Psychological distress and disclosure in psychologist training environments: decision making about disclosure among clinical psychology doctorate programme trainers and distress and coping in clinical and counselling trainees.

Simone Davies (Trainee Clinical Psychologist)

Primary Supervisor: Dr Imogen Rushworth (Clinical Associate Professor in Clinical Psychology)

Secondary Supervisor: Dr Paul Fisher (Clinical Associate Professor in Clinical Psychology)

University of East Anglia Faculty of Medicine and Health Sciences

Date of Submission: 24th August 2021 Word Count: 27,995

Candidate Registration Number: 27578291

Abstract

Background

Psychological distress is common and widespread among mental healthcare professionals, including psychologists. Promoting workplace wellbeing and creating open and supportive cultures within the psychology profession are of growing interest.

Method

A systematic review was conducted to explore the types and prevalence of distress within clinical and counselling psychology doctorate trainees and the factors which influence distress and coping. Studies reviewed were both qualitative and quantitative. A narrative synthesis approach, which offers a robust and transparent way to bring together data from heterogeneous studies and identify themes, was used. An empirical study explored the processes and factors involved in trainers on clinical psychology doctorates in the UK deciding whether or not to disclose personal experiences of distress to clinical psychology trainees. A constructivist grounded theory approach was used.

Results

Nineteen studies were included in the systematic review. Findings suggested that psychological distress may be common among clinical and counselling psychology doctorate trainees, many of whom experience training as a time of high stress and high demand. Personal and professional resources were found to be important influences on distress and coping. The empirical study suggested that the trainers on clinical psychology doctorate programmes may be predisposed to disclose, when they can do so safely and helpfully. Participants valued disclosure personally and professionally but were wary of the risks of disclosure. Participants applied six criteria to disclosure decisions, based around “being safe” and “considering helpfulness”. Outcomes, whether positive or negative, reinforced the value

of disclosure and importance of making considered, conscious and personally meaningful decisions.

Conclusions

Psychological distress may be frequent and common among clinical and counselling doctorate trainees. To encourage cultures of openness and to support trainee disclosure and help-seeking, trainers on clinical psychological courses may wish to consider modelling openness around personal experiences of distress. Both the systematic review and the empirical research had notable limitations. Implications for practice and for future research were discussed.

Table of Contents

List of tables

Chapter Two: Systematic Review

Chapter Four: Empirical Study

Chapter Five: Additional Methodology

List of figures

Chapter Two: Systematic Review

Chapter Four: Empirical Study

List of appendices

Chapter Two: Systematic Review

Chapter Four: Empirical Study

Acknowledgments

I would like to thank my supervisors, Dr Imogen Rushworth and Dr Paul Fisher, for their continual support and encouragement throughout this research process. Their guidance and knowledge was much appreciated. A special thanks also goes to Adam Akdag, for his input into the systematic review.

Thanks to all the brilliant participants who agreed to take part in this research! Talking to you about your experiences and insights has been transformative for me.

I also want to thank my family and friends for believing in and supporting me throughout the doctoral journey. You've made what has felt like an impossible task, possible. To my proof-readers, thank you from the bottom of my heart. Dad, Anne and Imogen, you rule.

Lastly, but not leastly, a huge thank you goes out to my son Art. You've cheered me up and cheered me on throughout this whole process and I could not have done it without you.

CHAPTER ONE

Introduction to the Thesis Portfolio

Introduction to the thesis portfolio

Research into clinical psychologists and psychology doctorate trainees (henceforth trainees) and psychological distress in the workplace is limited. Matters are further complicated by studies investigating different aspects of psychological distress (including stress, burn out, mental health difficulties, low self-esteem and secondary trauma) from different theoretical perspectives and using different terms and definitions. Within these constraints, the literature suggests that levels of psychological distress may be high (Hannigan et al., 2004; Hill et al., 2016). Burnout has been found to be common among applied psychologists and psychotherapists, with moderate to high levels estimated to affect between 27.8% and 56% of psychologists in a recent systematic review (McCormack et al., 2018). Cushway and Tyler (1994) further found that nearly 30% of clinical psychologists surveyed met the General Health Questionnaire (GHQ-28) cut-off for "caseness" ("caseness" indicates clinical levels of mental health difficulties). Tay et al. (2018) found that of a sample of 678 qualified clinical psychologists 63% reported past or current lived experience of a mental health problem. Trainees may experience slightly higher levels of psychological distress than clinical psychologists (Cushway, 1992; Galvin, 2015; Grice et al., 2018; Hill et al., 2016). Cushway (1992) found that of their survey of 287 UK trainees, 59% met the GHQ-18 cut-off for caseness. Grice et al. (2018) found that of the 564 trainees who responded to their survey, 67% reported lived experience of mental health problems, of which 29% were current. Pakenham and Stafford-Brown (2012) concluded that trainees were at significant risk of experiencing excessive levels of stress. Hill et al. (2016) found that trainees experience clinical training as both stressful and demanding, while Galvin (2015) found significantly high levels of psychological distress among trainees.

The high levels of psychological distress that clinical psychologists and trainees may experience could negatively impact on their ability to function in the workplace and deliver

high quality care (Galvin & Smith, 2017; Pakenham & Stafford-Brown, 2012; Pope et al., 1987). Pope et al. (1987) found that over 59% of the psychologists in their study reported that they had worked when too distressed to be helpful to their clients, while over 35% reported that they had worked when their distress had affected the quality of care they provided. Pakenham and Stafford-Brown's (2012) review of the literature on trainees summarised that elevated levels of stress were likely to have detrimental effects on professional functioning and therefore the care provided to clients. Guidelines for professional conduct and surveys of psychologists (American Psychological Association, 2000; 2010; Health and Care Professionals Council, 2015; Tay et al., 2018) emphasise that managing psychological distress in order to limit professional impairment is a key competency of clinical psychology, as high levels of stress are unavoidable in this profession. Clinical psychologists are routinely exposed to emotionally intense experiences, including multiple narratives of abuse, loss and suffering (Rabu et al., 2016). In the UK, doctorate in clinical psychology programmes operate in the context of ever-increasing demand for NHS services and corresponding increases in workplace stress and burnout (Health Education England, 2019). Pakenham and Stafford-Brown's (2012) review of the literature emphasised the importance of trainees developing stress management skills early in their training in order to be able to negotiate stress successfully as their careers progress. However, managing psychological distress is not only the responsibility of the individual: HEE (2019) recommends that NHS workplaces should actively encourage open conversations about mental health and disclosure processes. Recent studies have suggested that encouraging trainers on clinical psychology courses to be open about personal experiences of distress with trainees may be one method of both upskilling individuals and creating mentally healthy workplaces (Howkins et al., 2018; Willets, 2018). However, little is known about trainers' attitudes towards disclosing, how they make the decision to disclose or not, or the processes by which disclosure occurs.

The aim of this thesis was to address some of the aforementioned gaps in the literature. A comprehensive systematic review of the types and prevalence of psychological distress within counselling and clinical psychology doctorate trainees is presented in Chapter Two. Chapter Four reports on a constructivist grounded theory study of the processes and factors that impact upon trainer on doctorate in clinical psychology courses decisions about whether or not to disclose personal experiences of psychological distress to trainees. The theoretical and contextual links between these two chapters are further explored in Chapter Three. Chapter Five presents additional methodology for both the systematic review and empirical study. Finally, Chapter Six provides a summary and integration of findings from both studies, a critical review and discussion of practice implications and directions for future research, reflecting throughout on the strengths and limitations of the thesis portfolio as a whole.

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Chapter Two

A Systemic Review Investigating the Types, Prevalence of and Factors Influencing Psychological Distress in Clinical and Counselling Psychology Doctorate Trainees.

Prepared for submission to the Journal of Clinical Psychology (see Appendix A)

Word Count: 7148 (including tables, excluding supplementary material)

A Systemic Review Investigating the Types, Prevalence of and Factors Influencing Psychological Distress in Clinical and Counselling Psychology Doctorate Trainees.

Simone Davies[ac], Dr Imogen Rushworth[a] , Dr Paul Fisher[a] and Adam Akbar[c]

[a] Department of Clinical Psychology, University of East Anglia, Norwich, NR4 7TJ, England, UK Adam Akbar

[b] Norfolk and Suffolk NHS Foundation Trust, Great Yarmouth and Waveney Youth Team, Cranbrooke Centre, Northgate Hospital, NR30 1BU

[c] Corresponding author: simone.davies@uea.ac.uk

Role of funding sources: This work was supported by the Clinical Psychology Doctorate Programme at the University of East Anglia

Conflict of interest: All authors disclose no conflicts of interest

Abstract

Objectives: Psychological distress is known to be common within caring professions and to have negative implications for wellbeing and coping, as well as impacting on job performance. Recently there has been increased research into distress within clinical and counselling psychology doctorate trainees, expanding the literature. This review aims to identify the types and prevalence of psychological distress in trainee clinical and counselling psychologists, and the factors which influence distress and wellbeing.

Methods: This PRISMA review (Moher et al., 2009) searched three key databases: MEDLINE (CINAHL); PsychInfo; and SCOPUS for articles published prior to 16 March 2021. Articles concerning the prevalence of, and factors influencing, psychological distress in clinical and counselling doctoral trainees, which were published in the English language and were less than 30 years old, were included. Both qualitative and quantitative studies were included. Papers were quality appraised. A narrative synthesis approach (Lucas et al., 2007; Popay et al., 2006) was used to identify themes within the data.

Results: Nineteen papers were included in this review. The most commonly investigated types of distress were stress, burnout, mental health difficulties and low self-esteem. Clinical and counselling doctorate trainees were found to report high levels of stress and burnout, while a significant subsection (around a quarter to a third) reported experiencing mental health difficulties and low self-esteem. Three main groups of factors were found to affect trainees' experience of distress and coping: organisational factors, particularly programme culture; individual factors, particularly ways of coping and traits such as maladaptive perfectionism; and relationship factors, particularly relationships with supervisors and other trainees.

Conclusions: The results of this review suggest that stress, burnout and mental health difficulties are relatively common experiences for trainees, rather than individual issues experienced by a few. Access to resources such as organisational cultures of openness, supportive supervisory and peer relationships, and adaptive individual coping and help-seeking strategies were found to play important roles in the experience of distress in trainees. Tentative recommendations are made for training programmes on how best to support trainees to navigate the rigours of training.

Keywords: psychological distress, mental health difficulties, stress, burnout, clinical and counselling doctorate trainee psychologists

Introduction

Research on psychological distress in the workplace and in healthcare professionals suggests that stress, burnout and mental health difficulties (MHDs) are both common and problematic, with significant costs both to individuals' wellbeing and to the economy and society more widely. In the UK during 2019/20, depression and anxiety were estimated to account for 51% of all cases of work-related ill health and 55% of all working days lost due to work-related ill health (Health and Safety Executive: HSE, 2020). Healthcare workers, along with other public sector professionals, have been found to show higher levels of stress compared with all other jobs (HSE, 2020) and have higher rates of depression, anxiety and substance abuse (Health Education England: HEE, 2019; National Academies of Medicine: NAM, 2019; Shanafelt et al., 2012). Levels of stress, burnout and MHDs have been found to be high in psychologists (Hannigan et al., 2004; McCormack et al., 2018; Tay et al., 2018). Recent research suggests that there is a 'mental health crisis' among graduate students (Evans et al., 2018). As members of these three groups, clinical and counselling psychology trainees (henceforth trainees) may also be vulnerable to high levels of distress, and corresponding impairment (Pakenham & Stafford-Brown, 2012; Grice et al., 2018).

Healthcare professionals work to keep others well, yet their own wellness is often impacted by the demands of their jobs. High workloads and high expectations on efficacy and efficiency, alongside ever-changing health systems and technologies, add to job stress (NAM, 2019; HEE, 2019). The 'emotional labour' (showing emotions such as sympathy and understanding when they are not felt and suppressing emotions such as frustration and disgust when they are experienced) of healthcare work adds to stress and burnout (HEE, 2019). Clinical and Counselling psychology are professions that place especially high emotional demands on practitioners (American Psychological Association: APA, 2010; Health and Care

Professions Council: HCPC, 2015). Psychologists are routinely exposed to emotionally intense experiences, including multiple narratives of abuse, loss and suffering (Rabu et al., 2016). Furthermore, those with pre-existing experiences of MHDs may be drawn to the field of psychology (Kemp et al, 2021; Tay et al, 2018). Graduate students have generally been shown to be vulnerable to difficulties with work-life balance and poor mentoring relationships (Evans et al, 2018). Post-graduate healthcare professionals have been found to exhibit high levels of personality traits, such as perfectionism, which make them highly successful as learners, but also more susceptible to self-criticism, burnout and MHDs (HEE, 2019). As well as experiencing these same workplace stressors, there may be unique factors that influence psychological distress in trainees. 'Educational bottlenecks' – such as entry into clinical and counselling doctorate programmes – have been found negatively to impact student wellbeing (Cruwys et al., 2015). Continuous evaluation, assessment, learning and reflection, alongside regular rotation into different working environments, may add to trainee stress (Rønnestad & Skovholt, 2003). However, trainees may have access to resources, both personal and organisational, that aid coping. They have been through a rigorous selection process, for a programme of training that has a high pass rate, into a profession with high retention rates, suggesting that they have the skills and resources to navigate the demands of training (Scior et al., 2014).

Although interest has recently increased in psychological distress in trainees and the factors that influence wellbeing and coping (Kemp et al., 2020; Randall et al., 2019; Vally, 2019a; 2019b), research into psychological distress in trainees has been fragmented. Studies have investigated different aspects of distress (including stress, burnout, MHDs, low self-esteem and secondary trauma) from different methodological and theoretical perspectives. An overview of these findings is necessary to: understand the types and prevalence of distress

that trainees experience; identify the causes and mediators of distress; and guide interventions. This review has therefore sought to answer the following questions:

1. What types of psychological distress have been investigated in clinical psychology trainees and what is the prevalence of these types of distress?
2. What factors influence distress and wellbeing in clinical psychology trainees?

Method

Protocol and registry

This review was written following the PRISMA guidelines (Moher et al., 2009). A review protocol was registered on Prospero (CRD42021246759).

The review followed a seven-step process: i) criteria identification; ii) database searching; iii) duplicate and non-criterion paper exclusion, with reasons given; iv) additional paper identification and screening v) data extraction; vi) results synthesis (Frantzen & Fetters, 2007; Popay et al., 2006); and vii) presentation.

Study selection

Inclusion criteria

Articles were included which met the following criteria: i) population sampled were clinical or counselling psychology doctorate trainees; ii) study investigated prevalence and/or mediators of psychological distress or psychological wellbeing; iii) peer-reviewed publication available in English; iv) publications included original data.

Psychological distress was characterised as including stress and burnout, MHDs, emotional distress, low self-esteem and secondary trauma. Psychological wellbeing was characterised as including mental and emotional wellbeing, coping and help-seeking.

Exclusion criteria

Articles were excluded based on the following criteria: i) Population sampled includes trainees from specialisations, professions or stages of post-graduate training other than clinical or counselling psychology doctorate training and data on target population were not extractable; ii) studies involving clinical or counselling doctorate trainees in which the programme of training being undertaken is not equivalent to UK training programmes (i.e. did not include clinical, training and research elements) or where this is unknown/unclear; iii) intervention studies; iv) unpublished thesis; and v) reviews, meta-analyses, or theoretical or opinion articles.

Studies that were published more than 30 years ago were excluded following database searches.

Search strategy

Extant articles published on the topic of psychological distress in trainees were searched for using the following databases: MEDLINE (CINAHL); PsychInfo; and SCOPUS. See Appendix B for a table of search terms used. The final search date was 16 March 2021. Reference and citation lists of included articles were manually searched to identify any potential additions. Clinical Psychology Forum (British Psychological Society) back issues were also checked for relevant articles, as this publication is not included within databases.

Data extraction and analysis

Data and characteristics of all studies included in the review were extracted and summarised (see Table 2.1). Information collected included study design, location, sample size, speciality, country, aim, measures and main findings. Main findings were organised as: type and prevalence of distress; mediating factors; recommendations. The lead author completed the full process.

A narrative synthesis approach (Lucas et al., 2007; Popay et al., 2006) was used to analyse data, due to the suitability of this methodological approach for answering the review's research questions. A narrative synthesis approach allows for data to be synthesised across qualitative, quantitative and mixed methods studies (Hong et al., 2017), enabling researchers to make sense of large bodies of evidence produced using disparate methods (Rogers et al., 2009). Comprehensive guidelines (Popay et al., 2006) for conducting and reporting narrative synthesis were followed in order to minimise research bias and maximise transparency (Campbell et al., 2019). These guidelines outline four key processes that can be applied flexibly: developing a theoretical model of the intervention; generating a preliminary synthesis through an initial description of the results; exploring relationships and emerging patterns in the data to identify explanations for differences and similarities; assessing the synthesis for robustness (including assessing the methodological quality of the included studies).

All included articles were assessed for quality, using three different tools to account for the different observational methodologies used. The Appraisal Tool for Cross-Sectional Studies (AXIS; Downes et al., 2016), the Critical Appraisal Skills Programme (CASP) Cohort Study Checklist (CASP, 2017) and the CASP Qualitative Study Checklist (CASP, 2018) were selected, based on Sanderson et al.'s (2007) guidelines. Across tools, items rated

as ‘yes’ were assumed to meet the criteria. Items rated as “no”, “don’t know/can’t tell”, or mixed were rated as not meeting the criteria. A second reviewer checked a sample of 20% of the papers to assess reliability. Inter-rater reliability was 96% concordant, confirming the validity of the first reviewer’s assessment of methodological quality. Differences were resolved through discussion.

Results

Study selection

Following the study selection process (detailed in Figure 1), 19 studies met the criteria and were included in this review. Seventy-six studies were excluded. See Appendix C for reasons for full text exclusion.

Figure 2.1

Flow diagram of searches

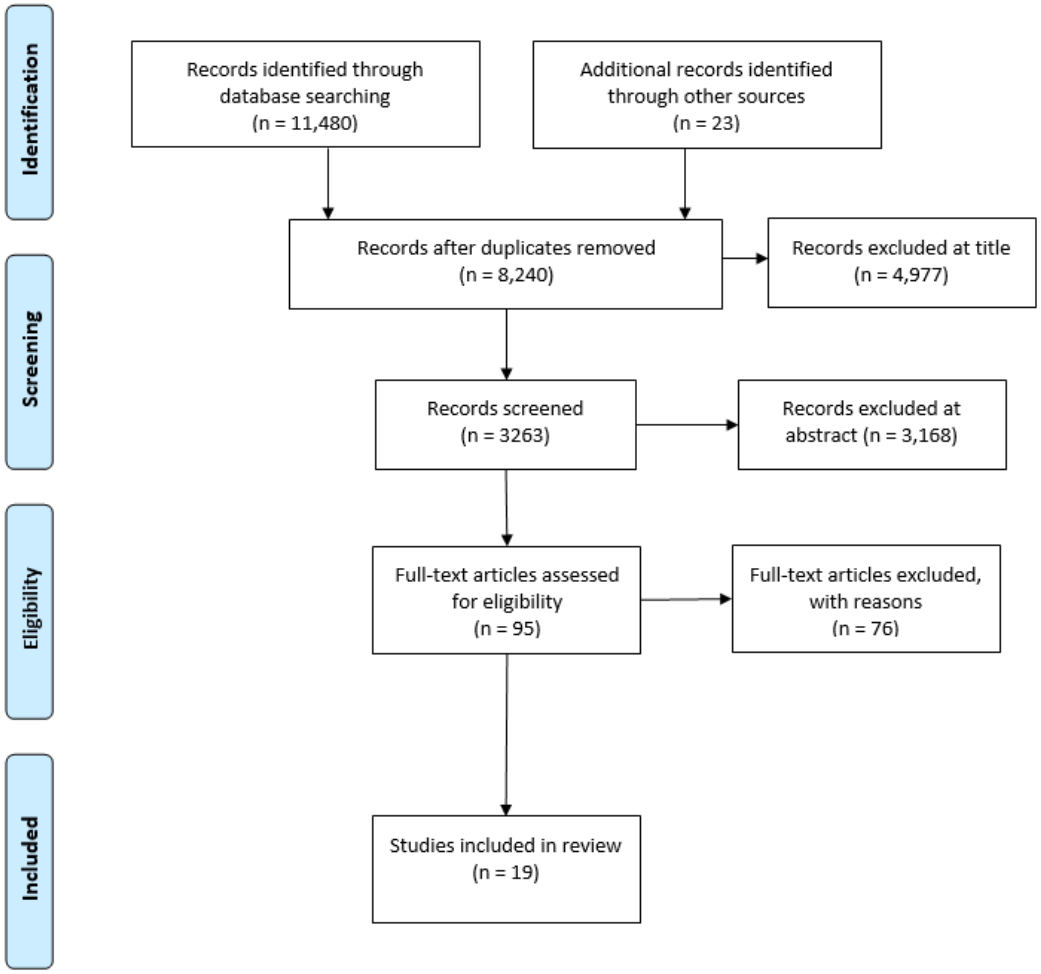

Diagram adapted from PRISMA, detailing flow of studies retrieved from searches through to inclusion.

