“Isn’t it mad that we’re all psychologists and we can't talk about our feelings?”: A mixed-methods study exploring trainee clinical psychologists’ experience of (non)disclosure of psychological distress during training

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Thesis Abstract

Background: Previous research exploring mental health difficulties and psychological distress among mental health providers, including (trainee) clinical psychologists, has highlighted, that a substantial proportion have lived experiences of distress. Despite this, they are least likely to disclose their experiences within their workplaces. Disclosure within the workplace may enable employers to make relevant adjustments and provide support, which they are legally obliged to do. However, for employees, disclosure may risk stigma, discrimination, and exclusion. Concealment of distress is linked to increased demoralisation, isolation, and depressive symptoms. Trainees also have dual roles in which they are required to cope with stressors, while developing knowledge and skills related to clinical work, adding additional demands and pressures on them.

Recent guidance from the British Psychological Society (2020) has highlighted that clinical psychologists have a responsibility for destigmatising mental health difficulties; this does not only extend to the stigma faced by service users, but also to the stigma experienced by colleagues, supervisees, and trainees. Within clinical psychology training, to date however, little research has explored trainee mental health and psychological distress disclosure experiences, including beliefs and assumptions related to disclosure and what responses trainees get from those they disclose to. This was considered important to explore, as it could inform how training programmes can support disclosure and appropriate responses, which do not inhibit further disclosure.

Aims: The current study aimed to explore 1) trainee clinical psychologists' experiences of disclosure and/or concealment of psychological distress during training, 2) what beliefs, assumptions or predictions decisions about disclosure are based on and 3) what response trainees got if they disclosed.

Method: A mixed-methods strategy was employed; 165 trainee or recently qualified clinical psychologists took part in an online survey. Thirteen of these were interviewed using purposeful sampling. Descriptive statistics and a reflexive thematic analysis, using an inductive-deductive approach, was used to analyse the quantitative and qualitative data, respectively.

Results: The sample across phase one and two largely consisted of participants who had disclosed distress. A range of distress experiences were described, most commonly anxiety and depression. Distress for some was exacerbated by the coronavirus pandemic, which also impacted disclosure opportunities. Six main themes were constructed: 1) Diagnostic or psychological conceptualisations 2) Worries about judgement complicate disclosure decisions; 3) Disclosure likelihood is determined by relationships; 4) Emotional support versus practical responses; 5) Desired changes that could increase disclosure; and 6) Legacies of disclosure experiences. Of these, four had subthemes.

Conclusions and recommendations: This study was largely consistent with previous disclosure literature within the workplace, however added a nuanced understanding to the complexities of disclosure for trainees. There is a need for programme staff to prioritise emotional support, increase permission giving, and enhance guidance on navigating disclosure. Training providers should seek to emphasise clarity of processes, possible actions, and outcomes of disclosure, support available, confidentiality and limits, consent, and choice. Further research that includes the other side of the dyad (those receiving disclosures), those who do not disclose, and those from underrepresented groups is required.

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Statement of Contribution

Systematic Review

The systematic review was designed by me, Aliya Zamir, with supervision from Dr Anna Tickle and Dr Rachel Sabin-Farrell. Relevant literature was reviewed by me, and data analysis was also conducted by me, with supervision from Dr Anna Tickle. Following submission to a peer-reviewed journal for publication, Dr Anna Tickle completed minor amendments to the paper. The final paper was reviewed by me and agreed with Dr Anna Tickle.

Journal Paper and Extended Paper

I, Aliya Zamir, declare this research is the product of my own original work conducted since I began the Trent Doctorate in Clinical Psychology training programme in 2019. The original idea was conceptualised and subsequently developed by myself and my supervisors: Dr Rachel Sabin-Farrell and Dr Anna Tickle. The idea was further developed following feedback from the submission of my research proposal to the Trent programme, by staff members Dr Mark Hudson and Professor Thomas Schröder. All supervisors provided regular guidance and supervision with all parts of the research project. I submitted ethics applications and completed amendments.

