and evidence-based interventions into their routine offer where they have one. Whilst the current literature does not give definitive answers regarding the exact nature and content of such an intervention, the combined findings of this PhD nonetheless provide several important

recommendations. Interventions to support trainee wellbeing should be experiential, practical, group-based and tailored specifically for trainees in the psychological professions. They should have a clear pathway of change, and a logic to how the proposed intervention or strategy is intended to address the challenges and stressors actually experienced by trainees. Such interventions should also be multi-component, and be designed to facilitate feelings of choice and autonomy. Whilst the 'Thriving in training' intervention designed and implemented for this thesis does not have the requisite evidence behind it yet to be universally recommended across institutions, it is nonetheless an example of an intervention that satisfies the recommendations set out here.

Recommendation 3: conceptualise wellbeing in training along eudaimonic terms, paying attention to how trainees can be supported to connect with values and pursue personally-meaningful activity, over and above a reductive focus on stress reduction

Further to the suggestions outlined in Recommendation 2, interventions or teaching strategies should also seek to facilitate eudaimonic wellbeing, giving attention to increasing values-based action and personal connection with values, rather than solely offering stress reduction techniques. Whilst the majority of interventions in the field to date have focussed on minimising or eliminating negative correlates of wellbeing, evidence from across this PhD suggests that trainees experience wellbeing (or an absence of it) in terms of connection with (or distance from) personal values. For this reason, interventions designed solely to reduce stress or anxiety, and measured for effectiveness solely in terms of the degree to which such constructs reduce across the intervention period, are liable to miss important features of the problem. Interventions that support trainees to connect with values however, and to experience positive features of wellbeing relating to feelings of connection, purpose and social value appear better aligned with wellbeing as it is described and experienced by trainees themselves.

Summary regarding recommendations to education providers: in recognition of the challenges of training in the field and the importance of trainee wellbeing, many education providers appear to already use some time for delivering content on trainee wellbeing. However, evidence across several studies produced here suggest that such time is not always used effectively. Where interventions or teaching strategies are offered in this area, they should be designed to build on the evidence regarding effective interventions for this population specifically. Too few existing studies in the field appear to have paid detailed attention to how an intervention is expected to help address the challenges trainees face, or whether it promotes wellbeing in terms aligned with how it is experienced by trainees in their role. Practical features of how teaching or interventions in this area are delivered appear important, with evidence to suggest that group-based, experiential and psychological professional specific interventions that facilitate choice and autonomy are likely to be most positively received.

Policy recommendations

Recommendation 4: Professional and/or commissioning bodies should require education providers to include content on supporting personal wellbeing during training, and should formally allocate time in training standards or curricula to support education providers in doing so

Whilst many education providers appear to be already holding time in curricula to include content on personal wellbeing, professional and commissioning bodies such as the BPS or NHS England (who oversee the standards and curricula from which psychological professional trainees are taught) are advised to formally require this from education providers. Whilst education providers may be able to adjust timetables in ways to free up some of the time and space needed for an intervention such as the one feasibility tested in this thesis, HEIs are already working under extremely challenged circumstances, with limited resources, and a commitment to the delivery of a high volume of taught content. Commissioners and accrediting bodies should therefore consider requiring inclusion of evidence-informed wellbeing supports, but ensuring that education providers are resourced

appropriately to include this additional content by allocating time in the training standards or curricula to do so.

Sufficient evidence exists regarding both the need for interventions and the extent to which such interventions are valued by trainees themselves, for formal requirements to be made on this front. Standards or curricula need not be prescriptive about the exact way this is done, but allocating some time into standards and curricula to support it, and requiring evidence of addressing this topic for course accreditation would help to ensure that trainees across institutions receive support in this important area. Across the psychological professions, the accreditation standards that courses are required to adhere to set out broad expectations for what must be included (e.g. 'Education providers must be able to document the intended programme and module learning outcomes' BPS, 2024, p.15). Building on the findings of this thesis, it is recommended that a requirement for including content on managing personal wellbeing during training is also included.

Summary of policy recommendations: In keeping with the ethos of major UK Government policy (DHSC, 2025) and planning for the healthcare workforce (NHS England, 2023), it is recommended that commissioners and professional bodies who oversee psychological professional training standards require the inclusion of content on managing personal wellbeing during training. To facilitate this and to ease the burden on education providers already feeling the pressures of a high academic delivery load, the allocation of time to support this work should be written into training curricula and standards.

Research recommendations Recommendation 4: Undertake comprehensive evaluation of the clinical and cost-effectiveness of the intervention across multiple sites

To answer questions regarding the ability of 'Thriving in training' to support trainee wellbeing and address the issues associated with poor wellbeing in this section of the workforce, evaluation of the clinical and cost-effectiveness of the intervention is required. Given the identified need for such intervention (e.g. Owen et al., 2021; Pakenham & Stafford-Brown, 2012), the promising levels of acceptability and feasibility identified in the study reported in Chapter 7, and the preliminary signals of efficacy identified regarding the clinical outcomes, this further evaluation is recommended.

To answer questions regarding the effectiveness of the intervention in real-world settings, a pragmatic cluster-based randomised controlled trial (RCT) would be ideal (Omerovic et al., 2024).