Study characteristics

Characteristics of the studies, including methodology, study size, sample, country, aims, measures, and main findings are presented in Table 2.1. Most studies were quantitative, cross-sectional surveys via either web (*n* 11) or paper (*n* 3). There were three qualitative studies and two longitudinal cohort studies. The two longitudinal studies (Kuyken et al.,

2000; Kuyken et al., 2003), followed up an earlier sample (Kuyken et al., 1998) and utilised the same data set. They were both included as they performed conceptually different analyses, providing different evidence for trainee psychological distress and the factors that impact upon it. Aims of the included studies varied, with some focusing on prevalence and levels of psychological distress, while others explored mediating factors in greater detail.

Table 2.1

Characteristics and data summary of findings for included studies

Authors	Design	Sample	Speciality	Country	Aim	Measures / methodology	Type of distress / factors investigated	Main findings
Borgogna et al (2020)	1	*n* 417 (80.4% female). Control: undergraduate students *n* 4054 (75.1% female)	*1*	US	Explore the mental health, financial stress and debt-at-graduation of doctoral psychology students and difference across specialities	Patient Health Questionaire-9 (PHQ-9; Kroenke et al., 2001) Generalised Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006)	MHDs: depression, anxiety; financial debt stress	Depression estimated at 18-26%. Anxiety estimated at 23-32%. Students on all doctoral programmes scored lower on measures of depression than undergraduate students. Differences in levels of anxiety between groups were not statistically different. Trainees on applied psychology programs were more resilient than undergrads. Financial debt stress positively correlated with mental health symptoms. Financial debt stress did not differ significantly between doctorate type, despite significant differences in anticipated debt-at-graduation
Brooks et al. (2002)	2	*n* 364 (83% female, 15% male, 2% did not answer)	2	UK	Explore the relationship between personality factors, expectations and psychological adaptation to training	Millon Index of Personality Styles (Millon, 1993). Employee Assistance Program Inventory (EAPI: Anton and Reed, 1994)	MHDs: anxiety, depression; low self-esteem; personality adjustment	Anxiety estimated at 18%. Depression estimated at 14%. Low self-esteem estimated at 23%. Mean overall personality adjustment for the sample was well above norms. Trainees were found to be (in descending order): enhancing, extravising, outgoing, agreeing and modifying. Poorly adjusted personality was estimated at 8%

Brown et al. (2020)	3	*n* 14 (86% female)	*2*	UK	Explore the impact of workplace bullying on wellbeing in clinical psychology doctorate trainees pre- and during training	Thematic analysis	Wellbeing; bullying	Four main themes: Bullying results in "activating threat responses" including hypervigilance, avoidance and self-criticism, even when no longer bullied; "making sense of bullying" including use of term, subtle and gradual processes, assumptions about helping and reflective practice; "difficulties negotiating power within the system" including impact of reporting on training and career; "finding safety and support" including positive regard from others and care
Cushway (1992)	2	*n* 287 (74% female)	*2*	UK	Explore the levels, causes and coping strategies of stress in clinical psychology trainees and relationship to mental health	Author-developed Stress Survey. Coping Questionnaire (developed from Health and daily living schedule; Moos et al, 1990) General Health Questionnaire-28 (GHQ-28: Sterling, 2011)	MHDs: stress	High stress reported by 27%. Moderate stress by 48%. Stressors were identified as: (1) course structure and organisation; (2) workload; (3) poor supervision; (4) disruption of social support; (5) self-doubt; and (6) client difficulties and distress. Coping strategies were identified as (1) talking to trainees (51%; (2) reduce tension by exercise (38%); (3) talking to friends (30%); (4) talking to partner (29%); and (5) talking to supervisor (25%). Years 2 and 3 reported higher stress levels than year 1. Those who reported high stress scored significantly higher on GHQ
Galvin (2015)	1	*n* 168 (90.5% female). Control: psychiatric nursing students *n* 94, PhD students *n* 253	2	UK	Compare clinical psychology trainees, psychiatric nursing student and PhD students stress and risk factors	Author-developed questions on mental health experience, resources and job demands. Wellbeing process questionnaire (WPG; Williams, 2012). Child Abuse and Trauma Scale (CATS Sanders & Becker-Lausen, 1995)	MHDs: stress; burnout; wellbeing; job demands; resources; childhood experiences	Clinical Psychology Doctorate trainees reported significantly higher levels of MHDs than non-clinical groups. They also reported more resources, greater job demands, higher stress and higher incidence of negative childhood experiences than all other groups

Galvin & Smith (2017)	3	*n* 15 (73% female)	*2*	UK	Explore the stressors and coping strategies in clinical psychology doctorate training	Thematic analysis	Stress; stressors; coping factors	Three themes were identified: application procedures (most stressful part of journey, in addition to job insecurity as AP), personal and professional relationships (helpful and unhelpful) and commonalities in personal history, experiences and self-reported personality characteristics (ready-made for clinical psychology, maladaptive coping strategies, too much reflection "pressure cooker")
Grice et al. (2018)	1	*n* 348 (86% female)	*2*		Investigate the incidence of MHDs among trainees and to understand some of the mechanisms that may underlie their decisions about disclosure, including the role of perfectionism	Author-developed measure of MHDs. Multidimensional Perfectionism Scale (MPS: Hewitt and Flett, 1996). Perceived Devaluation and Discrimination scale (PDD; Link, 1987). Author-developed questionnaire for anticipated likelihood of disclosure	MHD; maladaptive perfectionism; disclosure	67% reported lived experience and 29% (*n* = 100) reported current MHDs. Adaptive perfectionism was higher than maladaptive perfectionism. Maladaptive perfectionism was negatively correlated with anticipated disclosure
Hill et al. (2016)	4	*n* 26 (88% female) Year three clinical psychology doctorate students from a single training course	*2*	UK	Explore the personal and professional development of clinical psychology trainees	Author-developed Repertory Grid of ten elements	Stress; self-esteem; demands of training; work-life balance	Trainees had low self-esteem and reported currently feeling anxious, stressed, unsettled and lacking an appropriate work-life balance. These difficulties were attributed to the demands of training and were expected to resolve once training was completed with future selves being construed as similar to ideal selves

Kuyken et al. (1998)	2	*n* 183 (82% female) 15 randomly selected training courses	*2*	UK	Profile the psychological adaptation of psychologists in clinical training and examine the extent to which appraisal, coping and social support were related to psychological adaptation	Author-developed stress appraisal measure. Ways of Coping Questionnaire (WCQ: Folkman, & Lazarus, 1988). Significant Others Scale (SOS: Power et al., 1992) EAPI (Anton and Reed, 1994). Adaptation of World Health Organisation Quality of Life Assessment (WHOQOL Group, 1995)	MHD; stress; Low self-esteem: Gender; coping style; age	Anxiety estimated at 28%. Depression estimated at 26%. Stress levels reported as "high" and higher than normative samples. Low self-esteem estimated at 35%. Gender and coping styles: male trainees were significantly more likely to cope through distancing and less likely to cope through seeking social support than female trainees and were more likely to report substance abuse problems than female trainees (42% vs 13% above cut off). Age: older trainees reported feeling less control over the stresses of the course and having greater external stressors. Year of training: Across years there was a significant difference for work adjustment problems and depression, which increased across the years
Kuyken et al. (2000)	5	Time one*: n* 183 (82% female). Time two: *n* 167 (91.3% of first sample)	*2*	UK	Profile the psychological adaptation of trainee clinical psychologists across training courses in the UK throughout the three years of clinical training	See above	MHD; stress; low self-esteem. stage of training	Anxiety estimated at 28%. Depression estimated at 38%. Stress levels reported as "high" and higher than normative samples. Low self-esteem estimated at 38%. Stage of training: Work adjustment problems, depression and interpersonal conflict increased over the three years of training

Kuyken et al. (2003)	5	Time one: *n* 183 (82% female). Time two: *n* 167 (91.3% of first sample)	2	UK	Improve understanding of what factors predict changes in psychological adaptation and professional functioning over the course of clinical psychology training	See above	MHDs; stress; low self-esteem: appraisals; coping style; contextual support	Appraisals of threat and lack of control predict worse psychological adaptation and impact negative coping strategies. Coping style: Escape and avoidance coping is correlated with problems with psychological adaptation. Contextual support: Social support, supervisor support, and course support help trainees perceive stressors as controllable
Makadia, R., et al. (2017).	1	*n* 564 (90% female)	2	UK	Explore the relationship between exposure to trauma work and wellbeing in trainee clinical psychologists	General Health Questionnaire – 12 (GHQ-12; Goldberg & Williams, 1988) Secondary Traumatic Stress Scale (STSS: Bride et al., 2004) Trauma and Attachment Belief Scale (TABS: Pearlman, 2003). Trauma Screening Questionnaire (TSQ: Brenwin et al, 2002). Author-developed questionnaire on exposure to trauma work, stress and demographics	MHD; trauma; disrupted beliefs	27% of the sample above the cut-off for caseness on GHQ-12. 20 trainees (4%) met the cut off for increased risk of PTSD on the TSQ. No correlation between exposure to trauma and general MHDs. Exposure to trauma work was not related to disrupted beliefs. Level of stress of clinical work and quality of trauma training were significant predictors of trauma symptoms

Richardson et al. (2020).	1	*n* 119 (86% female)	*1*	US	Explore associations between self-critical perfectionism, depression, and burnout among doctoral trainees in psychology, investigating the mediating role of self-compassion	Discrepancy subscale of the Almost Perfect Scale-Revised (APS-R; Slaney et al., 2001). Self-Compassion Scale (SCS; Neff, 2003). Depression subscale of the Inventory of Depression and Anxiety Symptoms-Second Version (IDAS-II; Watson et al., 2012). Personal Burnout subscale of the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005)	Depression; burnout; self-critical perfectionism; self-compassion	Depression scores were slightly above the mean of IDAS-II normative samples. Burnout scores were well above the mean of a normative sample with the CBI. Perfectionism was a positive and significant predictor of both depression and burnout. Self-compassion was negatively and significantly associated with both depression and burnout
Rico & Bunge (2021)	1	*n* 204 (86.8% female)	*1*	US	Compare the levels of stress in both trainees and the general population and to examine levels of stress and burnout in trainees, as related to the students' year in the graduate programme	Maslach Burnout Inventory-Human Services Survey (MBI-HSS: Maslach et al., 1996). The Perceived Stress Scale-10 (PSS-10; Roberti et al., 2006).	Stress; burnout; stage of training	No significant differences in levels of stress were reported between trainees and participants from the general population. Third and fourth years (grouped together) reported significantly higher scores for stress and on the emotional burnout subscale than all other years

Rose et al. (2019)	1	*n* 219 (88.5% female)	*2*	UK	Explore factors linked with trainee resilience to stress, focusing on reciprocity in trainee relationships and self-efficacy beliefs and their associations with burnout and psychological wellbeing	The Reciprocity Questionnaire (author adapted from Van Horn, 2001) The Maslach Burnout Inventory (MBI; Maslach et al., 1986) The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007) The Clinical Psychology Inventory (CPI) self-efficacy measure specific to clinical psychology training (Matharu, 2012).	Burnout; wellbeing; relationship reciprocity; self-efficacy beliefs	Just over two-thirds were experiencing moderate to high emotional exhaustion. Just over a third had a low sense of personal accomplishment. Clinical psychology trainees experience levels of psychological wellbeing close to the population norm. Reciprocity in relationships: When trainees feel well supported (i.e. receive more than invest), psychological wellbeing is engendered – which protects against emotional exhaustion. Over-investment in relationships with clients is correlated with emotional exhaustion and is significantly correlated with low personal accomplishment and depersonalisation. Self-efficacy beliefs: Course and clinical self-efficacy beliefs jointly predict more than 40% of the variance in psychological wellbeing
Rummell (2015)	1	*n* 119 (77.3% female, 18.5% male, 1.7% transgender, 2.5% did not report)	*1*	Canada	Explore the relationships between workload, perceived stressors, mental and physical health, and program satisfaction	Author-developed measure – questions on working hours, chronic illness, frequency of physical symptoms, anxiety and depression (questions based on DSM V classifications) Inventory of College Students Recent Life Experiences (Kohn et al., 1990). Perceived Stress Scale (PSS: Cohen et al, 1983)	Depression; anxiety; stress; physical health; workload; perceived stressors; programme satisfaction; year of study	49.1% reported clinically significant anxiety. 39.2% reported clinically significant depression. 34.8% reported clinically significant symptoms of anxiety and depression – greater than population norms and medical students' means. Significant correlations were found for physical and mental health symptoms and number of school-related tasks. "High" levels of physical health symptoms reported. Trainees reported that either the training programme (60%) or their current financial situation (16%) were the most stressful aspects of their lives. Trainees early in programme were more prone to overwork

Spendelow (2017)	1	*n* 109 (83% female)	*2*	UK	Explore the relationship between course climate, relationship satisfaction and psychological wellbeing	Graduate Programme Climate Scale (GPCS; Veilleux et al., 2012). Author-developed Relationship Satisfaction Measure. Scale of Positive and Negative Experiences (SPANE; Diener et al., 2010)	Wellbeing; course climate; relationship satisfaction	"Positive" course climate was positively associated with trainee-staff and trainee-trainee relationship satisfaction. Climate was found to be significantly associated with trainee wellbeing – the more positive the perceived course climate the greater the wellbeing and vice versa: this effect was large
Swords & Ellis (2017).	1	*n* 203 (86.7% female 12.8% male, 0.5% identified as genderqueer)	*1*	US	Assess and identify predictors of burnout and vigour	Shirom-Melamed Burnout Measure (SMBM; Shirom, 2005a). Shirom-Melamed Vigour Measure (SMVM; Shirom, 2005b). Stress in General Scale (SIG; Stanton et al., 2001). Author-developed measure of financial strain. The Relationship Conflict Scale (RCS: Lee, 2006). The Supervisory Working Alliance Inventory–Trainee (SWAI-T; Bahrick, 1990)	Burnout; stress; vigour; financial strain; relationship conflict; supervisory relationship	Relative to normative samples, participants evidenced substantially higher burnout and markedly lower vigour. Supervisory alliance and perceived threat were the two most important predictors of stress and burnout. Financial strain, pressure and relationship conflict were associated but not significant when other variables were accounted for. Participants reported substantively higher levels of work-related stress, especially pressure, which in combination with higher levels of burnout and lower levels of vigour suggests that pursuing doctoral study is likely to be more stressful than a cross-section of other jobs and careers

Zahniser et al. (2017)	1	*n* 358 (87.1% female)	*1*	US	Explore self-care practices, the relationship between self-care and stress and wellbeing and the role of doctorate programs in promoting self-care in clinical and counselling psychology doctorate trainees	The Professional Self-Care Scale for Psychologists (PSCS; Dorociak et al., 2017) Author-developed Programme Self-care Culture Measure. Author-developed Perceived Progress in Graduate Training Measure. PSS-10; (Roberti et al., 2006). PANAS (Watson et al. 1988). The Flourishing Scale (Diener et al., 2010)	Stress; wellbeing; self-care; programme culture relating to self-care	Self-care is associated with both greater personal wellbeing and better self-reported progress. Self-care can serve as a buffer against the harmful effects of stress inherent to graduate training. Two important aspects of self-care were reported to be building professional support systems and maintaining awareness of one's needs and reactions to stressors. Trainees who perceived greater emphasis on self-care within their programmes reported engaging in more self-care.

Design: 1 = Quantitative, cross-sectional, survey, web; 2 = Quantitative, cross-sectional, survey, paper; 3 = Qualitative, cross-sectional, semi-structured interviews; 4 = Qualitative, cross-sectional, structured interview using repertory grid; 5 = Quantitative, cohort study, survey, paper. Speciality: *1* = clinical and counselling trainees; *2* = clinical trainees only; *3* = counselling trainees only

Psychological distress: types and prevalence

The studies included contain multiple definitions of psychological distress and employ a wide variety of tools and theoretical frameworks. Narrative synthesis of results found that studies investigated four main areas: MHDs, low self-esteem, stress and burnout. Additionally, a small number of studies investigated lack of wellbeing (Brown et al., 2020; Rose et al., 2019) and secondary trauma (Makadia et al., 2017).

Mental health difficulties

Ten studies investigated the prevalence of MHDs in trainees. The most commonly examined difficulties were anxiety (*n* 5 studies) and depression (*n* 6 studies). Four studies investigated unspecified/general MHDs. Studies used eight different measures to examine MHDs in trainees.

Using validated measures, studies found that clinical levels of anxiety were affecting between 18% (Borgona et al., 2020) and 28% (Kuyken et al., 1998; 2000) of trainees, while depression was affecting between 14% (Borgona et al., 2020) and 36% (Kuyken et al., 2000). Author-developed measures estimated anxiety at 49% and depression at 39% (Rummell, 2015). Validated measures of common MHDs found that between 27% (Makadia et al., 2017) and 57% (Cushway et al., 1992) of trainees met the cut-off for “caseness”. An author-developed question in a recent large-scale survey estimated that 29% of trainees were currently experiencing problem levels of MHDs (Grice et al., 2018).

Findings suggest that a small but significant subgroup of trainees (between 14-57%) may experience clinical or problematic levels of MHDs. Comparisons to normative samples were not made in a way that enabled substantiation. The exception to this was Borgona et al.

(2020), who found that trainees had similar levels of anxiety, and significantly lower levels of depression compared with undergraduate students.

Low self-esteem

Four studies investigated self-esteem in trainees. Three of the studies used the self-esteem subscale of the Employee Assistance Programme Inventory (EAPI: Anton & Reed, 1994), while one study used a repertory grid technique.

Using the EAPI, Brooks et al. (2002) and Kuyken et al. (1998; 2000) found that problem levels of low self-esteem were reported by 23%, 35% and 38% of trainees respectively. Hill et al. (2016) employed a repertory grid technique to understand trainees' constructions of personal and professional development. They found that trainees rated their "current selves" as significantly different from their "ideal selves". The discrepancy between current and ideal selves was used as evidence of low self-esteem in this population (Hill et al., 2016).

Studies included in this review suggest that a significant subsection (between approximately a quarter and a third) of trainees may experience low self-esteem.

Stress

Seven studies investigated stress. Four studies used the Perceived Stress Scale (PSS: Cohen et al., 1983) or the PSS-10 (Roberti et al., 2006), two used author-developed measures and one used qualitative methodology.

The PSS has no cut-offs; higher scores indicate higher stress only (Cohen et al., 1983). Studies using the PSS or PSS-10 found that trainees reported mean scores of between 17.37 (Kuyken et al., 1998) and 29.14 (Zahniser et al., 2017) out of 34. All studies interpreted

their findings as indicating “high” stress. Using an author-developed measure of stress, Cushway et al. (1992) found that 27% of trainees reported high stress, while 48% reported moderate stress.

Using the PSS, Kuyken et al. (1998) found levels of trainee stress to be high compared to a large normative sample (Cohen & Williamson, 1988). Using the same measure, Rico and Bunge (2021) found no significant differences in levels of stress between trainees and a comparison group of participants from the general population. Galvin (2015) compared stress in trainees to stress in mental health nursing and PhD students, finding that trainees reported higher stress levels than both other groups.

Studies suggest that levels of stress among trainees are high and may be higher than in other doctorate and student populations. Findings on whether levels of stress are higher than for general populations are mixed.

Burnout

Four studies included within this review measured burnout. Three different measures of burnout were used.

Richardson et al. (2020) found that trainees reported mean raw scores of 51.24 on the Copenhagen Burnout Inventory (CBI), well above those of normative samples (Kristensen et al., 2005). Rose et al. (2019) found that 68% of their sample reported moderate or high burnout, using the emotional exhaustion subscale of the Maslach Burnout Inventory (MBI: Maslach et al, 1986). Swords and Ellis (2017) found that trainees in their sample reported substantially higher burnout relative to normative samples. Rico and Bunge (2021) found that third and fourth years (grouped together) reported significantly higher scores on the

emotional exhaustion subscale of the MBI-Human Services Survey (MBI-HSS: Maslach et al., 1996). than all other years.

The evidence suggests that trainees may experience moderate to high levels of burnout and that these levels are well above those of population norms.

Factors that influence psychological distress in trainees: coping with the rigours of training

In addition to investigating the types and prevalence of distress, many of the studies included in this review have explored factors which may influence psychological distress and coping in trainees. Following narrative synthesis (Popay et al., 2006), three main themes emerged as important to the experience of distress and coping: training demands and environment; personal characteristics; and relationships.