Small Scale Research Project

The small-scale research project was designed by me and Dr Sarah Wilde. Data was collected by Dr Sarah Wilde and analysed by me. Dr Dave Dawson provided additional supervision. Following feedback from Professor Thomas Schröder and Dr Hannah Merdian, the paper was further amended by me, with supervision from Dr Sarah Wilde.

SYSTEMATIC LITERATURE REVIEW

A systematic review of the evidence relating to disclosure of psychological distress by mental health professionals within the workplace

Systematic review; distress disclosure

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Abstract

Objective: To systematically review evidence regarding prevalence and choices of disclosure of psychological distress, by mental health professionals within the workplace.

Method: Six databases were searched in June 2020. Studies were included if they were published in English language and included empirical quantitative, qualitative or mixed-methods data. Studies were excluded if they focused on general healthcare professionals or the general population, or on stress or physical health problems. Study quality was assessed using the Mixed Methods Quality Appraisal tool.

Results: Nine studies, with a total of 1891 participants, were included. Study quality varied, with studies generally reporting descriptive surveys using hypothetical disclosure scenarios. Distress was often conceptualised in psychiatric terms. These limitations mean conclusions should be treated with caution. Individuals were less likely to disclose in work and had negative experiences of doing so compared to social circles. Fear of stigma inhibited disclosure. There were differing levels of disclosure relating to recipient, trust, quality of supervision, how distress was conceptualised, and type of problem. Disclosure was experienced by some as valuable.

Conclusion: There is a need for further research, which addresses the nuanced complexities surrounding disclosure choices for mental health professionals.

Keywords: disclosure, mental health professionals, psychological distress, workplace, stigma

Introduction

Disclosure has been defined as an interaction between two individuals in which one shares personal information about themselves to the other person (Greene et al., 2006). Models of disclosure suggest that decision-making involves coping with dialectical dilemmas and weighing up the risks and benefits of disclosure (e.g., Disclosure Decision-Making Model [DD-MM], Greene et al., 2006; Petronio, 2003). Disclosure of stigmatised identities (e.g., mental health problems [MHPs]) or ‘mental’ distress at work, is a complex decision. It may be beneficial and enable individuals to seek care, gain adjustments and support (Brohan et al., 2014; Corrigan et al., 2016), however, it may also risk stigma and discrimination (Peterson et al., 2011). Whilst employers are prohibited from discriminating against individuals who are experiencing MHPs under the UK Equality Act 2010 and the Americans with Disabilities Act 1990, not all individuals who are distressed may describe their distress in terms of ‘mental impairment’ (Irvine, 2011), as defined by this legislation, thus leaving them unprotected from disability discrimination. Employers are also only able to make adjustment if the ‘impairment’ is known to them. As such, individuals experiencing distress may need to carefully consider their disclosure choices.

Literature on disclosure often uses psychiatric language in defining and understanding human distress which is reflective of the dominance of the ‘medical model’ (Johnstone, 2014). However, this reduces human suffering to categories and symptoms, lacking acknowledgement of the wider social, cultural, political and psychological influences on human distress (Johnstone & Boyle, 2018). The way in which mental health (MH) is conceptualised, indeed, may also impact upon disclosure prevalence and choices (Cvetovac & Adame, 2017; Irvine, 2011), therefore inclusion of studies that use both medicalised (e.g., MHPs/ diagnoses) and non-medicalised (emotional/ psychological distress) terms is important within this review. The review is also focused on psychological distress generally and not only when considered an ‘impairment’ in terms of disability legislation.

A disclosure model which specifically aims to explain decision-making processes among people with concealable stigmatised identities is the Disclosure Processes Model (DPM) (Chaudoir & Fisher, 2010). The DPM highlights five main components of the disclosure process including antecedent goals, the disclosure event, mediating processes, outcomes, and a feedback loop. The model posits that approach versus avoidance motivations may underlie disclosure behaviours. Whilst the DPM provides a more holistic account of disclosure processes than the DD-MM by including mediating mechanisms, it draws on wide-ranging literature on stigmatised identities, such as sexuality, which may limit its applicability to the processes and functions of disclosures relating to mental health.