In such a study, participants would be clustered by training provider or psychological profession (i.e. so that trainees from each psychological profession within a university, and/or trainees from separate universities formed clusters for randomisation), to minimise the risks of contamination amongst participants and to overcome the impracticalities of individual randomisation in an educational setting (Cook et al., 2016). A study of this type would be powered to detect anticipated levels of change in the primary outcome, which in this case would be expected to be a validated psychometric measure of wellbeing (such as the Warwick-Edinburgh Mental Wellbeing Scale). Secondary outcomes likely of interest to this study would include measures of psychological flexibility (e.g. the MPFI), stress (e.g. the Perceived Stress Scale) and resilience (e.g. the Connor-Davidson Resilience Scale). It may also be beneficial to include long-term concrete outcomes related to retention or academic attainment using linked data analyses.

The acceptability and feasibility study undertaken in this thesis indicated that the intervention was acceptable and feasible to trainees across multiple distinct psychological professions. However, remaining uncertainties exist. The key remaining uncertainties are: whether the existing recruitment and retention strategies can be effective across multiple sites, whether protecting time in the taught

curriculum for the intervention can further increase feasibility (of attendance and of data collection) without negatively effecting acceptability, whether randomisation is acceptable and feasible, and whether the intervention can be delivered at scale in a cost-effective manner. Given this, designing the pragmatic cluster-based RCT to begin with an internal pilot, to answer these remaining uncertainties and to maximise efficiency of the main trial, may be appropriate (Avery et al., 2017). In keeping with guidance for internal pilots, setting pre-established criteria for whether to progress to the full trial using a traffic-light style system (Red-Stop, Amber-Amend and proceed with caution, Green-Go) would be expected (Avery et al., 2017).

Given the significant cost-implications of a large multi-centre pragmatic trial with internal pilot such as that described here, it may be more feasible instead to begin with a well-designed external pilot. If this were the case, designing a small-scale version of the pragmatic cluster-based RCT described above (e.g. delivered over a small number of sites, without powering to evaluate effectiveness, but trialling the study as intended for a subsequent trial) may enable answering the remaining uncertainties, and help prepare the information and evidence needed to plan a subsequent full trial. A pilot of this type may be appropriate for a grant suited to an early-career researcher like myself such as an NIHR Research for Patient Benefit (RfPB) grant.

Recommendation 4b: Undertake an economic analysis of the cost-effectiveness of delivering the intervention

The potential benefit for patients (Delgadillo et al., 2018), employing services (Summers et al., 2021), and the economy (Daniels et al., 2022) that can be reached by supporting practitioner wellbeing is vast and well documented. However, to understand the cost-effectiveness of delivering the intervention developed here, an economic evaluation would also be required. This would support understanding about the resource and cost implications of routinely embedding an intervention of

this type into real-world training contexts, an important feature of understanding the value of delivering complex interventions in real-world settings (Skivington et al., 2021). Economic evaluations of psychological interventions delivered in university settings can be conducted alongside pragmatic RCTs such as that proposed here (e.g. Wagner et al., 2023) and the inclusion of an economic analysis in the evaluation proposed here is recommended.

Summary of research recommendations: To build on the findings of this thesis and to answer questions regarding the extent to which 'Thriving in Training' can help to address issues associated with poor wellbeing in training, clinical and cost-effectiveness evaluation is required. Evidence from across this thesis suggests that wellbeing interventions for trainees are valued and can be effective. However, the existing literature is comprised largely of small and underpowered studies, many of which have not used control groups, or sought to understand the cost-effectiveness of delivering interventions to often small groups of trainees. To advance the field, and to provide evidence from which to develop more concrete guidance and recommendations for policy-makers and education providers, comprehensive evaluation of the clinical and cost-effectiveness of this intervention is required. The use of a pragmatic cluster-based randomised controlled trial with an internal pilot would help to ensure that the resources required for such evaluation are used effectively, and that the full trial can be confident of being delivered in a way that will permit answering its primary objectives. Alternatively, it may be more feasible to seek to run an external pilot study initially, trialling the design planned for the main trial, and aiming to develop evidence to support establishing a full trial at a subsequent step.

Thesis conclusion

This PhD has explored the concept of wellbeing in psychological therapy trainees, seeking to develop an in-depth understanding both of how trainees experience wellbeing in their roles, and how an

effective intervention to support trainee wellbeing can be designed and delivered. Novel findings from the PhD that contribute to the evidence-base include those relating to the way in which trainees experience wellbeing in their roles, and the importance of measuring wellbeing broadly in intervention research, so as to incorporate both 'positive' and 'negative' correlates of wellbeing. This is an important finding, which aligns closely with recent developments in the field of positive psychology (Compton & Hoffman, 2023) but which pushes against many of the dominant trends in the healthcare staff and trainee literature (in which a predominant focus on eliminating or reducing 'negative' correlates of wellbeing is found) (Owen et al., 2025; Van Hoy & Rzeszutek, 2022).

Further, findings from across multiple studies emphasise the importance that wellbeing interventions for this population facilitate trainee autonomy, and are designed in ways which support feelings of choice and independence, something which many interventions in the field to date have not done. Chapters 6 and 7 of the thesis have emphasised the importance of careful intervention design, and deliberate efforts to set out a clear pathway of change that details how an intervention is anticipated to address the core challenges it is intended to resolve. Whilst a large number of studies have been published in recent decades reporting on studies designed to support trainee wellbeing, there was little prior evidence of how and why particular interventions had been selected, or how it was anticipated that they would work to address the core challenges of the trainee role.

Finally, there is sufficient evidence of success identified in this thesis to suggest that proceeding to a more comprehensive evaluation of the 'Thriving in training' intervention is warranted. The systematic efforts described in this PhD to explore and understand wellbeing in trainees, and to review and build on what is already known about interventions designed to support it in this population have therefore been successful. These efforts have led to the generation of important new knowledge with the potential to be impactful in supporting real-world efforts to improve trainee wellbeing.

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