Training demands and environment

The high demands of training emerged as one of the most significant factors contributing to psychological distress, repeatedly appearing as a cause of distress – and of stress especially – within the literature. Hill et al. (2016) found that trainees attributed their MHDs and poor work-life balance to the demands of training. Rummell (2015) found that 60% of the trainees in their sample reported training as the most stressful aspect of their lives. Furthermore, it appears that psychology doctorate training is both more stressful and demanding than non-clinical PhDs (Galvin, 2015) and a cross-section of other occupations and careers (Swords & Ellis, 2017).

Studies in this review suggest that year of training, workload, financial stress, clinical work and emphasis on reflective practice may all contribute to the stresses of training.

Several studies report higher levels of distress in later years of study, as academic pressures increase (Cushway, 1992; Kuyken et al 2000; Rico & Bunge 2021). However, Rummell (2015) reports that early in training, trainees were more prone to overwork, which increased anxiety levels. Cushway (1992) reports workload as one of six major stressors for trainees. The emphasis on reflective practice within training courses was also at times contributing to stress: "like being in a little psychological pressure cooker sometimes" (Gavin and Smith, 2017, p142). In contrast, course culture when perceived as supportive may positively impact trainees' stress levels (Spendelow, 2017). Zahniser et al. (2017) found that trainees who perceived greater emphasis on self-care within their programmes reported engaging in more self-care and experiencing fewer symptoms of MHDs.

Personal characteristics

Personality traits and cognitive appraisals emerged as consistently studied factors in the research on psychological distress among trainees. This review found that higher levels of self-doubt (Cushway, 1992; Galvin & Smith, 2017), self-critical perfectionism (Richardson et al., 2020; Grice et al., 2018) and negative core-self evaluations (Galvin, 2015) were related to an increase in psychological distress and unmet expectations, and a decrease in adaptive coping strategies. However, higher levels of self-compassion (Richardson et al., 2020), self-efficacy (Rose et al., 2019) and relationship focused personality traits (Galvin, 2015) were associated with increased wellbeing, decreased depression and burnout, and increased job satisfaction. Trainees' negative self-appraisals (Hill et al., 2017), perceived threat (Swords & Ellis, 2017; Kuyken, 2003) and lack of control were associated with increased vulnerability to psychological distress and use of maladaptive coping strategies. Maladaptive coping strategies, especially escape and avoidance coping, were found to be negatively correlated with MHDs, low self-esteem and poor work adaptation (Kuyken et al., 2003). In contrast, the

use of positive coping strategies, such as self-care, was found to be associated with greater wellbeing and increased self-esteem and self-efficacy (Zahniser et al., 2017, Cushway, 1992).

Although commonly included in the demographic variables, few studies found a significant relationship between gender and psychological distress. The two studies that reported significant relationships, presented contradictory findings. Kuyken et al. (1998) found that male trainees used more maladaptive coping methods than women, and that these were related to greater distress. Rummell (2015) found that female trainees reported higher levels of physical and mental health symptoms than male participants.

A limited number of studies have investigated protected characteristics other than gender that might influence levels of distress in trainees, including sexuality, race and age. Rummell (2015) found that compared with heterosexual participants, sexual minority students reported more experiences of stress. The same study found no differences between Black, Asian and Minority Ethic (BAME) groups and European/white participants, although the low number of BAME participants makes meaningful comparison difficult. Kuyken et al. (1998) found that older trainees reported both greater stressors external to training demands and feeling less control over training stresses.

Relationships

Relationships emerged as both an important resource for mediating distress and a central cause. Cushway (1992) found that poor supervision was the most commonly reported stressor in their sample, with 37% of trainees citing this as a cause of stress. Conversely, four of the five most commonly reported coping strategies in Cushway's study involved talking to others, especially other trainees. Swords and Ellis (2017) found that supervisory alliance was positively and strongly associated with increased wellbeing and negatively and strongly

associated with burnout. Rose et al. (2019) found that trainee over-investment in client relationships was correlated with emotional exhaustion, lowered personal accomplishment and increased depersonalisation, while strong supervisory relationships enabled trainees to feel well-supported, protecting against emotional exhaustion. Spendelow (2017) found a strong relationship between relationship satisfaction, particularly trainee-staff relationship satisfaction, and trainee wellbeing. Additionally, trainee-staff relationships were found to be largely and significantly associated with satisfaction with course climate. One of the central themes to emerge from Brown et al. (2020) was that "finding safety and support" including care and positive regard from others can help mediate the impact of experiencing workplace bullying.

Assessment of methodological quality

Studies included in this review were found to meet the criteria of between 62.5% and 93% (Mean = 75%) of quality appraisal questions, indicating methodological quality of a varying, but acceptable to excellent level (see Appendices D to F for tables documenting the appraisal processes and outcomes for each study). However, there were some limitations within the literature. All samples included in these studies were self-selecting, often at two levels, as many studies approached doctorate programme gatekeepers to disseminate participant information to trainees. The majority of studies, particularly the web-based surveys, had low response rates. Robust comparisons to normative and/or equivalent populations, in which data were provided to substantiate claims, were rare.

Discussion

The intention of this review was to investigate the types, prevalence and influencing factors of psychological distress in trainees. Research into trainee distress is growing but is still at a relatively early stage of development. There was considerable heterogeneity within the types of distress investigated, the terms employed to describe distress and the measures used. Nearly half of the quantitative studies employed author-developed measures, of unknown validity and reliability. Few studies specified operational definitions of distress or clearly stated theoretical frameworks for them and relationships between mediators of distress and levels of distress were often unclear. These factors made it difficult to compare findings across studies or to judge the validity of results. Most studies were cross-sectional: only one study was longitudinal, investigating the same cohort at two time points. This made it difficult to ascertain if levels of distress were present throughout training, different in different years or continued beyond qualification. Self-selection and response biases limit generalisability of findings to the wider trainee population. Few robust comparisons to normative populations were made. It was therefore unclear whether reported levels of distress were excessive or problematic. However, within these limitations, a picture of psychological distress in trainees, starts to emerge.

The most commonly reported types of distress within the literature were MHDs, stress and burnout. This is in line with research in other populations, including in qualified psychologists, where these phenomena have been investigated individually (Hannigan et al., 2004; McCormack et al., 2018). Although included as a type of distress within this review (as this is how it is framed within the literature), low self-esteem might be better characterised as a factor that influences distress, operating in a similar way to maladaptive perfectionism.

The studies in this review found that a large proportion of trainees reported high levels of stress and burnout. This finding is supported by literature on stress and burnout in qualified psychologists and healthcare professionals, which suggests that these professions are experienced as high stress sand high demand and that younger psychologists who are earlier in their careers may be more prone to burnout (Hannigan et al., 2004; HEE, 2019; Mc Cormack et al, 2018). A significant subsection of trainees were also found to experience problematic levels of MHDs. This is again consistent with the literature on qualified psychologists (Tay et al, 2018) and mental health professionals (HEE, 2019), and further supports the idea that psychologists may be drawn to the profession from their own experiences of distress (Bearse et al., 2013).

Despite experiencing relatively high levels of distress, trainee pass rates, employment and retention in the profession are consistently high (Scior et al., 2014, Leeds Clearing House, 2021; Macura & Ameen, 2021). In the UK, the national non-completion rates for NHS training courses in clinical psychology for the academic year 2018/2019 were only 0.9%, including both those who withdrew and those who failed. A recent survey of pass rates for the Examination for Professional Practice in Psychology (EPPP), the licensure examination for doctoral psychologists in the US and Canada, found that 87% of participants reported passing first time (Macura & Ameen, 2021). These findings suggest that experiences of psychological distress do not necessarily lead to impairment, and that trainees in the main meet the demands of training well, although at times this may be at some cost to their psychological wellbeing. This may be due to the relatively high level of resources – both personal and systemic – upon which trainees draw. Conversely, the absence of these may well be experienced as problematic and lead to increased distress.

The demands of training, personal characteristics and relationships emerged as the three most important factors influencing trainee distress and wellbeing. Evidence from qualified populations indicates that distress and impairment in psychologists is more strongly influenced by organisational factors, such as job demands, than by individual characteristics, such as personality (Hannigan et al., 2004; Smith and Moss, 2009; McCormack et al., 2018). This finding is partially supported by the studies included in this review. Training demands were found to influence distress in trainees, although there was mixed evidence that increased demands led to increased stress (Kuyken et al., 2000; 2003; Rico and Bunge, 2021). Organisational resources such as supportive professional relationships and open course cultures emerged as central to wellbeing and coping. Findings suggest that high quality supervisory relationships are key, as are relationships with peers. Individual characteristics did appear to be important in that they predicted the use of maladaptive versus adaptive coping strategies and problematic cognitive appraisals and expectations. Clinical and counselling psychology appears to have a "type": the very qualities that attract people to the profession and enable them to pursue a career successfully, such as interpersonal and emotional sensitivity, self-reflection and high standards (Tay et al., 2018; HEE, 2019), may also leave them vulnerable to burnout, self-criticism and maladaptive perfectionism.

Clinical relevance and application

The findings of this review suggest that stress, burnout and MHDs are relatively common experiences for trainees, rather than being individual issues experienced by a few. Given this, building professional competencies in understanding and managing psychological distress may be an important part of clinical training. Based on the factors found to influence wellbeing and coping within this review, the following recommendations are made:

- Encourage cultures of openness and normalise and validate experiences of distress by facilitating open and honest discussions between staff and trainees, and with the wider network of those involved with training programmes (Grice et al. 2018; Hill et al; 2016; Spendelow, 2017).
- Develop trainee skills in identifying difficulties and monitoring wellbeing by offering workshops and reflective practice groups on factors known to affect trainees (Borgona et al., 2017) such as low self-esteem (Hill et al, 2016; Kuyken et al., 1998; 2000), professional self-doubt (Galvin & Smith, 2017; Rose et al., 2019), maladaptive perfectionism (Richardson et al., 2020) and lived experience of MHDs (Brooks, 2002; Grice et al; 2018).
- Develop trainee skills in managing distress by offering formal training in self-care as a core part of the curriculum (Rummell et al, 2019; Zahniser et al., 2017). Self-compassion (Richardson et al., 2020), coping with stress (Makadia et al., 2017; Kuyken et al., 2003), and use of supervision (Galvin & Smith, 2017; Rose et al., 2019) all emerged as possible areas on which training could be focused.
- Promote openness, help-seeking and self-care among trainees by supporting trainers to model these as key professional competencies (Grice et al, 2018; Rummell et al., 2019; Zahniser et al, 2017).

Recommendations for future research

Although the studies included in this review give a consistent and clear picture of distress in a percentage of trainees, limitations within the literature suggest that further research is needed. There was a lack of contextual data and robust comparisons to normative populations. Participant demographics were not always reported in detail. It was not possible to ascertain if there were course specific factors that might be contributing to distress. All

studies used self-selecting samples and response rates for online studies in particularly were often very low, where reported. Studies which sample more of the trainee population, which compare experiences of distress on different courses, and within different demographics, are recommended. A greater role for accreditation and affiliation bodies in surveying trainee populations may be indicated, owing to the reach of these organisations, enabling the gathering of data over longer time-frames and using standardised measures and definitions. A focus on exploring the stressors that trainees currently experience both on and off courses is called for. Most stressors investigated within the studies included within this review were based on the findings of a single study (Cushway, 1992), which in turn used a focus group to determine the stressors included in the survey of trainees.

Research into interventions for trainee stress, wellbeing, and to support self-care is growing, especially within doctorate dissertations. A systematic review of interventions would be timely, as would an analysis of the recommendations for training courses made by articles included within this review. Recent guidelines have recommended that in order to create inclusive cultures of openness, trainers should normalise and validate psychological distress, through sharing personal experiences (Kemp, 2020). However, what support trainers would need in order to take this step has not been investigated.

Strengths and limitations

One of the strengths of this review was the robustness of the search strategy and screening, although it is acknowledged these were only undertaken by one researcher. The breadth of this review in terms of topic was both a strength and a limitation. Investigating all types of distress enabled an overview of literature within an emerging field. However, focusing on one type of distress might have allowed for better specification of concepts and comparison of data. Study inclusion criteria limited samples to doctorate level clinical and

counselling trainees only. This excluded studies (including all the Australian studies) which may have been pertinent, as many studies investigating trainee distress included small numbers of trainees from other specialisations or from Master's level programmes. Only studies from North America and the UK met the inclusion criteria. Given this, it may have been better to focus on one of these two groups, rather than assuming homogeneity, as training programmes differ between countries. Studies that collected but did not report prevalence data were not contacted for outcomes, reducing the completeness of the data presented. Studies were included from a 30-year time period. As both training and the profession have changed significantly during that time, it might have been more relevant to review more recent studies only.

Conclusions

The findings of this review indicate that the majority of trainees experience clinical training as a time of high demand and high stress. In addition, a significant subsection – around a quarter to a third – report experiencing MHDs while training. Despite this, trainees appear to cope well with the demands of training, and identify personal, relationship and organisational resources as key to successfully navigating training. Validating and normalising distress and promoting cultures of openness and inclusivity is recommended. Openness about distress, help-seeking and self-care should be seen as core professional competencies and be embedded within clinical training curriculums.

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List of Appendices

Appendix A

Author information and submission guidelines for the Journal of Clinical Psychology

1. Submission and Peer Review Process

New submissions should be made via the **Research Exchange submission portal**. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our **FAQs** or contact **submissionhelp@wiley.com**.

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Appendix B

Search terms employed

Database	Psychological distress		Clinical and counselling doctorate trainees
PsychInfo and Medline CINHAHL	((mental or emotion* or psycholog*) N3 (distress or diffic* or health or ill* or problem* or disorder*)) or trauma or depression or anxiety or perfection* or maladaptive or stress or burn#out or help#seek* or cop* or well#being	AND	(psycholog* or counsel* or clinical*) N1 (train* or graduate*)
Scopus	((mental or emotion* or psycholog*) W/3 (distress or diffic* or health or ill* or problem* or disorder*)) or trauma or depression or anxiety or perfection* or maladaptive or stress or burn?out or burnout or help?seek* or helpseeking or cop* or well?being or wellbeing	AND	(psycholog* OR counsel* OR clinical*) W/1 (train* OR graduate*)

Appendix C

Reasons for full text exclusions

Reason for full text exclusion	Number excluded (*n* = 76)
Dissertation	1
Foreign language article	2
Population: • Not clinical or counselling doctoral trainees • Mixed group, data on trainees not separable (other specialities/qualified psychologists/pre-training) • Courses not comparable to UK training programmes (pre-doctoral level/masters/unspecified/no clinical component)	44
Study design: • Not original study (reflection piece/review)	3
Topic: • Intervention study • Focus other than distress (including protected characteristics)	26

Appendix D

Quality rating scores of cross-sectional studies using AXIS

Assessment criteria	Borgogna et al. (2020)	Brooks et al. (2002)	Cushway (1992)	Galvin (2015)
Were the aims/objectives of the study clear?	Yes	Yes	Yes	Yes
Was the study design appropriate for the stated aim(s)?	Yes	Yes	Yes	Yes
Was the sample size justified?	Yes	Yes	Yes	No
Was the target/reference population clearly defined? (Is it clear who the research was about?)	Yes	Yes	Yes	Yes
Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Yes	Yes	Yes	Yes
Was the selection process likely to select participants that were representative of the target/reference population under investigation?	Yes, but self-selecting	Yes, but self-selecting	Yes, but self-selecting	Yes, but self-selecting
Were measures undertaken to address and categorise non-responders?	No	No	No	No
Were the risk factor and outcome variables measured appropriate to the aims of the study?	Yes	Yes	Yes	Yes
Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?*	Yes	Yes	Yes and no	Yes and no
Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	Yes	Yes	Yes	Yes
Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes	Yes	Yes
Were the basic data adequately described?	Yes	Yes	Yes	No
Does the response rate raise concerns about non-response bias?	Don’t know	57%	76%	Don’t know
Was information about non-responders described?	No	No	No	No
Were the results internally consistent?	Yes	Yes	Yes	Yes
Were the results presented for all the analyses described in the methods?	Yes	Yes	Yes	Yes
Were the authors’ discussions and conclusions justified by the results?	Yes	Yes	Yes	Yes
Were the limitations of the study discussed?	Yes	No	Yes	Yes
Were there any funding sources or conflicts of interest that may affect the authors’ interpretation of the results?	No, stated as none	Don’t know, as unstated	Don't know, as unstated	No, stated as none
Was ethical approval or consent of participants attained?	Yes: ethics No: consent	Don’t know, unstated	Don't know, unstated	Yes
Percentage of criteria met	82.5	75	77.5	67.5

Assessment criteria	Grice et al. (2018)	Kuyken et al. (1998)	Makadia et al. (2017)	Richardson, et al. (2020)
Were the aims/objectives of the study clear?	Yes	Yes	Yes	Yes
Was the study design appropriate for the stated aim(s)?	Yes	Yes	Yes	Yes
Was the sample size justified?	No	No	Yes	No
Was the target/reference population clearly defined? (Is it clear who the research was about?)	Yes	Yes	Yes	Yes
Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Yes	Yes	Yes	Yes
Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	Yes, but self-selecting	Yes, but self-selecting	Yes, but self-selecting	Yes, but self-selecting
Were measures undertaken to address and categorise non-responders?	No	No	No	No
Were the risk factor and outcome variables measured appropriate to the aims of the study?	Yes	Yes	Yes	Yes
Were the risk factor and outcome variables measured correctly using instruments that had been trialled, piloted or published previously?*	Yes and no	Yes and no	Yes and no	Yes
Is it clear what was used to determined statistical significance and/or precision estimates?	Yes	Yes	Yes	Yes
Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes	Yes	Yes
Were the basic data adequately described?	Yes	Yes	Yes	Yes
Does the response rate raise concerns about non-response bias?	Don't know	60.20%	Yes 33.3%	Don't know
Was information about non-responders described?	No	No	No	No
Were the results internally consistent?	Yes	Yes	Yes	Yes
Were the results presented for all the analyses described in the methods?	Yes	Yes	Yes	Yes
Were the authors' discussions and conclusions justified by the results?	Yes	Yes	Yes	Yes
Were the limitations of the study discussed?	Yes	Yes	Yes	Yes
Were there any funding sources or conflicts of interest that may affect the authors' interpretation of results?	Don't know, as unstated	Don't know, as unstated	No, stated as none	No, stated as none
Was ethical approval or consent of participants attained?	Yes	Don't know, unstated	Don't know, unstated	Yes
Percentage of criteria met	70	72.5	72.5	80

Assessment criteria	Rico & Bunge (2021)	Rose et al. (2019)	Rummell (2015)	Spendelow (2017)
Were the aims/objectives of the study clear?	Yes	Yes	Yes	Yes
Was the study design appropriate for the stated aim(s)?	Yes	Yes	Yes	Yes
Was the sample size justified?	No	Yes	No	No
Was the target/reference population clearly defined? (Is it clear who the research was about?)	Yes	Yes	Yes	Yes
Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Yes	Yes	Yes	Don't know
Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	Yes, but self-selecting	Yes, but self-selecting	Yes, but self-selecting	Don't know
Were measures undertaken to address and categorise non-responders?	No	No	No	No
Were the risk factor and outcome variables measured appropriate to the aims of the study?	Yes	Yes	Yes	Yes
Were the risk factor and outcome variables measured correctly using instruments that had been trialled, piloted or published previously?	Yes	Yes	No	Yes and no
Is it clear what was used to determined statistical significance and/or precision estimates?	Yes	Yes	Yes	Yes
Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes	No	Yes
Were the basic data adequately described?	Yes	Yes	Yes	Yes
Does the response rate raise concerns about non-response bias?	Don’t know	Don’t know	Don’t know	Don’t know
Was information about non-responders described?	No	No	No	No
Were the results internally consistent?	Yes	Yes	Yes	Yes
Were the results presented for all the analyses described in the methods?	Yes	Yes	Yes	Yes
Were the authors’ discussions and conclusions justified by the results?	Yes	No	Yes	Yes
Were the limitations of the study discussed?	Yes	No	Yes	No
Were there any funding sources or conflicts of interest that may affect the authors’ interpretation of results?	No, stated as none	Don’t know, unstated	Don’t know, unstated	Don’t know, unstated
Was ethical approval or consent of participants attained?	Yes	Yes	Yes	Yes
Percentage of criteria met	80	70	70	62.5

Assessment criteria	Swords & Ellis (2017)	Zahniser et al. (2017)
Were the aims/objectives of the study clear?	Yes	Yes
Was the study design appropriate for the stated aim(s)?	Yes	Yes
Was the sample size justified?	No	No
Was the target/reference population clearly defined? (Is it clear who the research was about?)	Yes	Yes
Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Yes	Yes
Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	Yes, but self-selecting	Yes, but self-selecting
Were measures undertaken to address and categorise non-responders?	No	No
Were the risk factor and outcome variables measured appropriate to the aims of the study?	Yes	Yes
Were the risk factor and outcome variables measured correctly using instruments that had been trialled, piloted or published previously?	Yes	Yes and no
Is it clear what was used to determined statistical significance and/or precision estimates?	Yes	Yes
Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes
Were the basic data adequately described?	Yes	Yes
Does the response rate raise concerns about non-response bias?	Don’t know	Don’t know
Was information about non-responders described?	No	No
Were the results internally consistent?	Yes	Yes
Were the results presented for all the analyses described in the methods?	Yes	Yes
Were the authors’ discussions and conclusions justified by the results?	Yes	Yes
Were the limitations of the study discussed?	Yes	Yes
Were there any funding sources or conflicts of interest that may affect the authors’ interpretation of results?	No, stated as none	Don't know, unstated
Was ethical approval or consent of participants attained?	Don't know, unstated	Yes
Percentage of criteria met	75	72.5

*Where studies employed both validated and unpiloted author-developed measures they were scored “yes and no” and awarded half marks.