Much of the research on MH stigma and disclosure in the workplace has focussed on the general population (Brohan et al., 2014; Brohan et al., 2012; Toth & Dewa, 2014), however MH professionals are just as likely, if not more, to have lived experiences of distress and/ or MHPs (Brooks et al., 2002; Elliott & Guy, 1993). Indeed, MH professionals with experiences of adversity and distress may be more drawn to pursuing a career in MH (Aina, 2015). Working in MH also risks greater exposure to trauma narratives which may exacerbate MHPs and distress (Engle et al., 2017). A previous systematic review on workplace disclosure within the general population suggests that reasons for non-disclosure at work were fears or experiences of discrimination and stigma, and reasons for disclosure were related to gaining support and adjustments, and being a ‘role model’ for others (Brohan et al., 2012). Among MH professionals, levels of disclosure at work has been found to be related to recipient type, type of MHP and whether difficulties are current or historic (Grice et al., 2018). However, this study focussed on hypothetical disclosures and MHPs, which may not necessarily reflect actual disclosure choices or experiences. Fear of stigma and negative impact on career are also commonly reported factors that prevent MH professionals from disclosing their difficulties at work (Somers et al., 2014; Tay et al., 2018).

One of the reasons disclosure decisions are complex for MH professionals is because they are bound by ethical guidelines regarding their ability to practice safely. Taking psychologists as an example, the American Psychological Society Code of Ethics (2017) includes Principle A: Beneficence and Nonmaleficence, which states “Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (APA, 2017, p. 3). Furthermore, the same code’s section on ‘competence’ includes a requirement that when psychologists “become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, including determining whether they should limit, suspend, or terminate their work-related duties” (p. 5). Similarly, psychologists in the UK are required by the Health and Care Professions Council (HCPC) to “make changes to how you practise, or stop practising, if your physical or mental health may affect your performance or judgement or put others at risk for any other reason” (HCPC, 2016, p. 8). While such ethical principles are imperative, it is possible that they may influence disclosure due to concerns that others may deem mental distress as automatically implying a need to significantly change or cease practice.

Stigma is a complex process and occurs when a specific attribute is considered as deeply discrediting within society (Goffman, 1963). It enables a range of social inequalities and discrimination to occur (Parker & Aggleton, 2003), and is evident within structural frameworks of society (Feldman & Crandall, 2007). People may internalise stigma and this can diminish one’s sense of self and identity, causing psychological harm (Corrigan et al., 2008). Whilst national efforts to reduce the stigma of MHPs have progressed (e.g., Time to Change, 2008) and have shown positive effects (Evans-Lacko et al., 2014), there is evidence to suggest that people with MHPs are continually stigmatised within societies (Cunningham et al., 2016; Roskar et al., 2017). Having the opportunity to disclose if desired is important, as concealing difficulties may impact identity integration (Richards et al., 2016), and increase low mood, isolation, demoralisation, feelings of shame and of being different (Link et al., 2001). de Hooge et al. (2010) suggest that shame may activate both approach and avoid behaviours, thereby impacting disclosure choices. Approach behaviours act to restore the threatened self and avoid behaviours serve to protect the self from further damage. Concealing MHPs can also cause strain and emotional stress, which may exacerbate MHPs (Keith, 2013), whereas enabling disclosure opportunities may enable access to support, adjustments, and improve well-being (Frattaroli, 2006). Given the complex structures surroundings disclosure and the lack of research among MH providers, research within this population is important.