Appendix E

Quality rating scores of cohort studies using CASP cohort checklist

Assessment criteria	Kuyken et al., 2000	Kuyken et al., 2003
Did the study address a clearly focused issue?	Yes	Yes
Was the cohort recruited in an acceptable way?	Yes	Yes
Was the exposure accurately measured to minimise bias?	Yes	Yes
Was the outcome accurately measured to minimise bias?	Yes	Yes
Have the authors identified all important confounding factors?	Yes	Yes
Have they taken account of the confounding factors in the design and/or analysis?	Yes	Yes
Was the follow-up of subjects complete enough?	Yes	Yes
Was the follow-up of subjects long enough?	Yes	Yes
What are the results of this study?	Yes	Yes
How precise are the results?	Yes	Yes
Do you believe the results?	Yes	Yes
Can the results be applied to the local population?	Yes	Yes
Do the results of this study fit with other available evidence?	Yes	Yes
What are the implications of this study for practice?	No	No
Percentage of criteria met	93	93

Appendix F

Quality assessment of cohort studies using CASP cohort checklist

Assessment criteria	Brown et al., 2020	Galvin & Smith (2017)	Hill et al., 2016
Was there a clear statement of the aims of the research?	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Can't tell
Was the recruitment strategy appropriate to the aims of the research?	Yes	No, recruited from a single course only, yet generalised across population	No, recruited from a single course only, yet generalised across population
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	Can't tell	Can't tell	Can't tell
Have ethical issues been taken into consideration?	Can't tell	Can't tell	Can't tell
Was the data analysis sufficiently rigorous?	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes
How valuable is the research? (Will the results help locally?)	Yes	Yes	Yes
Percentage of criteria met	80	70	60

Chapter Three

Bridging Chapter

Bridging chapter

The systematic review synthesised research into the types and prevalence of psychological distress, and the factors which influence coping and wellbeing, among clinical and counselling trainees (henceforth trainees). Mental health difficulties, stress and burnout were found to be the main types of distress investigated within trainee populations. Levels of stress and burnout were found to be high, and a significant subgroup of trainees were found to experience clinical levels of mental health difficulties. Findings from the review suggested that personal and professional resources, such as effective coping strategies, self-care, high quality supervisory relationships and open and supportive course cultures, may be important influences on trainee distress, indicating that these factors could be relevant to supporting trainee wellbeing and coping.

The review suggested that further high-quality studies were warranted, including studies aimed at investigating factors that may promote cultures of openness and may support trainees' development of professional competencies in managing distress, such as the modelling of disclosure by trainers. Recent guidelines from the British Psychological Society (Kemp et al., 2020) on supporting clinical psychology trainees with lived experience of mental health difficulties during training, and studies of trainee disclosure (Howkins et al., 2018; Willets, 2018) support this suggestion. The disclosure of lived experiences of psychological distress by trainers on psychology doctorate programmes may normalise and validate distress and encourage disclosure and help-seeking among trainees, increasing wellbeing and coping (Grice et al., 2018; Willets, 2018). However, little is known about how trainers on clinical psychology doctorate programmes decide whether or not to disclose to trainees, or the facilitators and barriers around this. The empirical study looked to address this gap, by presenting a constructivist grounded theory model of the factors and processes involved with trainer disclosure decision-making.

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Chapter Four

‘Being human’: A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees.

Prepared for submission to the Journal of Clinical Psychology (see Appendix A)

Word Count: 6657 (excluding supplementary material)

‘Being human’: A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees.

Simone Davies[ab], Dr Imogen Rushworth[a] and Dr Paul Fisher[a]

[a] Department of Clinical Psychology, University of East Anglia, Norwich, NR4 7TJ, England, UK

[ab] Corresponding author: simone.davies@uea.ac.uk

Role of funding sources: This work was supported by the Clinical Psychology Doctorate Programme at the University of East Anglia

Conflict of interest: All authors disclose no conflicts of interest

Abstract

Objective: Recent research and guidelines recommend that trainers on clinical psychology doctorate training programmes consider disclosing personal experiences of psychological distress. Disclosure is thought to promote cultures of openness, to validate and normalise trainee distress, encourage trainee disclosure and help-seeking and challenge stigmatising narratives. However, little is known about how trainers decide whether, what or how to disclose. This study aims to address that gap by exploring the processes and factors involved in trainers on clinical psychology doctorate programmes deciding whether or not to disclose personal experiences of distress to clinical psychology doctorate trainees.

Methods: In-depth interviews were conducted with nine trainers on UK clinical psychology doctorate programmes from around the country. Data were analysed in accordance with grounded theory methods through the iterative processes of initial, focused and theoretical coding.

Results: Findings indicated that participants began from a default position of disclosure if useful and appropriate, due to valuing disclosure personally and professionally and being wary of the dangers of disclosure. In-the-moment decisions were made by judging the context against six criteria associated with 'being safe' and 'considering helpfulness'. If criteria were not met then disclosures were not made. Outcomes, whether positive or negative, served to reinforce the value of disclosure and the importance of managing risks and creating a positive feedback loop.

Conclusions: The findings of this study suggest factors that are important for trainers to consider when deciding whether or not to disclose. The six-factor framework of 'being safe' and 'considering helpfulness' may be useful for trainers to consider within reflective

practice, supervision discussion or during guided self-reflection in order to make safe, helpful and ethical decisions.

Introduction

Clinical psychology is a profession which can place high emotional demands and stresses on practitioners (American Psychological Association: APA, 2010; Health and Care Professions Council: HCPC, 2015). Personal experiences of psychological distress reported by qualified clinical psychologists and clinical psychology doctorate trainees (henceforth trainees) may be frequent and common, impacting upon mental health and job performance (Grice, Alcock & Scior, 2018; Galvin & Smith, 2017; Hannigan et al., 2004; Simpson et al., 2018; Tay et al., 2018). Health Education England (HEE, 2019) recently recommended that in order to promote mentally healthy workplaces, National Health Service (NHS) employers should "Encourage open conversations about mental health and the support available when employees are struggling … [and] improve disclosure processes" (p. 82). Research suggests that this could be achieved on doctorate in clinical psychology programmes by encouraging trainers to disclose[1] personal experiences of psychological and emotional distress to trainees (Howkins et al., 2018; Willets, 2018). Modelling of this kind has been shown to be effective at breaking down personal stigma (Bos et al., 2009; Yanos et al., 2014). Recent guidelines from the British Psychological Society (Kemp et al., 2019) recommend that trainer disclosure is encouraged in order to normalise, validate and promote the disclosure of mental health difficulties amongst trainees.

Research into disclosure processes in people living with concealable stigmatised identities (such as mental health difficulties, an HIV-positive diagnosis or childhood sexual abuse) indicate factors that may be important in trainers' decision making. When people with concealable stigmatised identities disclose, they risk negative outcomes such as social

[1] Some participants in the study preferred the term 'share' to disclose, as disclosure was perceived as inherently stigmatising. Others used the terms interchangeable or preferred to use disclosure. As the literature uses the term disclosure, this has been the term employed here.

exclusion or discrimination (Pachankis, 2007; Quinn, 2006; Quinn & Chaudoir, 2009). However, concealing stigmatised identities has been found to be psychologically and emotionally stressful and to negatively impact personal and professional relationships (Major & Gramzow, 1999; Pachankis, 2007; Smart & Wegner, 1999, 2000). Ragins' (2008) model of disclosure processes in this population identified three central factors: internal factors (including centrality of stigmatized identity to self-concept); anticipated consequences of disclosure; and environmental factors (including presence of similar others and supportive relationships). Chaudoir and Fisher's (2010) model similarly points to the importance of perceived stigma, avoiding negative outcomes and pursuing positive outcomes in decisions to disclose. It also emphasizes the importance of how the disclosure is received by the confidant in how helpful or unhelpful the outcome of disclosing will be.

Literature on disclosure of mental health difficulties in the workplace suggests further factors and processes which may impact on trainer decision-making. Toth and Dewa's (2014) model found that fear of stigma meant that employees adopted a default position of non-disclosure. Disclosures were only made if there was a triggering incident and a 'good' reason. Even then, the benefits and risks of disclosure were carefully weighed. Outcomes of disclosure decisions supported the default position. A literature review identified seven reasons for workplace disclosure: role modelling; gaining adjustments; positive disclosure experiences; gaining support; being honest; explaining behaviour; and finding concealing stressful (Brohan et al., 2012).

Studies looking at disclosure of mental health problems by mental health professionals, including clinical psychologists and trainees, support the idea that stigma, identity-cohesion and disclosure environment may be factors in whether trainers decide to disclose personal experience of psychological distress to trainees. For example, Tay et al.'s

(2018) survey of clinical psychologists found that the central reasons for non-disclosure were fear of being judged negatively, impact on career, shame and impact on self-image. Fears around being found incompetent by employers, colleagues and faculty members may also prevent disclosure (Dearing et al., 2005; Gough, 2016; Moll et al 2013; Walsh & Cormack, 1994). Having a personal experience of a mental health problem and being a mental health professional may feel like incompatible identities (Richards et al., 2016). Clinical psychologists may be reluctant to disclose mental health problems for fear of adopting the role of the client and stepping out of their professional 'helper' roles (Scior, 2017), or of failing to live up to a perceived 'ideal' of the clinical psychologists as impartial, professional and neutral (Aina, 2015; Charlemagne-Odle et al., 2014).

Conversely, breaking down stigma and 'coming out proud' has been cited amongst the reasons that mental health professionals, including clinical psychologists, have chosen to disclose (Corrigan et al., 2013; Corrigan & Mathews, 2003; Grant & Barlow, 2016; Tay et al., 2018; Waugh et al., 2017). Identity coherence may also be a motivating factor. Coherence between being a mental health professional and a mental health service user can have benefits including bringing meanings of hope and recovery to personal experiences of psychological distress (Richards et al, 2016).

The processes involved in therapist self-disclosure to clients in therapy suggest further factors that may be relevant to trainers decide whether or not to disclose. Therapist self-disclosure is broadly defined as any statement that reveals something personal about the therapist and includes both immediacy statements and statements about personal background (Hill & Knox, 2001). There is little consensus within the literature on whether therapist self-disclosure is positive or negative, suggesting an unresolved dilemma (Müller, 2019). Disclosure is seen as both a useful clinical tool, which normalises, validates and promotes

therapeutic alliance (Hill & Knox, 2001); and as potentially unethical and dangerous, risking role reversals such as care elicitation, client overwhelm and the focus of therapy shifting to the therapist (Peterson, 2002). Clinician skill in disclosure decision-making and in managing the risk of disclosures may be the intervening factor in whether disclosures are received as helpful and appropriate or unhelpful and inappropriate (Audet & Everall, 2010; Hanson, 2005).

Although disclosure decision making is a well-researched area, no studies to date have investigated how trainers working on Doctorate in Clinical Psychology programmes decide whether or not to disclose personal experiences of psychological distress to trainees. Little is known about whether the same processes and factors apply to this context. The current study aimed to address this gap by developing a model of the processes and factors involved in trainer disclosure, using constructivist grounded theory methodology (Charmaz, 2014)

Research questions

Primary Question:

- How do trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to trainees?

Secondary Questions:

- What do trainers' perceive the purpose of disclosing personal experiences of psychological distress to trainees?
- What are the processes involved in trainers disclosing personal experiences of psychological difficulties to trainees?

Method

Study design

The study employed a constructionist grounded theory approach (Charmaz, 2014) to address the research questions. Grounded theory is particularly suited to the investigation of embedded social processes such as subjective decision making (Willig, 2008), and to the construction of theory (Harper & Thompson, 2012). A constructivist (Charmaz, 2014) rather than a positivist grounded theory approach (Glasser & Straus, 1967) was used as the study aimed to explore how disclosure decisions are created within the specific social contexts of UK training courses. Constructivist grounded theory starts with an assumption that 'social reality is multiple, processual and constructed' (Charmaz, 2014, p.14), as are the researchers' contributions. This reflective stance is especially important as the researcher works within the same culture that is being investigated (i.e., is a trainee on a UK training course) (Charmaz, 2017).

Participants

Nine participants took part in the study (six women and three men). Participants were required to meet the inclusion criteria of: i) currently employed as a trainer on a UK doctorate in clinical psychology programme; ii) a qualified clinical psychologist. Trainers currently working at the University of East Anglia (UEA) were excluded from the study. Participants did not need to have experienced a mental health problem, used mental health services or received a psychiatric diagnosis to be included. The term psychological distress was used to encompass these meanings as well as understandings based outside of medical models of diagnosis. All participants had both teaching and supervisory responsibilities. Time in trainer

role varied from one to 20 years (M: 10.6). Three participants had 3 years or fewer experience: the remaining six had 9 years plus. Ages ranged for 25-34 to 55-64. All participants identified as White (British) or White (other).

Procedure

Recruitment

The study information sheet (Appendix B) was emailed to UK Doctorate in Clinical Psychology programme directors, along with a request to disseminate to trainers working on UK programmes. Later rounds of recruitment included snowballing to informal contacts among participants and research team members.

Both purposive and theoretical sampling were used in line with guidance on grounded theory research (Charmaz, 2014). Three rounds of recruitment were conducted. Recruitment was widened after round two to include trainers with either teaching or supervisory responsibilities rather than both. This achieved variation in participants' ages, gender, and experience in trainer role. However, despite snowballing to find those who were not open to disclosing or did not believe in the value of disclosure, significant variation in degree of openness was not attained. There was no ethnic diversity within the sample, which was likely to be unrepresentative of the population: Black, Asian and Minority Ethnic individuals represent fewer than 10 percent of qualified clinical psychologists in England and Wales (Health and Social Care Information Centre, 2013). Theoretical sampling – collecting data pertinent to emerging categories – was achieved by modifying the focus of the interview guide (Appendix C) as interviews progressed. All participants were interviewed once.

Data collection

Data were collected in one-to-one semi-structured interviews, lasting an average of 76 minutes. An interview guide was developed (Appendix C) based on a literature review conducted for the topic and in discussion with trainers from the research team. The guide was reviewed with a clinical psychologist with links to the lead researcher's training programme. The guide was used flexibly and changed over time. A reflective diary was employed, to record these developments.

Participants were sent copies of the confidentiality agreement (Appendix D), demographic information sheet (Appendix E) and participant information sheets (Appendix B) ahead of interview. Due to the COVID-19 pandemic, all interviews were conducted via video conferencing. Interviews were audio recorded and transcribed verbatim.

Ethical issues

The study was approved by the University of East Anglia (UEA) Faculty of Medicine and Health Sciences (FMH) (Appendix F). All participants gave informed consent to taking part in the study. Limits to confidentiality were outlined in the information sheet. Personally identifiable information was anonymised during transcription. Although all participants gave consent with a full awareness of the intention of the study, several were concerned that they might be identifiable from quoted data even if given pseudonyms, due to the nature of the information being collected and the 'tallying' of information across quotes. It was therefore decided to remove pseudonyms, after ensuring that the range of participants were represented within direct quotes. For the same reason, demographic information, although provided by participants, is only reported broadly. Participants were given the opportunity to debrief at the

end of the session and were reminded of the signposting information on the participant information sheet. Data were securely stored, in line with General Data Protection Regulation (2018) protocols.

Reflexivity

Multiple strategies were employed to increase the awareness and transparency of the researchers' impact on the research process. During the early stages of research, the primary researcher (SD) reflected on her position in relation to the research topic, writing a series of memos (excerpt in Appendix G). SD reflected that she occupied many unique spaces in relation to the topic. She was currently a trainee herself and had been the recipient of multiple disclosures from trainers, experienced as varying in helpfulness and appropriateness. Prior to commencing doctorate training, SD had worked as a Peer Support Worker. She had received training and supervision in the use of disclosure and gained considerable experience of disclosing, as well as participating in and conducting research into peer support working. In preparation for interviewing, SD reflected on the power dynamics between herself and the participants and the parallels between the dynamics in the interview and the disclosure context. She noticed worries associated with being a naïve researcher and interviewing trainers with much greater experience than herself.

Throughout the research process the primary researcher and the supervision team held reflective discussions on their assumptions and experiences in relation to the topic and responses to the data. Additionally, SD conducted an interview with an Expert by Experience Lead on a UK training programme, exploring differences and similarities in disclosure processes.

Data analysis

Iterative data analysis was conducted using a constructivist grounded theory approach (Charmaz, 2014). Analysis began during transcription and took place concurrently with interviews, to allow for interview questions to be adapted and changed to fill emerging knowledge gaps. Iterative data analysis moved forward and back through the three main processes of initial coding practices, focused coding and theoretical coding as more data were added to the analysis, while memo-writing took place continuously (Charmaz, 2014).

Memo-writing occurred throughout all stages of analysis and coding and involved keeping a methodological journal/reflective log of the development of coding, which focused on identifying actions and processes of interest through effective titling of memos and flagging of inaccuracies. Initial memos took a questioning stance, looking both at what was and wasn't said and done by participants. Early memos included responses to the relevant literature and to discussions with supervisors and collaborators. Advanced memos described category emergence and changes, identified the beliefs and assumptions underpinning categories, positioned categories within arguments and sharpened comparisons.

Throughout the analysis process steps were taken to ensure the credibility of the theoretical model produced (Yardley, 2017). The quality standards of sensitivity to context, rigour and impact were discussed regularly in supervision (Yardley, 2000). Emerging categories and concepts were checked by the research supervisors. Records of the iterative process of constant comparison were kept and are evident within the development of categories in particular (see Appendix H for example).

Results

This study aimed to understand how trainers decide whether or not to disclose personal experiences of psychological distress to trainees. Four theoretical categories and 11 subcategories were constructed during the analysis. These are presented in Table 4.1.

Table 4.1

Theoretical categories and subcategories

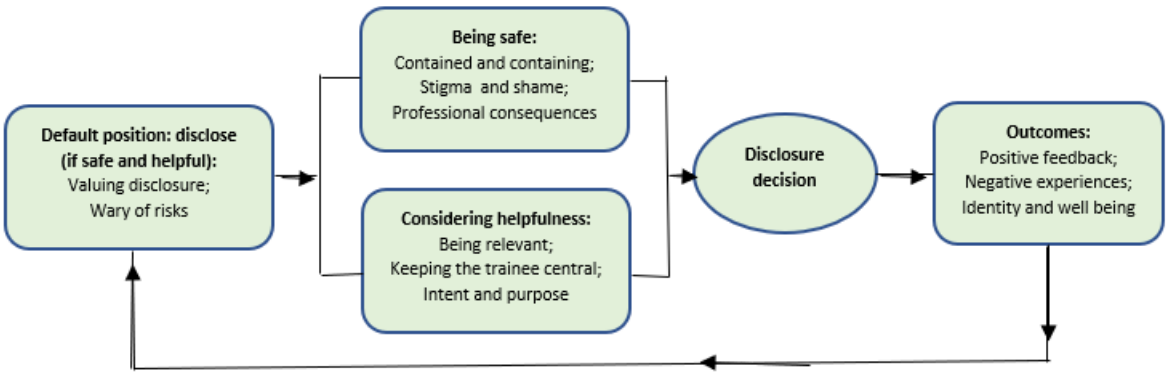
Theoretical category	Subcategory
Default position: disclose (if useful and appropriate)	Valuing disclosure
	Wary of risks
Being safe	Being contained and containing
	Stigma and shame
	Professional consequences
Considering helpfulness	Being relevant
	Keeping the trainee central
	Monitoring intent and being purposeful
Outcomes	Receiving positive feedback
	Experiencing a negative outcome
	Identity cohesion and wellbeing

Narrative summary of the model

The findings of this study indicated that participants adopted a default position of disclosing to trainees. They adopted this position due a belief in the usefulness of disclosure for trainees and because disclosure aligned with personal and professional values. While valuing disclosure, participants also recognised risks, both to self and to trainees, and were cautious in how, what and when they disclosed. They reported applying a series of criteria to ensure that disclosures were safe and helpful. These criteria were applied flexibly and were dependent on context. If the criteria were not met, then disclosures were not made. Outcomes of disclosure, whether positive or negative, served to reinforce the value of disclosure and the importance of carefully considering how safe and helpful disclosures would be, creating a positive feedback loop. Confidence and perceived skill in disclosing safely and helpfully increased with experience. A visual representation of the model is presented in Figure 4.1.

Figure 4.1

Decision-making processes in trainer disclosure of distress to trainees



Theoretical categories and subcategories

Default position: disclose (if safe and helpful)

All participants had disclosed personal experiences of distress to trainees. Participants talked about being predisposed to disclose, as this was in alignment with their personal and professional values and beliefs. Disclosure content included: distress related to anxiety, depression, work stress, relationships, parenting, childhood adversity, including neglect and abuse, and physical health conditions. However, every participant also spoke about choosing to keep some experiences private. Their awareness of the risks of disclosure meant that they only disclosed if they could do so safely and helpfully.

Participants talked about applying a set of 'criteria', a 'rule of thumb', or of asking themselves a series of questions, to ensure that they were disclosing safely and helpfully.

"I've sort of developed a rough sort of criteria in my head now as to when it's best to share."

Participants also described being cautious, conscious, and controlled in their decision-making.

"So it is a conscious decision about bringing that material into the teaching room or the supervision room."

Participants spoke about applying the criteria of being safe and helpful flexibly and in response to the context. Maintaining awareness of their own responses and of the responses of recipients was central to this.

"there's no set rule and you know if it comes up and it feels appropriate then that's when I would do it."

Valuing disclosure

Participants talked about valuing disclosure both professionally and personally. Disclosing experiences of psychological distress aligned with beliefs and values around 'being human', open and authentic.

"acknowledging that you are human and that part of being a person is having difficult feelings, difficult experiences, conflicts, stress as well as all the good stuff."

Participants described disclosure as a natural extension of their beliefs, values and personal and professional identities. Disclosure was perceived to benefit participants through increased identity-cohesion and wellbeing.

"it was just consistent with how I want to live my life, and it's consistent with my approach to my professional life, including my clinical work"

Participants valued disclosure as it enabled them to challenge narratives viewed as stigmatising and debunk myths about clinical psychology.

"I absolutely want to try and smash, try and debunk any myth that clinical psychologists are immune to psychological distress and… or any myth that we don't need help ourselves"

Participants perceived containing trainee distress as central to their professional roles as trainers.

"what I think is really important to my role is containing…being able to contain the distress of trainees. Because training is hard work."

Disclosing was conceptualised as a tool to validate and normalise distress, promote disclosures from trainees and as part of modelling professional competencies in managing distress, stress and fitness to practice.

"Normalising and validating… I think there's something about having somebody who is in a position, someone above, like that modelling, that makes you know it's okay for me to do this as well"

"I think by sharing disclosure, you're modelling that that's okay to be vulnerable. And I definitely feel that then enables other people to be more open and honest about their own challenges."

Additionally, disclosure was seen as a way to bring teaching to life: to illuminate applying theory to clinical practice; to generate reflection on what trainees brought to therapy; to demonstrate good practice or model expectations.

"the way to bring teaching to life for trainees is to make it personal, is to make it live and worked"

"I'm role modelling what I want them to do which is to connect with something in a real way, to really feel it and to share that with other people,"

Awareness of risks

Participants talked about how their awareness of risk shaped their stance towards disclosure, leading them to be cautious about what, when and how they disclosed.

"I'm making careful decisions around what will be helpful and what will not and I'm not just "bleugh" just for the sake of it."

They perceived uncontrolled disclosures – 'spilling' 'splurging' 'going bleurgh' – as inappropriate and potentially leading to professional boundary violations, such as seeking care, overwhelming trainees and role reversals.

"I do kind of think, it's not okay for me to offload to a trainee, it's okay for a trainee to offload to me."

Participants identified a risk around making the interaction about themselves, and 'taking up' the space.

"if you tell too much of your own story, you risk the space becoming about you and not about those other people in it."

Participants were also aware of risks to self, including reawakening past distress, receiving negative judgements, having their professional competency questioned, career non-progression, stigma, and discrimination.

"if I shared that level of psychological distress that I've experienced with my trainees I would definitely feel fearful of them changing their view of me a little bit, in a negative way."

Being safe

All participants spoke about the importance of disclosures being safe, both for trainees and for themselves.

"There are times in life where someone else will be in that professional role and I can just go "bleugh" but […] in this particular role, I think it's for me to package it and keep it safe"

Three subcategories were constructed relating to disclosing safely: being contained and containing; stigma and shame; and professional consequences.

Being contained and containing

By being contained and containing participants saw themselves as being authentic to the relationship or 'honouring the contract' with trainees. Participants identified that being able to contain and control their own distress was important to disclosing safely and in

avoiding professional boundary violations, such as role reversals, overwhelming others and care elicitation.

"I wouldn't want that to be something that anybody felt like they had to hold for me. So I […] share it in a way that demonstrates that I've got it. I share both the vulnerability, but in sharing that vulnerability a clear sense that I am in control of it, it's okay and that they don't need to worry about me."

Participants spoke about distress needing to be processed enough and not sharing current, hot or live distress.

"it was too hot, too current and it wouldn't have kind of been in the best interests of the people I'm talking to, to, hear about that stuff um."

Participants spoke about needing to feel they could manage the emotional impact of a disclosure on themselves. Unresolved and ongoing distress was often identified as not safe to share and was 'taken elsewhere'. Having other spaces in which to process distress – therapy, supervision, with peers, colleagues and friends and partners – was seen as an important part of disclosing safely.

"it needs to be safe for me. That I feel comfortable with what I've shared and how I'm going to feel afterwards."

The ability to be containing was construed as dependent on having knowledge and control over the disclosure environment. Participants were more cautious when they had less knowledge (i.e., when disclosing to a group; when online; to an individual they knew less well) and fewer opportunities to adjust how the disclosure was received.

"I think there's something about the control over how people are hearing it, especially in an online world. Maybe in the classroom it's a little bit different, but online, you can't really see people, you don't know how people are hearing it."

Stigma and Shame

Some participants identified a dilemma, whereby they simultaneously wanted to disclose to break down stigma, but also felt unsafe to disclose, due to stigma and discrimination. This resulted in certain experiences being kept private, especially distress which participants thought they 'should' not experience as psychologists, such as parenting difficulties, abusive relationships and self-harm. Participants identified that some of this stigma was internalised as well as externally perceived.

"I think especially being a psychologist, there's almost this duality of I'm supposed to be able to manage this better, so sometimes there's a fear or a sense of shame coming from if I am having a really difficult time"

Professional consequences

Participants spoke about needing to be free from negative professional consequences to feel safe disclosing. Participants spoke about how cultures that were explicitly open and supportive, with shared views and values, enabled them to feel safe to disclose. Participants identified that open supportive cultures were created both 'bottom-up' through trainee recruitment processes and 'top down' from the values of senior leadership.

"Being part of a culture that you know there aren't going to be negative consequences to what you disclose, or that's how I feel […] Knowing that people will support it, won't judge you for it."

Where participants feared professional consequences, either through implicit stigma or from explicitly being told not to share personal experiences, they did not disclose.

“for me it feels quite a dangerous area to get into actually, in that team, and I’m really struck that I’m using quite a strong word there, it’s quite sad that it… yeah. I don’t know how much appetite there would be within the team. And when I have tried to push us in that direction it’s not, it really hasn’t met with much… support.”

Considering helpfulness

All participants considered helpfulness as a key criterion for sharing appropriately.

“That's the basic question "is my sharing going to help them?"

Three subcategories were identified: being relevant; keeping the trainee central; and monitoring intent and being purposeful.

Being relevant

Participants spoke about how being relevant was an important part of a disclosure being helpful or useful for trainees. Relevant disclosures were constructed as those that responded to communications from trainees such as “I feel on my own with this”; were related to common difficulties for trainees; or were embedded in/related to teaching or reflective practice. Being relevant was evident in what participants chose to disclose (i.e., distress related to academic failures) and in what they chose not to disclose (i.e., managerial conflict).

“I went quite kind of targeted. I’m saying this, I’m disclosing this because I wonder if it might help this particular person right now"

Keeping the trainee central

Keeping the trainee central was constructed as important to considering helpfulness.

"I do think there is a line where you can talk about yourself too much. So, there is something about the trainee's always at the centre of it."

Part of keeping the trainee central was to make disclosures short, general and without much detail, and to move on to modelling coping quite rapidly.

"not necessarily in any depth or detail, but just kind of naming that and acknowledging it"

Monitoring intent and being purposeful

Participants monitored their intentions closely, to ensure that they were trying to be helpful to trainees and were not motivated by their own needs. Monitoring intent was tied to being purposeful: participants would not disclose unless they felt there was a good reason to. Reasons to disclose included normalising and validating, fostering trainee disclosure, increasing connection and alliance, debunking myths about clinical psychology and challenging stigmatising narratives.

"that's my intention. Just to be helpful to the trainees, to their learning and development"

Outcomes

Outcomes of disclosure and non-disclosure, whether positive or negative, served to reinforce participants' default position of disclose if safe and helpful. Three subcategories were constructed: receiving positive feedback; experiencing a negative outcome; and identity-cohesion and wellbeing.

Receiving positive feedback

All participants spoke about receiving positive feedback about disclosures from trainees; a minority also received positive feedback from colleagues. Feedback confirmed and validated the participants' intentions when disclosing, reinforcing beliefs in the value of openness. Feedback also helped confirm to participants that they were disclosing safely, as trainees reported feeling safe and contained.

"the feedback I get from trainees is that […] they feel that I can be approached, and if I self-disclosed it or shared experiences in teaching, it's always positively fed back."

Experiencing a negative outcome

Participants talked about being adversely affected by disclosures. Negative experiences served to reinforce the importance of thinking carefully about safety before disclosing, and about the importance of supervision and reflective spaces.

"I remember after it, just being, I don't know how to describe it… a little bit off balance. Like I remember getting back in touch with the counsellor and saying "I need to talk through some stuff", because it felt like a load of stuff had just come back to the surface."

Identity-cohesion and wellbeing

Many participants identified increased identity-cohesion and authenticity as an outcome of disclosure. They associated this with increased wellbeing, both personally and professionally.

"I'm in a much, much better place that I've ever been, both professionally and personally and I think a lot of that is due to sharing who I am more fully and not feeling that I have to play a role that's not perhaps as authentic as I'm comfortable with, that it's okay to just be who I am."

When participants did not disclose due to fears around professional consequences, they felt like they lacked authenticity and were acting in opposition to their values of openness. They felt as though they were letting trainees down, as they were not teaching them as effectively as they might do.

“the times I have probably been most miserable in my own working life, is when I’ve felt the least authentic in what I am doing.”

Discussion

This study aimed to explore the processes and factors involved in trainers deciding whether or not to disclose personal experiences of psychological distress to trainees. Participants were found to adopt a default position of disclosure if safe and helpful, due to their belief in the value of disclosure and their awareness of the potential risks. Participants applied a set of criteria to disclosing in order to maximise benefits and minimise risks. Outcomes of disclosure and of non-disclosure, whether positive or negative, served to reinforce the default position, creating a positive feedback loop.

Within grounded theory research there is a tension between staying true to the origins of the methodology, ensuring that theory is 'grounded' in the data, and more pragmatic approaches that allow the influence of pre-existing models and concerns within the research topic area (Barbour, 2001). The current study used the later variant, adding value by identifying new themes from the data alongside those from the existing literature (Melia, 1997), drawing on models of mental health disclosure in the workplace (Toth and Dewa, 2014), concealable stigmatised identity disclosure (Chaudoir & Fisher, 2010) and therapist self-disclosure (Müller, 2019). In common with models of mental health disclosure in the workplace and of concealable stigmatised identities, themes of personal support, safety and meaning were prevalent. In line with studies of therapist self-disclosure there was a focus on the other and on ensuring that disclosures were safe, useful and helpful.

Adopting a default position: being predisposed to disclose

Participants in the current study spoke about being predisposed to disclose. They valued disclosure, as an extension of personal and professional beliefs in 'being human', authentic and open. Acting authentically was perceived as bringing personal and professional selves into alignment and to have benefits for wellbeing. Richards et al. (2016) similarly

found that cohesion between professional identities and lived-experience identities was reported as a motivation for disclosure. In this study, being open about difficulties was valued as a way to challenge narratives perceived as stigmatising and to debunk myths about clinical psychology. This finding is supported by research which found that breaking down stigma and 'coming out proud' has been cited amongst the reasons that mental health professionals, including clinical psychologists, have chosen to disclose (Corrigan et al., 2013; Corrigan & Mathews, 2003; Grant & Barlow, 2016; Tay et al., 2018; Waugh et al., 2017). Where this study extends the literature is in the finding that participants valued disclosure as a professional tool, useful for validating and normalising distress, promoting disclosure from trainees and in bringing teaching to life. Participants spoke about drawing on psychological models, including systemic, third-wave and pedagogic approaches, to inform their use of disclosure as a tool for benefiting trainees.

Considering helpfulness and being safe: applying a framework to disclosure

This study found that participants applied the criteria of "helpful-and-safe" to all their disclosure decisions. Being helpful was constructed as: being relevant; keeping the trainee central; and monitoring intent and being purposeful. Being safe was constructed as: being contained and containing; experiencing no stigma and shame; and experiencing no negative professional consequences. These factors acted as a series of prompts or reflective questions that can be seen as forming a framework for disclosure decision-making. Applying a framework was perceived by participants as essential for making ethical and supportive decisions and avoiding boundary violations. By reflecting on the factors within the framework, participants felt more confident in making conscious, considered decisions that would be safe and helpful. These findings support and extend the wider literature related to disclosure decision-making. Drawing on the ethical principles of psychologists and code of conduct (APA, 2002), the literature on therapist self-disclosure considers the most salient

factors to be benefice and non-maleficence (Barnett, 2011 Gutheil, 2010; Müller, 2019). Sadighim (2014) further recommends that therapists reflect on a series of questions when deciding whether or not to disclose, in order to ensure that decisions are ethical and useful to clients. The Sharing Lived Experiences Framework (Dunlop et al., 2021) was recently developed to support mental health professionals in making conscious, reflective and considered decisions about disclosures and has many commonalities with the findings in the current study.

Considering helpfulness

'Considering helpfulness' was constructed as: being relevant; keeping the trainee central; and monitoring intent and being purposeful. These factors and processes map onto the areas found to be clinically important in therapist self-disclosure: therapist intent; keeping the client central; and client need and preference, supporting the importance of these considerations when making disclosures (Barnett, 2011; Gutheil, 2010; Müller, 2019). The current study extends the literature on therapist self-disclosure in the emphasis placed on being relevant and purposeful by participants. Participants reported that they looked for signals from trainees before making disclosures and tied disclosures very tightly to the content of teaching or reflective practice. They drew on their own experience and knowledge of the training environment to predict and respond to unmet needs within trainees. Being relevant and purposeful was constructed as essential to disclosures being received as helpful and appropriate.

Being safe

Being safe was constructed as: being contained and containing; considering stigma and shame; and freedom from professional consequences. Participants talked about tensions between wanting to disclose, in order to challenge stigma, and feeling stigmatised, especially around experiences of distress they felt they 'shouldn't' have as psychologists. These findings support and extend the literature on concealable stigmatised identities and mental health disclosure in the workplace, including among clinical psychologists and trainees. Fear of stigma, discrimination and being judged as incompetent have been found to prevent disclosures (Chaudoir & Fisher, 2010; Ragins, 2008; Toth & Dewa, 2014; Willets, 2018). Self-stigma, shame and perceptions that 'good' clinical psychologists do not struggle with distress were also found to deter clinical psychologists and trainees from disclosing mental health difficulties (Aina, 2015; Charlemagne-Odle et al., 2014; Tay et al., 2018; Willets, 2018). In the current study the culture of the training programme was found to be instrumental in how safe participants felt to disclose. The findings that open, supportive environments encouraged disclosure, while uncertainty about how disclosures would be received or actively discriminatory environments deterred discloses, is supported in the wider literature (Chaudoir & Fisher, 2010; Charlemagne-Odle et al., 2014; Toth & Dewa, 2014; Willets, 2018).

Where the current study extends the literature is in the importance participants placed on being contained and containing, considering both their own safeness and that of trainees. They carefully weighed the impact that disclosures would have, thinking about their ability to manage the emotions associated with the disclosure in the moment and how they would be affected in the future. Current and unprocessed distress was taken elsewhere: sharing such distress was viewed as inappropriate and leading to boundary violations such as eliciting care. Participants emphasised the use of self-reflection, reflective practice and supervision in ensuring that they could be both contained and containing. This finding is supported by the

wider literature, which recommends such steps as an important part of preparedness for making disclosures (Dunlop et al., 2021; Müller, 2019).

Outcomes

Outcomes of disclosure decisions, whether positive or negative, served to reinforce the default position, creating a positive feedback loop. A novel finding of this study was that participants perceived that there were negative outcomes associated with non-disclosure as well as with disclosures: some participants reported feeling as though they were not acting in alignment with their values or supporting trainees to the best of their abilities when they did not use disclosure within their teaching and supervisory responsibilities.

When disclosures were perceived to have been received badly, or participants felt unsafe sharing, they tended to blame a lack of preparation or knowledge about the disclosure context, including sharing too early in a relationship before trust was established. This reinforced the importance of applying a framework for sharing and the use of self-reflection, reflective practice, and supervision to ensure that disclosures were both safe and helpful.

Between the participants there was nearly 100 years of experience within the training role. Three participants had 3 years or fewer experience in the role, while 6 had nine years or more. There was a split between these two groups, with the more experienced trainers feeling more confident in disclosing safely and appropriately and having a greater clarity in describing the use of a framework for disclosure. However, despite varying levels of experience, all participants reflected that disclosing was a learning process, with skill and confidence in disclosing increasing over time and with experience in using psychological models that encourage therapist self-disclosure.

Strengths and limitations

This study is the first to explore the processes involved in trainers' decisions about whether or not to disclose personal experiences of psychological distress to trainees. One of the strengths of the study was in the methodology that was employed and the richness of data that was generated. The active role of the researchers within a Doctorate in Clinical Psychology training programme was seen as both a strength and as a potential limitation. The insider knowledge of the researchers stimulated additional lines of enquiry and was useful in formulating the potential implications of the research (Jones & Bartunek, 2019). However, it is also acknowledged that the researchers will have brought their own assumptions and preconceptions, relationship dynamics and research focus to the process (Galdas, 2017). By being critically self-reflective, and constantly questioning assumptions and biases (Morse et al, 2002) the researchers hoped to avoid the potential biases of 'mesearch' (Gardiner et al, 2017).

Recruitment processes and participant information materials may have limited the range of positions on disclosure that were represented within the sample. All participants both valued disclosure and chose to disclose: the views of those who perceive disclosure as inappropriate or unhelpful were not represented. This has meant that the model may be unrepresentative: researchers could have conducted a further round of recruitment, with new participant information, in order to collect a broader perspective.

Further validation checks could have been completed to ensure rigour (Yardley, 2000). Although multiple reflective discussions on the model were held within the research team, the researchers could have returned to the original participants to receive feedback on the model or explored this with independent researchers.

Recommendations

This study found that participants used a six-factor framework based around 'being safe' and 'considering helpfulness' to make decisions about disclosing to trainees. Participants spoke about the importance of using the framework, self-reflection, reflective practice and supervision in supporting effective and ethical decision-making. It is therefore recommended that Doctorate in Clinical Psychology training programmes consider offering training on the use of disclosure to trainees and consider the framework during reflective practice and supervisory discussions.

A minority of participants did not disclose due to fearing professional consequences or uncertainty about how disclosures would be received due by the Doctorate in Clinical Psychology training programmes. It is recommended that training programmes make views on disclosure explicit and consider the both the benefits and risks of disclosure when making decision on their ethos in relation to it. Understanding of how course cultures are perceived by both trainers and trainees, may be an important part of this.

Future research

Future research in this area could focus on exploring trainees' perspectives on trainers' disclosure and on the perspectives and disclosure decision making among trainers who do not disclose and/or who feel less positive about disclosure. Studies which aim to explore how course culture in relation to disclosure both from a trainee and from a trainer perspective would add greatly to this area of research. Further development of the current research is also recommended. The utility of the six-factor framework could be explored with trainers, and the concepts refined through the use of focus groups. Information from new research into how trainees receive disclosures

and the processes at work in those trainers who chose not to disclose, could also be included in the model.

Conclusion

This study aimed to understand the processes and factors involved in trainers on clinical psychology doctorate programmes decisions about whether or not to disclose personal experiences of psychological distress to clinical psychology trainees. Trainers were interviewed about their experiences of disclosure. A constructivist grounded theory approach was used to develop a decision-making model. The model shows that participants were predisposed to disclose, due to believing in the value of disclosure, both personally and professionally. They were also wary of the potential risks of disclosure and sought to minimise risk and maximise benefit by applying a six-factor framework to disclosure decisions based around ‘being safe’ and ‘considering helpfulness’. Confidence in using a framework for disclosure and in being free from professional consequences of disclosing, both enabled participants to choose to disclose, when they thought it would be helpful.