There is a growing body of work and interventions that aim to promote open discussions about MH disclosure and choices in the workplace (e.g., Honest Open Proud (HOP) programme) (Corrigan et al., 2013). Whilst this programme is a step towards encouraging discussions around disclosure, it focuses upon the general population and self-stigma specifically. The HOP programme has been adapted for

MH professionals by University College London (UCL) (Scior, 2017). As well as disclosure decision-making, this project aims to encourage open conversations within the MH professions about stigma and lived experience of MHPs, aiming to in turn tackle the ‘us and them’ dichotomy, where professionals may be seen as relatively powerful and clients relatively powerless (Richards et al., 2016).

It is possible that the coronavirus (COVID-19) pandemic may also lead to changes in disclosure of distress by MH professionals, as the consequent additional pressure on their mental health is recognised (e.g., Joshi & Sharma, 2020; Kar & Singh, 2020). Studies specifically about disclosure by MH professionals in the workplace, in the context of COVID-19 are not yet available. However, Billings et al. (2021) found that their sample of 28 MH professionals supporting frontline health and social care workers during COVID-19, reported working in isolation, with blurred boundaries and anxiety. However nearly all subjugated their own mental health needs, in part because of guilt about prioritising their own needs. Many laughed when asked what support they had put in place for their own mental health needs and all, but one said they had not considered seeking help for their own distress. Although help-seeking is not completely interchangeable with disclosure, these findings hint at an absence of disclosure by MH professionals, even in a context of widely recognised and increased mental health needs.

Notwithstanding the ongoing efforts to reduce stigma and promote open discussions about disclosure, a detailed systematic review which provides a critical appraisal of the literature has not yet been conducted. Given that much of the previous literature has focussed on the general population, MH disclosure prevalence and choices within the MH professions remain unclear. Much of the previous literature also focusses on psychiatric conditions and it is of importance to include studies that focus on both psychological distress and psychiatric diagnoses within the current review. The current review aims to synthesise and critically appraise the literature on the prevalence and choices related to MH disclosure among MH professionals within the workplace.

Aims

The aims of the current review were to systematically identify, appraise the quality of, and synthesise the evidence regarding:

- The prevalence of disclosure of psychological distress and/ or MHPs among MH professionals within the workplace
- How MH professionals respond to disclosure of psychological distress and/ or MHPs within the workplace
- The choices related to disclosure or nondisclosure of MHPs and/ or distress in the workplace

Methods

Design

This review largely followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). While they are relevant for mixed-methods reviews, the PRISMA guidelines state that guidelines for the synthesis of qualitative data should also be consulted. The PRISMA guidelines require assessment of “risk of bias”, rather than broader ‘quality assessment’ or ‘critical appraisal’. However, despite debates and a range of approaches to conducting it (Garside, 2014), quality appraisal is a standard feature of qualitative systematic reviews and was therefore undertaken rather than a narrower assessment of risk of bias.

A critical realist epistemological position was adopted, which acknowledges the existence of an observable reality but views reality as constructed through our individual standpoints, privileges, meanings, social contexts and perceptions (Creswell & Plano Clark, 2011). The authors acknowledge that their own positions, experiences, and biases may shape interpretations of the findings. The first author (A.Z.) is a trainee clinical psychologist and has worked in both private and public mental health sectors. The author noticed differing responses to workplace disclosures of distress by colleagues and supervisors. The second and third authors are clinical psychologists who work within clinical settings and clinical psychology training and have supervisory and management roles, in which they may receive disclosures of distress. The first author kept a reflective diary throughout the review process and discussions between the three authors were used to check and manage biases in interpretations of the results.