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List of Appendices

Appendix A

Author information and submission guidelines for the Journal of Clinical Psychology

1. Submission and Peer Review Process

New submissions should be made via the **Research Exchange submission portal**. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our **FAQs** or contact **submissionhelp@wiley.com**.

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- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
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- Abstract structured (objective(s)/methods/results/conclusion)

- Up to six keywords;
- Main body:
    1. regular section formatted as introduction, materials & methods, results, discussion, conclusion
    2. In Session (invitation only) formatted as introduction, Case Illustration (including separate sections on Presenting Problem & Client Description, Case Formulation, Course of Treatment, Outcome and Prognosis), Clinical Practices and Summary, and Selected References & Recommended Readings
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Training and Professional Issues	Original research and training methods related to the education and training of professional psychologists	Yes, structured	Data Availability Statement
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Appendix B

Participant Information Sheet

Exploring how trainers on doctorate in clinical psychology training programmes decide whether or not to disclose personal experiences of psychological distress to trainees.

My name is Simone Davies and I am conducting this research as part of my studies on the Clinical Psychology doctoral training programme at the University of East Anglia, Norfolk, United Kingdom.

What is the study about?

Clinical psychologists and clinical psychology trainees work in emotionally intense and highly stressful environments. Research suggests that levels of psychological distress in clinical psychologists and clinical psychology trainees may be high. Professional guidelines see managing personal experiences of psychological distress as a core competency of clinical psychology that should be addressed within training programmes. Studies have suggested that trainers disclosing their experiences to trainees would be one way to support this. However, little is known about how trainers decide whether or not to disclose or what they think happens when they do.

The purpose of this study is therefore to explore the processes involved in deciding to disclose and in disclosure through a series of one-to-one interviews. From this exploration a grounded theory model of trainers' understandings, perceptions and experiences of

disclosure will be developed, with the hope that this will be useful as a tool for training and supervision.

Why have I been approached?

You have been approached because the study requires information from people who are working as trainers with either teaching or supervision responsibilities (or both) on Clinical Psychology doctoral training programmes in the UK. You do not have to identify as having experienced a mental health problem, received a mental health diagnosis or been a mental health service user to take part in this study. For the purpose of this study the term psychological distress is defined as including these experiences but is used flexibly to incorporate understandings of distress that sit outside medical models of illness. Trainers who are staff members at the University of East Anglia are not eligible to take part in this study.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part, and you will be able to withdraw at any point during the interview or up to one week following the interview.

What will I be asked to do if I take part?

If you decide take part in this study, you may be asked to participate in an interview lasting approximately 60 - 90 minutes. This interview would take place via a secure teleconferencing facility. The interview will be audio recorded and then transcribed and analysed.

Due to the design of the study, not everyone who consents to participate will be invited to interview, as the study is hoping to interview people from a wide range of backgrounds. Your information would be treated with the same levels of confidentiality whether or not you complete an interview.

We may approach you to participate in another interview at a later date. You do not have to agree to this if you do not want to. We will ask you again at the time if you would still like to take part.

Will my data be identifiable?

The audio recording of your interview will be transferred to an encrypted memory stick where it will be securely stored and deleted from the Dictaphone as soon as the interview has taken place. After a minimum period of one week, the audio recording will be transcribed and anonymised, prior to analysis taking place. At this time, all personally identifying information will be removed, for example names, workplace etc., if mentioned, and the audio recording will be deleted. Direct quotes from your interview may be used in the report or a publication from the study. These would be anonymised, and your name would never be attached.

Any documents including personal information (i.e. consent forms) will be securely stored on an encrypted memory in a locked cabinet at the researcher's remote working location. This location was chosen to ensure confidentiality from the wider University of East Anglia supervision team, after the first choice location was unable to be accessed due to COVID-19 working restrictions. These documents will be destroyed once you have completed the study or, if you have requested a summary of the results, after this has been received

The only time that confidentiality would be broken is in the unlikey event that something you say suggests there is significant risk of harm to yourself or someone else. If this were the case, we would need to escalate our concerns to the appropriate safeguarding team. Wherever possible we would hope to discuss this with you prior to escalation.

Data collected for this study will be stored securely and only the researchers conducting this study will have access to these data.

What will happen to the results?

The results of this study will be summarised and reported as part of my thesis. They may also be submitted as part of a publication in an academic journal or as a conference poster presentation.

Are there any risks?

The anticipated risks of taking part in this study are low. Should you experience any distress during participation or following participation, you are encouraged to inform the researcher and contact the resources provided at the bottom of this information sheet.

Are there any benefits to taking part?

While there are no direct benefits of taking part in this study, we hope that you find participating interesting and enjoyable.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Medicine & Health Sciences Ethics Committee at the University of East Anglia.

Where can I obtain further information about the study if I need it?

If you would like to take part in the study, or have any questions, please contact the lead researcher via email:

Simone Davies, Trainee Clinical Psychologist

Department of Clinical Psychology

Norwich Medical School

University of East Anglia

NR4 7TJ

Simone.Davies@uea.ac.uk

Primary Supervisor:

Dr Imogen Rushworth

See address above

I.Rushworth@uea.ac.uk

Secondary Supervisor

Dr Paul Fisher

See address above

P.Fisher@uea.ac.uk

Complaints

If you wish to raise a complaint or concern about any part of this study and want to contact someone independent of the research study, you can speak to:

Professor Niall Broomfield, UEA Doctorate in Clinical Psychology Course Lead

Department of Clinical Psychology

Norwich Medical School

University of East Anglia

NR4 7TJ

Thank you for taking the time to read this information sheet

Resources in the event of distress

Should you feel distressed as a result of participating in the research interview, or feel as though you require more support, the following resources may be of assistance:

GP – Your GP will be able to signpost you to access relevant support if needed.

In an emergency – Call 999 or present at Accident and Emergency.
Samaritans – Provide 24 hour support, 365 days a year on 116 123.
MIND – Provide support Mon – Fri, 9am – 6pm on 0300 123 3393.

You may also wish to talk with your supervisor about any issues raised during the interview or contact your employee wellbeing service.

This study has been reviewed and approved by the Faculty of Medicine & Health Sciences Ethics Committee at the University of East Anglia.

Appendix C

Interview guide version 1

Initial questions

Why were you interested in taking part in this study?

How do you understand the phrase ‘personal experiences of psychological distress’?

How long have you been teaching on the training program? What are your roles on the training program? (put in version 2 only, along with asking about term disclosure)

Intermediate questions

Have you ever disclosed personal experiences of psychological distress to trainees?

- How did you make that decision?
- Who if anyone, influenced that decision?

Why is it important to you to share/not share these experiences?

Are there experiences that you chose not share while others you do share?

- How do you decide what to share?
- Are there experiences that have shaped this decision making?

Do you make different decisions about disclosure in different situations and with different trainees? Why? How to you come to these decisions?

Have you encountered stigma when you have made disclosures?

- Has stigma prevented you from making disclosures?
- Do you think trainees and/or colleagues view you differently/would view you differently if you disclosed personal experiences of psychological distress?

Who have you talked to about your decision to disclose/not to disclose?

- Was this before or after you disclosed or part of an ongoing process?

What has made it difficult/easy to disclose?

Ending questions

Has your decision making about disclosure changed over time?

- Why has it changed/stayed the same?

How do you think disclosure/non-disclosure shapes your relationships with trainees?

- And the culture of the course/organisation/psychology profession?

Could I ask you to describe the most important lessons you have learnt through disclosure/non-disclosure?

- How do you think disclosure/non-disclosure has changed you?
- What do you value about it? What do you think others value about it?

Is there something that you might not have thought about before that occurred to you during this interview?

Is there something else you think I should know to understand your decisions better?

Is there anything you would like to ask me?

Notes for changes to the interview guides

Interview guide notes post interview one listen through

Ask short clear questions. Sum up in their words, not your own. BE BRIEF, don't elaborate.

Use 'can you tell me more about that?'

Ask about the first time they disclosed and how they made that decision

What is important for them about disclosing/not disclosing?

What supports them to disclose?

What stops them from disclosing?

Ask about shame.

Ask about intersectionality, including disability.

Create more of a narrative flow and less about the ideas behind – be more interested in their experience – what did it feel like, how did they react afterwards, what did they gain?

Interview guide notes post interview 3 listen through

Asking about sharing vs disclosure explicitly. Make sure have joint understanding of terms and agree useage.

Interview guide notes post interview 7 interview

Ask explicitly about safety for self and safety for others.

Ask what they consider before they make a disclosure.

Ask about contexts more explicitly.

Interview guide final version

Initial questions

Why were you interested in taking part in this study?

How do you understand the phrase ‘personal experiences of psychological distress’?

Are you happy to use the word disclosure? Would you prefer the word sharing?

How long have you been teaching on the training program? What are your roles on the training program?

Intermediate questions

Have you ever disclosed personal experiences of psychological distress to trainees?

- What was that like?
- How did you make that decision? What did you consider?
- Who if anyone, influenced that decision?

Why is it important to you to share/not share these experiences?

- Are there characteristics about you (age, gender, ethnicity) that you feel influence these decisions?
- Are there characteristics of the environment?

Are there experiences that you chose not share while others you do share?

- How do you decide what to share?
- Are there experiences that have shaped this decision making?

Do you make different decisions about disclosure in different situations and with different trainees? Why? How to you come to these decisions?

Have you encountered stigma when you have made disclosures?

- Has stigma prevented you from making disclosures?
- Do you think trainees and/or colleagues view you differently/would view you differently if you disclosed personal experiences of psychological distress?

- Has disclosing changed how you see yourself?

Who have you talked to about your decision to disclose/not to disclose?

- Was this before or after you disclosed or part of an ongoing process?

What has made it difficult/easy to disclose?

- Who what/ has supported your decision making around this?

Ending questions

Has your decision making about disclosure changed over time?

- Why has it changed/stayed the same?

How do you think disclosure/non-disclosure shapes your relationships with trainees?

- And the culture of the course/organisation/psychology profession?

Could I ask you to describe the most important lessons you have learnt through disclosure/non-disclosure?

- How do you think disclosure/non-disclosure has changed you?
- What do you value about it? What do you think others value about it?

Is there something that you might not have thought about before that occurred to you during this interview?

Is there something else you think I should know to understand your decisions better? Have I missed anything? Let me check if there was anything I thought would come up but didn't (mention shame if they haven't)

Is there anything you would like to ask me?

Appendix D

Participant confidentiality consent form

CONSENT FORM

Title of Project: A grounded theory approach to exploring how trainers on clinical psychology doctorates decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees.

Name of Researcher: Simone Davies, Trainee Clinical Psychologist

	Please initial box
1. I confirm that I have read the information sheet dated 2021 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that once my data has been anonymised (one week following interview), and the analysis begun, I can no longer request that my data be destroyed.	☐
4. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix E

Demographic information sheet

Demographic information

Your age:

18-24

25-34

35-44

44-54

55-64

65-74

75 years or older

Prefer not to say

Your gender:

Male

Female

Other

Prefer not to say

Do you have any long-standing illness or disability?

Yes

No

Prefer not to say

To which of the following groups to you consider yourself to belong?

White – British

White – Irish

White – Any other White background

Mixed – White & Black Caribbean

Mixed – White & Black African

Mixed – White & Asian

Mixed – Any other mixed background

Black or Black British – Caribbean

Black or Black British – Caribbean

Black or Black British – Any other Black background

Asian or Asian British – Indian

Asian or Asian British – Pakistani

Asian or Asian British – Bangladeshi

Asian or Asian British – Any other Asian background

Chinese

Other (please specify)

Prefer not to say

Length of time in trainer role (total time, although indication of multiple organisations worked for helpful):

Qualification year:

Doctorate in Clinical Psychology course currently employed on:

Doctorate in Clinical Psychology course trained on:

Appendix F

Ethical Approval from Faculty of Medicine and Health Sciences Research

Approval in principle, subject to changes

Faculty of Medicine and Health Sciences Research Ethics Committee

NORWICH MEDICAL SCHOOL

Bob Champion Research & Educational Building

James Watson Road

University of East Anglia

Norwich Research Park

Simone Davies

Department of Clinical Psychology and Psychological Therapies

Norwich Medical School

University of East Anglia

Norwich Research Park

Norwich

NR4 7TJ

4th December 2019

Dear Simone

Project Title: A grounded theory approach to exploring how trainers on clinical psychology doctorates decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees

Reference: 2019/20-023

The submission of your research proposal was discussed at the Faculty Research Ethics Committee meeting on 27th November 2019.

The Committee was happy to approve your application in principle but have the following concerns which they would like you to address and amend accordingly:

Issues to address on information sheets

- Where Skype is mentioned, the Committee suggests you consider a more secure teleconference facility.
- The programme should really be referred to as "Clinical Psychology doctoral training programme" rather than "DClinPsych programmes" as courses vary as to how they describe their award.
- There should be an explanation as to why consent forms are being stored at NSFT rather than UEA. It would be helpful to clarify the confidentiality of all identifiable information from the wider UEA research supervision team – it sounds like this has been carefully thought about, but it could be made clearer to participants.
- Interviews off site to a voice recorder should be transferred to a UEA encrypted memory stick straight away.
- The Committee felt that stating that interviews can take place "anywhere" is unwise and would refer you to the MRes guidance.
- If staff on Doctorate in Clinical PsychologyPsy programmes who only have teaching, or supervision, responsibilities are not eligible for the study, that should be made clear on the information sheet. Likewise, it should be made clear that staff from UEA are not able to participate.
- There is no UEA logo on the information sheets. This is important for transparency.
- There should also be a contact for complaints, making clear that person is independent of the research.
- There are also a number of typographical errors which should be corrected:-
  - 'Clinical' not "clinically" psychology trainees
  - It should be programmes, not programs
  - "Faculty of Medicine and Health and Ethics Committee" should be Faculty of Medicine & Health Sciences Ethics Committee.

Comments on the FMH application form:

- How will the demographic information collected be stored and matched to the audio recordings (eg allocation of unique participant ID number, ID-name matching spreadsheet stored in secure way)?
- There should be a statement that only the lead researcher and any external transcription service will listen to audio recordings (ie nobody else from UEA staff team will listen to the recordings, and they will only participate in coding/analysis from fully anonymised transcripts in order to maintain confidentiality).

- The gatekeeper role also applies to social media, so you should use selective social media, and specify this.
- “Ethical approval will be sought from the University of East Anglia (UEA) Faculty of Mental Health (FMH)” should read Faculty of Medicine & Health Sciences.

Please write to me once you have resolved/clarified the above. I require documentation confirming that you have complied with the Committee’s requirements. The Committee has requested that you detail the changes underneath the relevant point on the text in this letter and also include your amendments as a tracked change within your application/proposal.

The revisions to your application can be considered by Chair’s action, rather than a further committee meeting, which means that you can resubmit the documentation at any time. Please send your revisions to me as an attachment in an email as this will speed up the decision making process.

I need to remind you that you should not be undertaking your research project until these issues have been resolved and you have ethical approval from the Faculty Research Ethics Committee. Planning on the project or literature based elements can still take place, but not the research involving the ethical issues. This is to ensure that you and your research are insured by the University and that your research is undertaken within the University's 'Guidelines on Good Practice in Research' approved by Senate in July 2015.

Yours sincerely

Prof Alastair Forbes

Chair

FMH Ethics Committee

Confirmation of approval, following required amendments

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Simone Davies
Department of Clinical Psychology and Psychological Therapies
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational Building
James Watson Road
University of East Anglia
Norwich Research Park
Norwich NR4 7UQ

Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

12th February 2020

Dear Simone

Project title: A grounded theory approach to exploring how trainers on clinical psychology doctorates decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees

Reference: 2019/20-023

Thank you for your email of 28th January 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Prof Alastair Forbes
Chair
FMH Research Ethics Committee

Further amendments for COVID-19 adjustments

University of East Anglia

Simone Davies
Department of Clinical Psychology and Psychological Therapies
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational Building
James Watson Road
University of East Anglia
Norwich Research Park
Norwich NR4 7UQ

Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

12th February 2020

Dear Simone

Project title: A grounded theory approach to exploring how trainers on clinical psychology doctorates decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees **Reference: 2019/20-023**

Thank you for your email of 14th May 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Prof Alastair Forbes
Chair
FMH Research Ethics Committee

COVID-19: *The FMH Research Ethics Committee procedures remain as normal. Please note that our decisions as to the ethics of your application take no account of Government measures and UEA guidelines relating to the coronavirus pandemic and all approvals granted are, of course, subject to these. If your research is COVID-19 related it will naturally be expedited. If the current situation means that you will have to alter your study, please submit an application for an amendment in the usual way.*

Further amendments to expand recruitment criteria

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Simone Davies
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational Building
Rosalind Franklin Road
University of East Anglia
Norwich Research Park
Norwich NR4 7UQ

Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

18th December 2020

Dear Simone

Project title: A grounded theory approach to exploring how trainers on clinical psychology doctorates decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees **Reference: 2019/20-023**

Thank you for your email of 15th December 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Dr Jackie Buck
Chair
FMH Research Ethics Committee

Appendix G

Excerpt from memo: Bringing myself to the research

One of the things that came in up in the Pecha Kucha format was that I'd obviously done a lot of thinking about what I was bringing to the research project and that it would be important to get that into the data right from the start.

So, why is this research important / meaningful to me? Why was I drawn to it? I always knew that I wanted to something personally meaningful. Initially I wanted to try and do something around perinatal mental health, as that is where my lived experience is and my route into psychology, but there wasn't anything at the research fair and the subject of mental health disclosure really interested me, because of my role as a peer support worker.

I wonder about how much to share with participants. One of the things about disclosing is that it elicits disclosures. So do I share at the beginning that I have lived experience of mental health difficulties (such a wordy phrase!) and so place people at their ease? Do I make my stance clear? Or will that do too much shaping of interview – will I be imposing my ideas right from the outset. It's so tricky, because implicitly my views are already there. Just thinking about the wording of the participant information sheet and the use of the term psychological distress. It's like the person first stuff in autism – by putting diagnosis first or by putting person first you are signalling your stance (although again, this is half what the other person brings, reminds me of the literature studies I have done). By being 'impartial' what am I really doing? I think that this will need some more thought and discussion about what, how and when I choose to disclose myself. The timing will be important.

Interesting that I am going through a parallel process thinking about this to the one I think my participants will experience!

Especially relevant as they will be disclosing to a trainee. So many parallel processes.

Oof.

I wonder if they will feel okay about disclosing things to me, or if they will want to keep the content of disclosures private. If they disclose at all of course. Hopefully will get people that don't as well. I wonder what people will keep private. Maybe they will disclose things which they have not been okay disclosing in the past. It's interesting too to think about how this means that people might be identifying as 'other'. I know that this was something that I always found hard about the peer support worker role. That it said for me what my experiences were and that these difficulties were 'mental health difficulties'. It was labelling and inherently stigmatising and really shook my sense of who I am – that my identity at work was so bound up in some of my most difficult experiences. It's interesting that I very rarely shared with people what my experiences had been – merely that I had them. Trying to remember back and I think I very rarely gave any context to what I had experienced.

Disclosing with clients is different anyhow. Or is it? Really? This isn't a peer-to-peer disclosure. There is an imbalance between us in terms of power. Ooo 'us'. There is a signaller – already I can see myself relating to them in the way I might relate to one of my own tutors. Trying to think about when I have been the recipient of disclosures as a trainee. Sometimes these have been fine – really helpful in fact. What's made them helpful? A sense of openness? Normalising distress? But other times they have been less so. I think because I've ended up feeling like the person has disclosed for their own purposes. Or neither helpful / unhelpful but rather have been used as a way to explain why someone is absent etc. in which case I feel like I have valued the honesty, rather than having some made-up excuse given.

Appendix H

Category development process

Practice example: tracking the development of the category "valuing disclosure" via the strand of 'being human and authentic'.

'Valuing disclosure personally and professionally' was one of the last subcategories to be constructed within the model. The development process of one strand of this subcategory is tracked below, through first appearance within memos and line by line coding, into the final model. Data from a single participant is used, so the process can be better understood.

Memos

A number of memos were written about "being human" and authentic. Extracts from three memos are included in Table 4.2. Memos were written and added to at different times, as new data was coded and ideas emerged.