Search strategy

Articles were searched for in PsycInfo, MEDLINE, EMBASE, Web of Science, Grey Literature and ProQuest Dissertations and Theses in June 2020. Including grey literature was important to allow for inclusion of unpublished studies and developments within the field, which may otherwise have been missed. These databases were selected because they were most relevant to the topic of interest in the current review. It was beyond the scope of this review to include all MH diagnoses search terms. Anxiety, depression and schizophrenia were most commonly used within previous MH disclosure literature (Brohan et al., 2012; Grice et al., 2018), therefore these terms were included over other diagnoses. In addition, terms such as ‘emotional distress’ and ‘psychological distress’ were included within the search strategy, so that relevant studies were not excluded. The term ‘impairment’ was not included because the term offers protection against discrimination under disability legislation in both the UK (Equality Act, 2010) and the USA (Americans with Disabilities Act, 1990). Although such legislative protection cannot eliminate discrimination, it may influence the likelihood of disclosure for individuals who describe their distress in terms of ‘impairment’ and ‘disability’, compared to those who do not, as well as the likely responses of employers. Given the interest in broader conceptualisations of psychological distress, ‘impairment’ was not included.

The search terms used in PsycInfo are outlined in Table 1. These terms were tailored for each database to ensure suitability in relation to database-specific thesaurus terms. A published date limit was not applied to ensure that relevant studies were not excluded. The terms were combined using the Boolean terms 'OR' and 'AND' to search for studies including all three disclosure, MH professionals in workplace and MHPs related terms.

Table 1

Literature review search terms

Disclosure	Mental health professionals within workplace context	Distress / MHPs
disclos*	"mental health" adj2 clinician* OR	psychological distress
conceal*	worker* OR therapist* OR personnel*	emotional adj2 distress* OR difficult* OR
nondisclos*	OR practitioner* OR nurse*	problem* OR suffering* OR disorder*
secrecy	counselor*	psych* adj2 illness* OR disorder OR
self-disclosure	counsellor*	diagnos* OR problem* OR disabilit*
	psycholog*	"mental health" adj2 problem* OR difficult*
	psychiatr*	OR disabilit* OR disorder* OR issue*
	occupation*	mental disorder*
	job	mental illness*
	employ*	anxiety
	work	depress*
	workplace	schizophren*

Studies were selected based on the following criteria:

Studies were included if they:

- Related to the prevalence of disclosure of psychological distress or MHPs among MH professionals within the workplace
- Related to how MH professionals respond to disclosure of psychological distress or MHPs within the workplace
- Focussed on the choices related to disclosure or nondisclosure of MHPs or distress in the workplace
- Related to workplace contexts (paid, voluntary, part-time, full-time, private, and public sector)
- Included empirical data (quantitative or qualitative)
- Included data about MH professionals that could be independently extracted from datasets including other groups
- Were published in English

Studies were excluded if they:

- Did not focus on disclosure within a workplace context
- Focussed on general healthcare professionals or the general population
- Focussed on stress or physical health problems

Studies relating to both hypothetical and actual disclosure/ nondisclosures were included within the search. Whilst it is not clear how much actual and hypothetical disclosures may vary (Bell et al., 2011), excluding studies relating to hypothetical disclosures may have resulted in losing relevant data on disclosure choices among MH professionals. One study, which specifically used the terminology ‘help-seeking’ was included because it appeared to use this interchangeably with ‘disclosure’ (4). Furthermore, to seek help one is required to disclose their difficulties (Pederson & Vogel, 2007) therefore this study was judged as relevant and included within the review.

Data abstraction and synthesis

Information relating to study characteristics, including lived experiences of distress /MHPs (if reported), prevalence of disclosure, and choices related to disclosure or nondisclosure was abstracted for all studies by first author A.Z. A meta-analysis was not suitable for the quantitative studies within this review due to the descriptive nature of studies and the heterogeneity of outcome measures and participants (Boland et al., 2017). For qualitative studies, all text related to disclosure prevalence or choices was extracted and analysed using thematic synthesis (Thomas & Harden, 2008). First data pertaining to prevalence and choices were coded into ‘free codes’ and then into ‘descriptive’ themes. Similarities and differences between codes were identified and ‘analytic’ themes, were developed by A.Z. The analytical themes were discussed and reviewed with the wider research team. For the one mixed-methods study, both the quantitative and qualitive data was extracted and analysed according to the description above.

Quotations from the reviewed studies are included in the results section to illustrate the themes. However, it is acknowledged that the present authors cannot determine the criteria the original authors used to determine which quotes they included from their dataset.

Quality appraisal

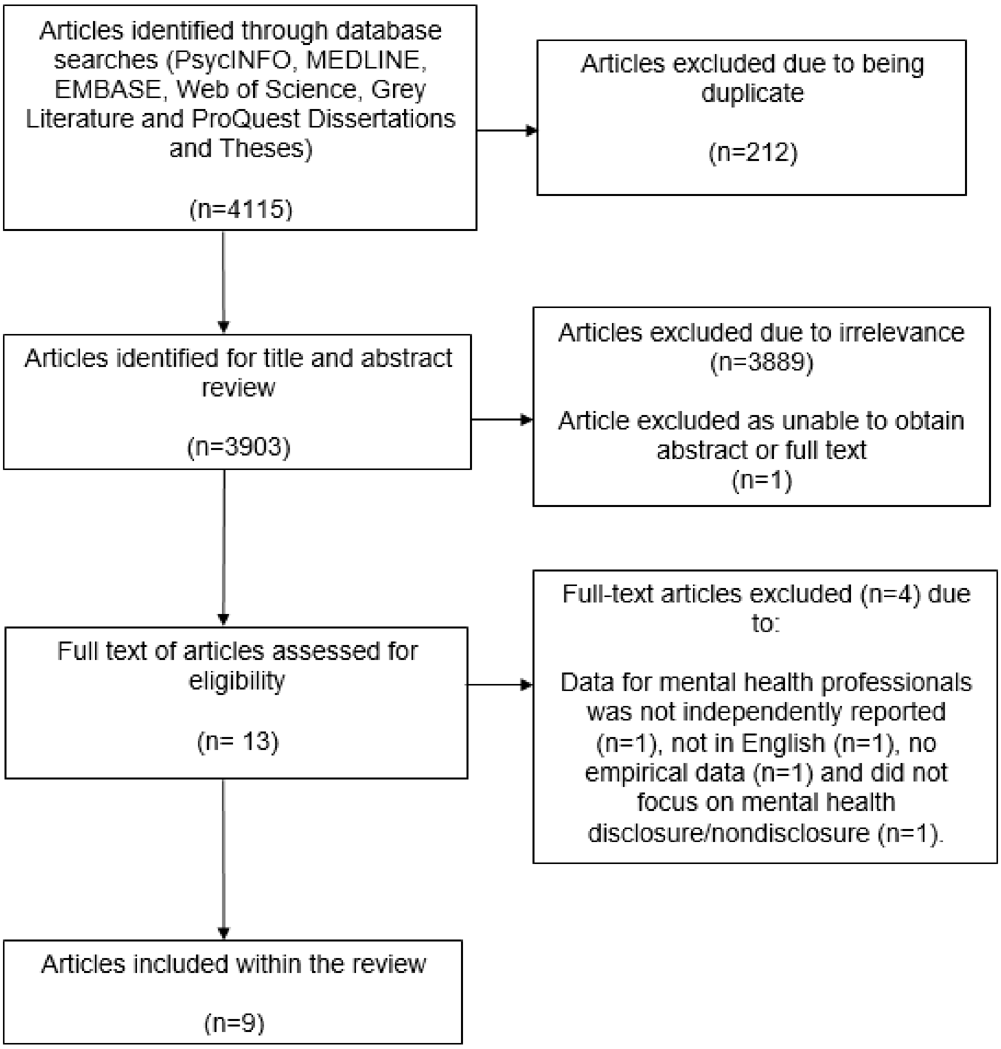
A range of tools and checklists are available to appraise the quality of qualitative research, but given the review included both qualitative and quantitative studies, the quality of studies was appraised using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). The MMAT has good validity and reliability (Pace et al., 2012; Pluye et al., 2009). The five subsections of the MMAT each provide quality appraisal statements for quantitative studies (randomised control trials, non-randomised comparative studies, and descriptive studies), qualitative studies and mixed-methods studies. For the current review, the 'descriptive' subsection for the quantitative studies was used, as well as the qualitative and mixed-methods subsections.