Table 4.2

Extracts from memos on "being human" and authentic

Being authentic	A number of the participants talk about being authentic. It seems to involve something about bringing together personal and professional identities (remembering the hand clasping motion). Something PX mentioned as well about there being a difference in being authentic to yourself and authentic to the relationship. So not having to share everything, as that would not be authentic to the relationship. And going back through

	that idea, I wonder if this is another dilemma - between being yourself and being professional and how being authentic to the relationship may bridge this gap - so as well as trying to extend the definition of what is 'appropriate' as a professional to involve the sharing of self and use of self.
Being human	So there is something tricky here about this as lots of participants use this phrase, but they don't necessarily mean the same thing (even within the same interview). So maybe on one level, participants are sharing in order to show that they are human - so as an activity/action they are 'being human' with trainees, being just another person. But also something about not being immune to suffering, about the actual state of being a human and allowing yourself to know all parts of your experience. Gosh, hard. It can seem a bit nebulous and wishy-washy, I can see why everyone was struggling with this one a bit. I wonder if there is something wider, that will feel better in a bit. Hmmm. So page 11, highlighted PX trying to normalise for everybody in that cohort that actually psychologists are human. PX p 26 "You know it is about being human" Participants seem to be trying to capture something about their world views here, and how self-disclosure is rooted in a fundamental belief of all of them that suffering is part of being human, that diversity is part of being human AND that we can only be 'good' psychologists if we are being human. So it has a moral value to it and aspect of moral judgement. This is

	something that I myself am wrestling with, as it is coming up a lot in regards to my current clinical work. That I have an alignment to a world view, that sits at odds with the service I am working within. I think I can see that same dilemma in PX - and the result can be ethical distress / moral injury. Blimey they all talk about being human a lot! PX is straight in there on like p3 "It's about being human".
Believing in a common humanity	Being human is about believing we have a common humanity **and** about being human with others - so a world view (we have a common humanity, part of the common humanity is the experience of suffering and the randomness of life, the unfairness, which we as psychologists are not immune to). And a lot of people are expressing this world view as if it is an basic truth, rather than a moral stance. So PX p28 "it's about psychology being human and being no different from other people essentially, essentially there's no us and them." Beginning to think about this stuff more clearly - so there is a belief in a common humanity, which psychologists are part of, which is expressed as 'being human' much of the time, but there is also the act of sharing your humanness with others. Being human with trainees is described well by PX p8 "but yes I think it does enhance. Making the trainers real people just feels to me completely crucial."

Initial and focused codes

Initially line by line coding was used to familiarise the author with the data and to look for emergent themes. Gerunds were used where possible to focus on the processes and actions being performed by participants. During initial coding, highlighters were used to identify words and phrases that captured emerging concepts. An example of initial and focused coding for "being human" is captured in Table 4.3.

Table 4.3

Example of initial and focused coding on "being human"

Transcript	Initial coding	Focused coding
P1: Yes, yes I mean it's because I was I thought, you know, when you know, you've got to be human. And I think the worries are, are put in the, and a lot these studies show, that any therapeutic effect of efficacy has to come from you know warmth, unconditional positive regard, um, being open. And part of that is sharing who you are, so. Transparency. There was a book by, an old book by	Being human Evidencing importance of 'being human' Defining being human as sharing who you are – transparency	Being human Being open Sharing self

Sidney Jourard, in the 60s called 'The Transparent Self' and he made the case, for actually it's the opposite of psychoanalysis, it's, it's not holding back, it's not having a blank slate, it's not waiting for a projection to be made onto you. It's about actually connecting fully as a human being and that means sharing who you are so for me it was a matter of thinking about how do you go about thinking about that in a manner that is helpful for other people and doesn't put you at the centre of it, doesn't take away from the process	Evidencing legitimacy of position Defining position in opposition to psychoanalysis ’blank slate’ Connecting fully as a human being Sharing who you are Sharing in a way that is helpful and doesn’t take away from process/focus	Evidencing / justifying position Identifying opposing position Connecting fully Sharing self/identity Finding a way to share helpfully Identifying danger/risk of sharing (loss of focus, taking up therapeutic space, dominating with self)

Developing categories from focused codes

Once focused coding was complete, focused codes from a subsection of participants were grouped together in a database. Preliminary categories and subcategories were

developed. Many of these were later renamed, but the way the data was grouped together remained remarkably consistent. “Being human” and authentic, which eventually became part of the subcode of “valuing disclosure”, was initially categorised across “Motivation for disclosure” and “Stance towards disclosure”. Table 3 details an extract of the relevant focused codes, and how they were initially categorised, for a single participant.

Table 3

Focused codes and initial categories and subcategories for “being human” and authentic

Category	Subcategory	Subcategory	Focused codes
Motivation	Challenging narrative	Stereotype of CP	Motivation: challenging stereotype
Motivation	Challenging narrative	Stereotype of CP	Motivation: challenging unhelpful stereotype; shaping a new type of CP
Motivation		Connecting	Motivation: connecting
Motivation	Challenging narrative	Stereotype of CP	Motivation: identifying need; unhelpful stereotype of ‘what is a clinical psychologist’
Motivation	Fostering relationships	Connecting	Motivation; fostering relationships; being authentic; connecting
Motivation	Being human	Universal suffering	Motivations: promoting universal suffering / being human
Stance			Stance: being opposite to professional mask
Stance	Beliefs / values	Standing up	Beliefs / values; standing up for what is right even if it is difficult

Stance	Beliefs / values	Values of LE	Stance: beliefs: value of LE
Stance	Beliefs / values		Stance: importance of intersectionality; understanding diversity and difference; understanding and bring whole self
Stance	Beliefs / values	Universal suffering	Stance: universal suffering
Stance	Beliefs / values	Being human= being a good psychologist	Stance: using the evidence base / being human central to professional role
Stance	Beliefs / values	Being human	Stance: values; being human

Emergent categories and subcategories

The next stage of coding was to add theoretical codes to each interview. An example of theoretical coding alongside the focused codes is detailed in Table 4.

Table 4

Example of theoretical and focused coding

Transcript	Categories / subcategories	Focused coding
P1: Yes, yes I mean it's because I was I thought, you know, when you know, you've got to be human. And I think the worries are, are put in the, and a lot these	Stance: values; being human	Being human

studies show, that any therapeutic effect of efficacy has to come from you know warmth, unconditional positive regard, um, being open. And part of that is sharing who you are, so. Transparency. There was a book by, an old book by Sidney Jourard, in the 60s called 'The Transparent Self' and he made the case, for actually it's the opposite of psychoanalysis, it's, it's not holding back, it's not having a blank slate, it's not waiting for a projection to be made onto you. It's about actually connecting fully as a human being and that means sharing who you are so for me it was a matter of thinking about how do you go about thinking about that in a manner that is helpful	Motivation; fostering relationships; being authentic; connecting Stance: using the evidence base / being human central to professional role Motivation: connecting Considering helpfulness: focus on trainees	Being open Sharing self Evidencing / justifying position Identifying opposing position Connecting fully Sharing self/identity Finding a way to share helpfully

for other people and doesn't put you at the centre of it, doesn't take away from the process	Dangers: taking over process	Identifying danger/risk of sharing (loss of focus, taking up therapeutic space, dominating with self)

Refining categories and subcategories

Once each interview had theoretical codes, these were brought together on a database with linked quotes and compared to other participants, leading to a refining of categories. Table 5 details extracts relating to 'being human' from a single participant.

Table 5

Extracts relating to "being human"

Theoretical category	Subcategory	Sub, subcategory	Quote
Stance	Being human	Being human / experiencing distress	everybody has mental health issues at some point or another
Stance	Being human	Being human / experiencing distress	it's about psychology being human and being no different from other people essentially, essentially there's no us and them

Stance	Being human	Being human / experiencing distress	it's just about being human and sharing your humanity with someone else
Stance	Being human	Open	It's about actually connecting fully as a human being and that means sharing who you are

Developing a model

Alongside focused and theoretical coding, multiple iterations of the model were being developed. Detailed in Table 6 is an extract from iteration 26 of the model, that shows how 'being human and authentic' was initially part of a category called 'developing a stance on disclosure'. This category also included a subcategory called 'awareness of risk' which went on to be constructed as 'wary of risk'. Taken together, the remaining four subcategories went on to become 'valuing disclosure personally and professionally'.

Table 6

Extract from iteration 26 of the developing model

Developing a stance on disclosure	
Being human and authentic	Universal suffering (being human) Authenticity (bringing your whole self) connecting

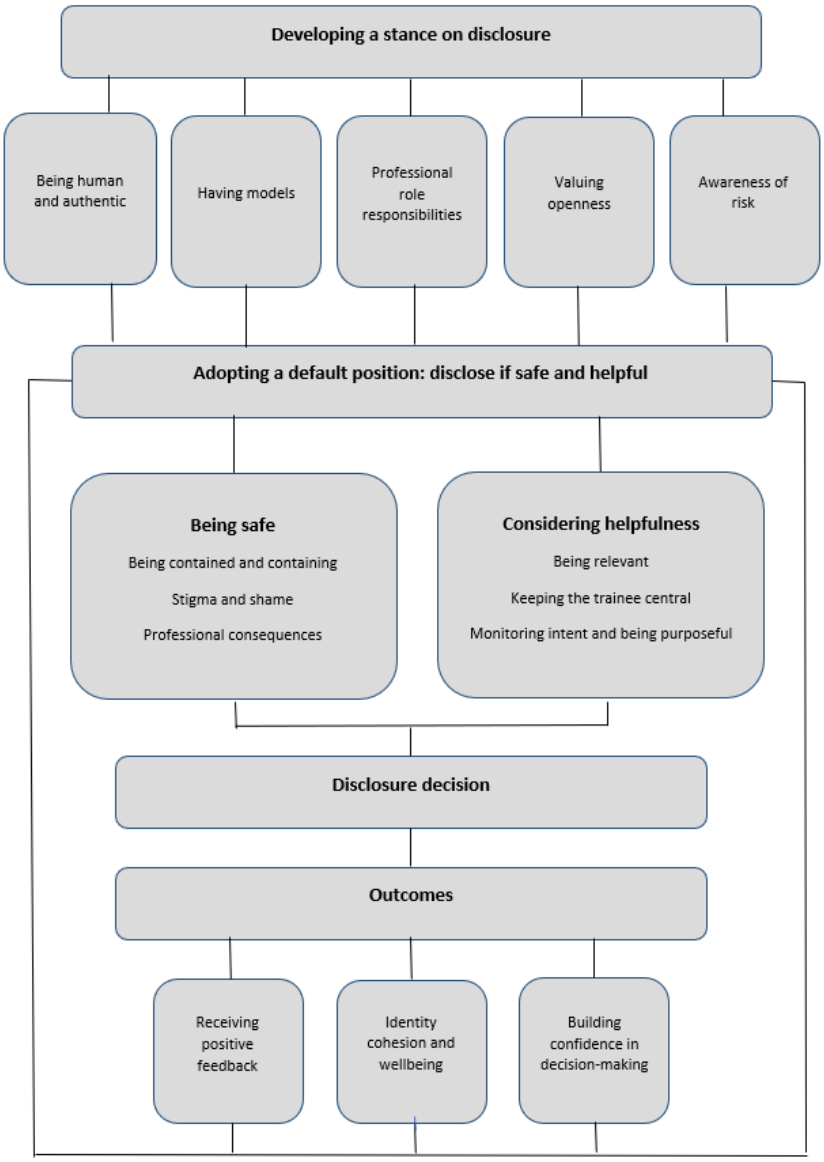
	Benefits to personal wellbeing	
	Disclosure as a natural extension of beliefs	
Having models	Role models and theoretical models	
	Being given ‘permission’	
Professional role responsibilities	Containing trainee distress	
	Promoting disclosures	
	Developing professional competencies	
	Modelling good practice	
	Enhancing teaching	
Valuing openness	Normalising and validating	
	Fostering connection and alliance	
	Challenging narratives viewed as unhelpful or stigmatising	individualised distress distress being a sign of incompetency clinical psychologists being free from distress

Refining the model

Following feedback on an early draft and discussion in thesis supervision, the model was refined to focus more on the processes involved in decision-making and less on the predisposing factors. This meant that rather than being an individual subcategory "being human" and authentic was subsumed by 'valuing disclosure' in the final iteration of the model. Figure 2 details the version of the model discussed in the early draft.

Figure 2

Early draft of the theoretical model



Chapter Five

Additional methodology

Additional methodology

Part One: Systematic review

The systematic review aimed to explore the types and prevalence of psychological distress in clinical and counselling trainees and the factors which influence coping and wellbeing, while providing an overview of the current state of the literature. It was noted during initial scoping that studies employed a variety of different terms when describing psychological distress, including stress, distress, burnout and mental health difficulties (MHDs) as well as applying concepts such as psychological adaptation and low self-esteem. The term "psychological distress" was chosen for the systematic review in order to capture both this variation and the breadth of experiences that might be affecting trainees. Mixed methods, qualitative and quantitative papers were included in the review, in order to answer the research questions. Search terms were iteratively broadened and refined to maximise the return of relevant papers. Key papers (*n* 6) were identified early on in the review process and search terms were tested against their ability to return these studies.

The data was analysed using a narrative synthesis approach, due to the suitability of this methodological approach for answering the review's research questions (Lucas et al., 2007; Popay et al., 2006). A narrative synthesis approach allows for data to be synthesised across qualitative, quantitative and missed methods studies (Hong et al., 2017), enabling researchers to make sense of large bodies of evidence produced using disparate methods (Rogers et al., 2009). Popay et al.,'s (2006) comprehensive guidelines for conducting and reporting narrative synthesis were followed in order to minimise research bias and maximise transparency (Campbell et al., 2019). These guidelines outline four key processes that can be applied flexibly: developing a theoretical model of the intervention; generating a preliminary synthesis through an initial description of the results; exploring relationships and emerging

patterns in the data to identify explanations for differences and similarities; assessing the synthesis for robustness (including assessing the methodological quality of the included studies).

Developing a theoretical model of the intervention

The researchers initially developed theoretical understanding of the central concepts, rather than a model of the intervention, adapting Popay et al.'s (2006) guidance for use within observational studies. A theoretical understanding of psychological distress was developed through discussion and reflection among the research team: the literature on psychological distress in the healthcare workforce and among qualified psychologists was scoped and fed into discussions.

Generating a preliminary synthesis

Preliminary synthesis proceeded through an initial textual description of characteristics and findings of included studies, tabulation, grouping and clustering data and transforming data into a common rubric. A table for data extraction was developed and piloted, based on discussions within the research team and drawing on examples within the literature. Characteristics of included studies and findings were extracted and tabulated. Once this was completed, clustering and grouping of data was conducted iteratively alongside transforming data into a common rubric.

Exploring relationships in the data

Relationships in the data were explored primarily through conceptual mapping – constant comparisons were made to explain differences and similarities between findings. The influence of heterogeneity was explored in detail. As part of this process a separate

database was created to investigate the different measures employed within the study, paying attention to the types of distress measured, the factors related to distress that had been investigated and the quality and diversity of the measures employed. Within the studies included in this review, 57 different measures were identified, 15 of which were author developed. These included 25 different measures of psychological distress within which six categories of distress were identified, and 32 different measures of factors mediating psychological distress, in which 19 different factors were identified. Narrative descriptions were developed, and reflective discussions were held within the research team, in order to group these factors together into themes.

Assessing the robustness of the synthesis

The narrative synthesis was assessed for robustness, including assessing the methodological quality of studies individually and as a body of literature. Three different quality assessment tools were used to account for the different methodologies of the observational studies included in the review. They were selected based on the guidelines set out by Sanderson et al. (2007). It was noted during this process that some studies had implemented measures but not reported findings such as raw data scores, as their focus was on other factors. Gaps in the literature when taken as a whole were noted and explored, including weaknesses relating to a lack of cohort studies, limited follow-up, low sample sizes, lack of comparisons to other populations and response biases.

Part Two: Empirical Study

Data analysis was conducted using a constructivist grounded theory approach (Charmaz, 2014). Analysis began during transcription and took place concurrently with interviews, to allow for interview questions to be adapted and changed to fill emerging

knowledge gaps. Iterative data analysis moved forward and back through the three main processes of initial coding practices, focused coding and theoretical coding as more data were added to the analysis, while memo-writing took place continuously (Charmaz, 2014). Theoretical categories and subcategories were developed from theoretical codes and during the process of advanced memo-writing and drafting and redrafting the pictorial model (Charmaz, 2014).

Memo writing

Memos were written continuously throughout the research process, beginning as personal reflections and in response to the literature, and continuing throughout coding, category development and model building. Initial memos were both handwritten and typed into word processing documents. Later they were added to an electronic database. Memos were 'tagged' with key words and phrases, often incorporated in the memo name, but also added to subheadings within the database. This enabled memos to be easily grouped and regrouped around different themes. Grouping and regrouping enhanced the exploration of the relationships between memos and the development of codes and categories. There was an iterative process of feeding new understandings back and forth between memos, codes and categories as the data analysis proceeded. Quotes were included in memos early in the process to keep constructs as close as possible to the data and to allow constant comparisons to be made between participants. Excerpts from a cluster of mid-process memos related to the subcategory "valuing disclosure", which explore the themes of "being human" and authentic are shown in Table 5.1.

Table 5.1

Excerpt from memos related to the subcategory "valuing disclosure"

Being authentic	A number of the participants talk about being authentic. It seems to involve something about bringing together personal and professional identities (remembering the hand clasping motion). Something PX mentioned as well about there being a difference in being authentic to yourself and authentic to the relationship. So not having to share everything, as that would not be authentic to the relationship. And going back through that idea, I wonder if this is another dilemma - between being yourself and being professional and how being authentic to the relationship may bridge this gap - so as well as trying to extend the definition of what is "appropriate" as a professional to involve the sharing of self and use of self.
Being human	So there is something tricky here about this as lots of participants use this phrase, but they don't necessarily mean the same thing (even within the same interview). So maybe on one level, participants are sharing in order to show that they are human - so as an activity/action they are 'being human' with trainees, being just another person. But also something about not being immune to suffering, about the actual state of being a human and allowing yourself to know all parts of your experience. Gosh, hard. It can seem a bit nebulous and wishy-washy, I can see why everyone was struggling with this one a

	bit. I wonder if there is something wider, that will feel better in a bit. Hmmm. So page 11, highlighted PX trying to normalise for everybody in that cohort that actually psychologists are human. PX p 26 "You know it is about being human" Participants seem to be trying to capture something about their world views here, and how self-disclosure is rooted in a shared fundamental belief of all of them that suffering is part of being human, that diversity is part of being human AND that we can only be 'good' psychologists if we are being human. So it has a moral value to it and aspect of moral judgement. This is something that I myself am wrestling with, as it is coming up a lot in regards to my current clinical work. That I have an alignment to a world view, that sits at odds with the service I am working within. I think I can see that same dilemma in PX - and the result can be ethical distress / moral injury. Blimey they all talk about being human a lot! PX is straight in there on like p3 "It's about being human".
Believing in a common humanity	Being human is about believing we have a common humanity **and** about being human with others - so a world view (we have a common humanity, part of the common humanity is the experience of suffering and the randomness of life, the unfairness, which we as psychologists are not immune to). And a lot of people are expressing this world view as if it is a basic truth, rather than a moral stance. So PX p28 "it's about psychology being human and being no different from other

	people essentially, essentially there's no us and them." Beginning to think about this stuff more clearly - so there is a belief in a common humanity, which psychologists are part of, which is expressed as 'being human' much of the time, but there is also the act of sharing your humanness with others. Being human with trainees is described well by PX p8 "but yes I think it does enhance. Making the trainers real people just feels to me completely crucial."

Initial coding

Initial coding practices included: the familiarisation with data through reading and rereading; extraction of data into tables; and line-by-line coding using words descriptive of actions (gerunds), enabling the researcher to focus on processes, whilst remaining both open to undetected patterns in everyday talk (Glaser & Strauss, 1967) and questioning of participants' world views. Highlighters were used to identify words or phrases within the text with particular resonance. Many on these became key elements of theoretical categories and were used to illustrate the results of the empirical paper. An excerpt of initial coding is shown in Table 2, alongside focused codes.

Focused coding

Focused coding practices included: studying and comparing initial codes, asking "what sort of theoretical categories do these codes indicate?"; selecting significant and/or frequent codes; collapsing related initial codes into new codes; and using focused codes to direct analysis and the gathering of future interview data. While staying close to the data, focused codes were used to think conceptually about models and categories. During focused

coding memo writing intensified: many memos were named for codes identified within the data, and relationships between codes were explored, beginning the process of theoretical coding. An excerpt of focused coding is shown in Table 5.2, alongside initial codes.

Table 5.2

Example of initial and focused coding

Transcript	Initial coding	Focused coding
P1: Yes, yes I mean it's because I was I thought, you know, when you know, you've got to be human. And I think the worries are, are put in the, and a lot these studies show, that any therapeutic effect of efficacy has to come from you know warmth, unconditional positive regard, um, being open. And part of that is sharing who you are, so. Transparency. There was a book by, an old book by Sidney Jourard, in the 60s called 'The Transparent Self'	Being human Evidencing importance of 'being human' Defining being human as sharing who you are – transparency Evidencing legitimacy of position	Being human Being open Sharing self Evidencing / justifying position

and he made the case, for actually it's the opposite of psychoanalysis, it's, it's not holding back, it's not having a blank slate, it's not waiting for a projection to be made onto you. It's about actually connecting fully as a human being and that means sharing who you are so for me it was a matter of thinking about how do you go about thinking about that in a manner that is helpful for other people and doesn't put you at the centre of it, doesn't take away from the process	Defining position in opposition to psychoanalysis 'blank slate' Connecting fully as a human being Sharing who you are Sharing in a way that is helpful and doesn't take away from process/focus	Identifying opposing position Connecting fully Sharing self/identity Finding a way to share helpfully Identifying danger/risk of sharing (loss of focus, taking up therapeutic space, dominating with self)

Theoretical coding

Theoretical coding and model/theory building included: developing theoretical codes from focused codes by specifying categories of focused coding; conceptualising how categories of focused codes relate to each other; and using specified categories of focused codes and conceptualisations of how categories relate to each other to build a theory/model

from the data. Memos from focused codes were extended and linked and care was taken to explore relationships and describe categories according to actions. Focused codes from individual participants were extracted and compiled into a database. Focused codes were grouped and regrouped in order to explore relationships and develop theoretical codes/categories. An example of this process is illustrated in Table 5.3.

Table 5.3

Excerpt of initial grouping of focused codes and naming of categories and subcategories

Category	Subcategory	Subcategory	Focused codes
Stance			Stance: being opposite to professional mask
Stance	Beliefs / values	Standing up	Beliefs / values; standing up for what is right even if it is difficult
Stance	Beliefs / values	Values of LE	Stance: beliefs: value of LE
Stance	Beliefs / values		Stance: importance of intersectionality; understanding diversity and difference; understanding and bring whole self
Stance	Beliefs / values	Universal suffering	Stance: universal suffering
Stance	Beliefs / values	Being human = being a good psychologist	Stance: using the evidence base / being human central to professional role
Stance	Beliefs / values	Being human	Stance: values; being human

After categories and subcategories had been developed and "tagged", the process of theoretical coding began. An excerpt of theoretical coding is presented in Table 5.4, alongside focused codes.

Table 5.4

Excerpt of theoretical codes and focused codes

Transcript	Categories / subcategories	Focused coding
P1: Yes, yes I mean it's because I was I thought, you know, when you know, you've got to be human. And I think the worries are, are put in the, and a lot these studies show, that any therapeutic effect of efficacy has to come from you know warmth, unconditional positive regard, um, being open. And part of that is sharing who you are, so. Transparency. There was a book by, an old book by Sidney Jourard, in the 60s called 'The Transparent Self'	Stance: values; being human Motivation; fostering relationships; being authentic; connecting Stance: using the evidence base / being human central to professional role	Being human Being open Sharing self Evidencing / justifying position

and he made the case, for actually it's the opposite of psychoanalysis, it's, it's not holding back, it's not having a blank slate, it's not waiting for a projection to be made onto you. It's about actually connecting fully as a human being and that means sharing who you are so for me it was a matter of thinking about how do you go about thinking about that in a manner that is helpful for other people and doesn't put you at the centre of it, doesn't take away from the process	Motivation: connecting Considering helpfulness: focus on trainees Dangers: taking over process	Identifying opposing position Connecting fully Sharing self/identity Finding a way to share helpfully Identifying danger/risk of sharing (loss of focus, taking up therapeutic space, dominating with self)

Refining categories and subcategories

Theoretical codes were extracted and collated on a database with linked quotes. Codes and quotes were grouped and regrouped, and participants compared to one another, while memos were used to explore and delineate concepts within the emerging model, leading to a

refining of categories. Presented in Table 5.5 are transcript extracts from three participants relating to "being human", a strand of the subcategory "valuing disclosure".

Table 5.5

Extracts relating to "being human"

Theoretical category	Subcategory	Sub, subcategory	Quote
Stance	Being human	Authentic	I am a real believer in trying to be as authentic as we can in our practice.
Stance	Being human	Authentic	the times I have probably been most miserable in my own working life, is when I've felt the least authentic in what I am doing.
Stance	Being human	Being human / experiencing distress	It's about being human, psychological distress in the broadest sense, that you know, as [redacted] I do my job – the training job or the clinical job – as me and I bring my experience and I am impacted by work and some of that is about psychological distress.
Stance	Being human	Being human / experiencing distress	That to pretend that we don't experience distress is disrespectful and neglectful of ourselves
Stance	Being human	Being human / experiencing distress	acknowledging that you are human and that part of being a person is having difficult feelings, difficult experiences, conflicts, stress as well as all the good stuff. And it is okay to be a person.
Stance	Being human	Being human / experiencing distress	my position is that I feel like everyone is a bit messed up, probably psychologists and psychotherapists more so than others, because otherwise why would we get here and why would we do this?

Stance	Being human	Being human / experiencing distress	everybody has mental health issues at some point or another
Stance	Being human	Being human / experiencing distress	it's about psychology being human and being no different from other people essentially, essentially there's no us and them
Stance	Being human	Being human / experiencing distress	it's just about being human and sharing your humanity with someone else
Stance	Being human	Open	So that ability to be open is a quality that I admire, so when I take the risk, or when I think about bringing that part of myself into my work, I am – proud is too strong a word – but somewhere along that sort of, somewhere towards thinking, this is not an easy thing to do but it is the right thing to do.
Stance	Being human	Open	It's about actually connecting fully as a human being and that means sharing who you are

Developing a model

Alongside focused and theoretical coding, multiple iterations of the model were being developed. These took the form of grouping categories and subcategories together and drawing out pictorial representations of how categories might relate to each other. Table 5.6 contains an extract from iteration 26 of the model, that shows how “being human and authentic” was initially part of a category called “developing a stance on disclosure”. This category also included a subcategory called ‘awareness of risk’ which went on to be constructed as “wary of risk”. Taken together, the remaining four subcategories went on to become ‘valuing disclosure personally and professionally’.

Table 5.6

Extract from iteration 26 of the model

Developing a stance on disclosure	
Being human and authentic	Universal suffering (being human)
	Authenticity (bringing your whole self) connecting
	Benefits to personal wellbeing
	Disclosure as a natural extension of beliefs
Having models	Role models and theoretical models
	Being given ‘permission’
Professional role responsibilities	Containing trainee distress
	Promoting disclosures
	Developing professional competencies
	Modelling good practice
	Enhancing teaching
Valuing openness	Normalising and validating
	Fostering connection and alliance

Challenging narratives viewed as unhelpful or stigmatising	individualised distress distress being a sign of incompetency clinical psychologists being free from distress

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Refining the model

Following feedback on an early draft and discussion in thesis supervision, the model was refined to focus more on the processes involved in decision-making and less on the predisposing factors. This meant that rather than being an individual subcategory “being human and authentic” was subsumed by “valuing disclosure” in the final iteration of the model. This brought the six-factors relating to participants’ decision-making about whether or not to disclose into the centre of the model.

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Chapter Six

Discussion and critical evaluation

Discussion and critical evaluation

Summary of findings and relation to practice

The overarching aim of this thesis was to explore psychological distress within clinical and counselling trainees and the use of disclosure by trainers in clinical psychology doctorate training programmes. There is a growing agenda to support mental health and increase psychological wellbeing within both the psychology profession and the healthcare workforce more widely (American Psychological Association: APA, 2010; Health Education England: HEE, 2019; Rhodes, 2016), and to encourage cultures of openness and honesty in which managing distress and fitness to practice through timely disclosure, help-seeking and self-care are seen as core professional competencies (APA, 2000; Health and Care Professions Council: HCPC, 2015; Kemp et al., 2020).

Psychological distress among the helping professions, disclosure decision-making in the workplace and of concealable stigmatised identities, and therapist self-disclosure are all well explored areas of research (Brohan et al., 2012; Health and Safety Executive, 2020; Müller, 2019; Ragins, 2008; Toth and Dewa, 2014). However, the evidence base for these phenomena within clinical and counselling psychology doctorate trainees (henceforth trainees) and clinical psychology doctorate trainers (henceforth trainers) was lacking. This research aimed to contribute to bridging these gaps in the literature by determining the types, levels and factors influencing psychological distress in trainees and by exploring the processes and factors involved in trainers deciding whether or not to disclose experiences of psychological distress to trainees.

To knowledge, there appears to be no published systematic review of psychological distress in trainees, or Prospero registered proposal, since Pakenham and Stafford-Brown in 2012, despite a recent upswell in publications. A recent systematised literature review on the

prevalence of trainee distress was found within a doctorate thesis (Warren, 2018), however no registration on Prospero, or intent to publish was identified. Within the current review, data from nineteen studies was extracted and analysed, using a narrative synthesis approach (Lucas et al., 2007; Popay et al., 2006). Although studies were generally of a good methodological quality when considered individually, there was considerable heterogeneity and potential for bias, limiting the reliability and generalisability of findings. Overall, results suggested that experiences of psychological distress may be frequent and common among trainees and that training is experienced by many trainees as high stress and high demand. Personal and professional resources, such as effective coping strategies, self-care, high quality supervisory relationships and open and supportive course cultures, were found to be important influences on trainee distress, suggesting that these factors could be relevant to supporting trainee wellbeing and coping. The review suggested that further high-quality studies were warranted, including to investigate factors that may promote cultures of openness and support trainees' development of professional competencies in managing distress, such as the modelling of disclosure by trainers.

An empirical study followed from the systematic review, aiming to explore the processes and factors involved in trainers deciding whether or not to disclose personal experiences of psychological distress to trainees. A constructionist grounded theory methodology was used (Charmaz, 2014): nine participants were recruited from training programmes around the United Kingdom (UK). A model of trainer decision-making in disclosing to trainees was developed. Participants were found to be predisposed to disclose, due to valuing disclosure both personally and professionally, and to be wary of the risks of disclosure. This led them to apply a six-factor framework to making disclosure decisions, constructed within the criteria of "being safe" and "considering helpfulness". Outcomes of disclosure decisions, whether perceived as positive or negative, served to reinforce both the

value of disclosure and the importance of using a framework in order to make safe appropriate disclosures, creating a positive feedback loop. The findings suggest factors and processes that may be important for trainers to consider when deciding whether or not disclose experiences of psychological distress to trainees. Personal reflection, reflective group practice and supervision all emerged as central to making considered, ethical and conscious decisions. These findings have implications for informing professional practice and training programmes support for staff. Potential areas of development for the model were noted, including the exploration of decision making in those who chose not to disclose and do not value disclosure, and how disclosures are received by trainees.

Critical evaluation

Systematic review

The systematic review contributes to and expands on the existing evidence base about the types and prevalence of psychological distress in clinical and counselling psychology trainees, and the factors that influence coping and wellbeing. The current review included 14 studies published since Pakenham and Stafford-Browns' 2012 review, and six papers published since Warren's 2018 dissertation. It offers a novel contribution to an expanding research area and a timely insight for training programmes concerned with promoting psychological wellbeing among trainees.

The review utilised a narrative synthesis methodology for data analysis, due to the suitability of this approach for meeting the aims of the study (Lucas et al., 2007; Popay et al., 2006). This approach allows for the synthesis of data across quantitative, qualitative and mixed methodology papers (Hong et al., 2017). It is often used with quantitative data when high levels of heterogeneity or a lack of data prevent the statistical pooling integral to meta-analysis (Campbell et al., 2019). Narrative synthesis enables researchers to make sense of

large bodies of research with evidence produced by a disparate range of methods, and as such has considerable utility for public policy making (Rogers et al., 2009).

A common criticism of narrative synthesis is that it is opaque and potentially subject to researcher bias (Campbell et al., 2019). In the current systematic review, steps were taken to preserve transparency and avoid bias. Popay's (2006) comprehensive guidance for conducting and reporting of narrative synthesis was adapted for use with non-intervention studies. A theoretical understanding of psychological distress was developed through discussion and reflection among the research team. Preliminary synthesis proceeded through initial textual description of characteristics and findings of included studies, tabulation, grouping and clustering data and transforming data into a common rubric. Relationships in the data were explored through conceptual mapping – constant comparisons were made to explain differences and similarities between findings and reflective discussions were held within the research team. The robustness of the synthesis product was assessed: three different quality assessment tools were used to assess studies individually and a narrative assessment of methodological quality was completed for the overall body of included literature. The narrative appraisal and quality appraisal tools presented differing pictures of the quality of the literature. This may result from known problems with quality assessment tools for observational studies, which can lack rigour (da Costa et al., 2011), from bias within the researcher's narrative analysis (Campbell et al., 2019) or be a reflection on the current state of the literature (with individual studies being of moderate to good quality, but when taken as a whole, gaps in the literature emerging). Further reflective discussions to resolve or explain these differences could have been undertaken by the research team.

Empirical research

The empirical research adds to the growing evidence base on disclosure decision-making about mental health difficulties and other concealable identities in the workplace and within therapist self-disclosure. It provides an insight into the factors and processes that may be important for trainers to consider when disclosing in order to make disclosure decisions that are personally meaningful, appropriate and useful. It further suggests the support that training programmes could give to trainers who are considering modelling disclosure to trainees, pointing to the importance of reflective spaces and discussions of disclosure in supervision, as well as of personal reflexivity.

When considering the utility of this research for informing practice it is important to evaluate its quality against the standards of sensitivity to context, rigour, transparency, and impact and importance (Yardley 2000; 2008). Throughout the research process steps were taken to ensure the credibility of the model produced. Within grounded theory research there is a tension between staying true to origins of the methodology, ensuring that theory is 'grounded' in the data, and more pragmatic approaches that allow the influence of pre-existing models and concerns within the research topic area (Barbour, 2001). The current study used the later variant, adding value by identifying new themes from the data alongside those from the existing literature (Melia, 1997), drawing on models of mental health disclosure in the workplace (Toth and Dewa, 2014), concealable stigmatised identity disclosure (Chaudoir & Fisher, 2010) and therapist self-disclosure (Müller, 2019). By acknowledging the influence of this theoretical starting point, it has been possible to include pre-existing theoretical knowledge within a grounded theory approach (Charmaz, 2006; Corbin & Strauss, 2008). Sensitivity to context was maintained by staying close to the data and carefully considering participants' perspectives as well as the sociocultural setting and researchers' contributions (Yardley 2017). Rigour was demonstrated by in-depth engagement

with the topic, the iterative process of data collection and analysis and the constant comparison processes employed during analysis (Yardley, 2000). Steps were taken to ensure that the researcher's decision making was transparent and that clear records were kept so that the decision-making process could be tracked. Emerging themes and categories were discussed with the research team and reflected on during memo writing. Focused codes and theoretical codes were grouped and regrouped, comparing data extracts between participants. Within the recruited sample the model demonstrates that it stays close to the data by using direct examples to illustrate categories and decision-making processes. Arguably the current study represents a "GT-Lite" as it only uses some stages of a full grounded theory (i.e., initial coding and category development). These were sufficient to allow an understanding of the relationships between categories to be reached, but not for the generation of a full theory (Braun and Clarke, 2013).

It is acknowledged that this model may not be representative of the wider views of trainers on UK training courses and so may lack generalisability. Gatekeepers played a role in recruitment: emails were initially sent out to clinical psychology doctorate programme directors with a request to disseminate to trainers, and it is unknown how many circulated participate information or how they decided whether or not to. Further rounds of recruitment relied on snowballing among informal and professional contacts of the research team and participants, which is also likely to have generated bias. There has been increased interest recently in sharing lived experiences of mental health difficulties, both within health care more widely, and clinical psychology training in particular (Dunlop et al., 2021; Kemp et al., 2020). This was perhaps reflected in who was recruited to the current study: all participants were deeply interested in the topic, valued disclosure and used it within their role as trainers. Attempts to recruit those that might hold different views through snowballing yielded no results. Sampling stopped after nine interviews as it was agreed that there was enough depth

and breadth within the data to allow an exploration of the processes and factors involved in disclosure decisions and for tentative conclusions to be drawn, within the parameters of the limitations described above. A criticism could be made that sampling in the current study did not reach theoretical saturation (Charmaz, 2014) or sufficiency (Dey, 1999) as it did not contain data from those with opposing positions on disclosure, although the model may be useful for those that do wish to consider disclosing.

Clinical and theoretical implications and directions for future research

Psychological distress among trainee clinical psychologists has been of increasing interest in recent years (Kemp et al., 2020). However, evidence regarding types and prevalence of distress, and the factors that influence coping and wellbeing has been lacking. Following the systematic review, training programmes can have an increased awareness of the types and levels of distress trainees may be experiencing and how these are impacted by factors such as personal and professional resources. Psychological distress, including mental health difficulties, stress and burnout should be understood as common and widespread among trainees, rather than rare and individualised. Increasing access to resources that support coping and wellbeing should be a priority. Nonetheless, it is important that training programmes note the limitations within the review. There was considerable heterogeneity and a lack of longitudinal studies, making it hard to compare findings across studies and to understand if findings are stable over time. Robust comparisons were rare: it is unclear if levels of trainee distress are high compared to normative groups and comparable population. There is scope for further, high quality investigations exploring distress in trainees and other learners within healthcare settings. Investigating different types of distress separately is indicated. By exploring stress, burnout and mental health difficulties as separate phenomenon, these concepts could be better delineated and defined.

Given the findings of the systematic review that many trainees experience high levels of psychological distress and find training stressful and demanding, it is indicted that that training programmes should implement measures to support trainees' coping and wellbeing. Within the studies included in the review, it was recommended that training programmes develop trainee skills in managing distress by offering formal training in self-care as a core part of the curriculum (Rummell, 2015; Zahniser et al., 2017). The search terms used within the review search strategy generated multiple recent studies of interventions designed to increase training wellbeing and coping, focusing mainly on third wave and mindfulness-based approaches (Dereix-Calonge et al., 2019; Pakenham, 2017; Pintado, 2019; Yela et al., 2020). A systematic review investigating these interventions and recommendation to decrease trainee distress and support wellbeing and coping may be timely.

Findings of the systematic review also suggest that training programmes should encourage trainers and trainees who feel comfortable doing so, to consider sharing personal experiences of psychological distress, with the aim of creating more open and supportive cultures and challenging narratives that can stigmatise those with lived experience of mental health difficulties. Trainers and trainees may need support to consider whether or not they feel comfortable sharing their experiences and how to do so appropriately and usefully. The empirical research presented here offers insights into the factors that trainers may find helpful to consider when sharing, and points to the importance of reflective spaces, self-reflection and supervision in making appropriate, ethical decisions. These findings add to a growing number of resources that may help trainees and well as trainers' decision-making around disclosure of lived experience. These resources include: the decision-making tool Conceal or Reveal (CORAL: Henderson, 2013), the training programme Honest, Open, Proud for Mental Health Professionals (HOP-MHP: Mills & Scior, 2017), in2gr8mentalhealth, a members only forum and mentoring service for mental health professionals with lived experience, and the

Sharing Lived Experience Framework (SLEF) for mental health professionals (Dunlop et al., 2021).

Although there are multiple resources available which could support trainers and trainees' decision making about disclosing psychological distress, none of them focus on training environments. Trainers' professional roles mean they have multiple concerns when they consider disclosure: they are supporting, evaluating and teaching trainees, but are also individuals within a workplace setting. The empirical study found that when deciding how, what and when to disclose, participants were considering both the impact on themselves and the impact on trainees: disclosure was simultaneously being used as a tool for the benefit of trainees and being experienced as an event that impacted trainers personally and professionally. Participants' intentions when disclosing were to benefit trainees: disclosures motivated by their own needs were perceived as inappropriate. These findings have parallels within the literature on decision-making within therapist self-disclosure to clients in therapy and the literature on decision-making in mental health and other concealable stigmatised identity disclosure in the workplace, but do not fully align with either. This may reflect the dual considerations of self and other within the current study: within the literature on therapist self-disclosure the focus is on the client; within the literature on mental health and concealable identity disclosure the focus is on the impact of disclosure on the individual disclosing. The six-factor framework within the current model is able to capture these dual concerns of self and other and as such may be particularly suitable for supporting decision making in the training environment. However, the limitations of the empirical research mean that trainers should be cautious in using the framework. More research is needed, especially when considering how disclosures are received by trainees and whether trainer intentions to be helpful and supportive are being borne out by the experiences of recipients.

Conclusion

Improving the mental health and wellbeing of the psychological workforce, including those in training, by creating open and supportive cultures, is becoming a national priority within the UK. Studies on learners within the healthcare professions have tended to focus the experiences of doctors, with less understanding of the factors and processes that affect other professionals, such as psychologists. This thesis portfolio contributed to the current research by synthesis data from studies on clinical and counselling trainees to understand the types and prevalence of distress and the factors that impact on coping. It also investigated the processes involved in the trainers on clinical psychology doctorate courses decision-making around disclosing to trainees. Findings suggested psychological distress was common and widespread among trainees and the disclosure might be a useful tool for normalising trainee distress and promoting disclosure and help-seeking. Further, that trainers should consider a six-factor model based around the criteria of “being safe” and considering “helpfulness” in order to make appropriate, useful and personally meaning decisions about disclosing to trainees. Limitations and areas for future research were discussed.

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