Results

The database searches yielded 4115 results. A total of 212 titles were excluded due to being duplicate and 3889 due to irrelevance. The library and author were contacted for the one article where the full text could not be obtained. The paper copy of the study was locked at their university library and inaccessible due to COVID-19. There was no electronic copy available. A total of nine studies were included in the review after reviewing against the eligibility criteria. Figure 1, based on the PRISMA (Page et al., 2020) below summarises the selection process.

Figure 1

PRISMA Flow Diagram



General characteristics

Table 2 outlines the characteristics of all studies. Six were quantitative (4, 5, 6, 7, 8, 9), two were qualitative (2, 3) and one used a mixed-methods approach (1). The total number of participants across the quantitative studies was 1891. The total sample within the qualitative studies was 22, and the mixed-methods study had a sample of 77. This resulted in an overall sample of 1990 across all the studies. Two of the nine studies were conducted in the UK (5, 8), five in the USA (1, 2, 3, 7, 9), one in Canada (6) and one in Australia (4). MH professionals within samples included MH nurses, psychiatrists, clinical psychologists, psychotherapists, and psychology faculty staff. The current review focused on MH professionals, rather than students, who may have different issues around disclosure compared to practicing professionals. No exclusion criteria were included as it was assumed that the search terms would identify MH professionals rather than student-specific studies. However, it is important to note that one study (4) included students (approximately 30% (N=31) of the total sample (N=98)). It was not possible to separately extract data relating to students vs. qualified professionals and, on balance, it seemed more important to include the study results in this review than to exclude the views of the majority proportion of practicing MH professionals. It is also noteworthy that another study (5) focused on UK trainee clinical psychologists. Although in a training position, this group hold a dual identity of student and employed, salaried MH professional and thus was included.

Two studies were related to recipients of disclosure (7, 9), whereas all others were related to disclosure/nondisclosure by MH professionals. Most of the studies also included data on lived experiences of MHPs within their samples. Of the quantitative studies, three focussed upon hypothetical disclosure (4, 5, 6) and two on disclosure recipients and their responses to hypothetical disclosures (7, 9). The remaining quantitative study (8), the two qualitative studies (2, 3) and the mixed-methods study (1) all focussed on actual disclosure experiences. All studies used either survey methods of data collection or a fictional vignette. Apart from one study (2) all were published within the last ten years.

Table 2

Summary of articles included in the review

Author(s), Year Location	Aims	Sample characteristics **Recruitment/ sampling**	Methodology	Disclosure context	Summary of key findings
1. Boyd et al. (2016) USA	To document lived experience, investigate commonality of disclosure to patients and colleagues and what advice would be given to colleagues with MHPs	MH professionals (psychology (50%), nursing (12%), social work (29%) and other (9%)). **Sample size** (N=77) **Age range** N.R. **Gender** N.R. **Ethnicity** N.R. Recruited via email to Veteran Health Administrations groups Purposive sampling method	**Mixed methods** Questionnaires **Analysis** Descriptive statistics, exploratory analysis, and manual descriptive coding	Actual disclosure experiences of MHPs	**Lived experience** Majority reported PTSD, anxiety disorders, depression, bipolar disorder, and psychosis, however exact prevalence N.R. **Prevalence of disclosure** 31% did not disclose to colleagues 16% had disclosed to colleagues People with bipolar disorder had disclosed to a larger number of colleagues than other diagnoses. **Choices related to disclosure or nondisclosure** 11% of sample advised against disclosing MHPs based on their experiences and 36% reported to be cautious about disclosing. One theme in relation to this was punishment, discrimination, and cruelty (18%) and that stigma still existed. Participants also made comments such as ‘we are evidence of recovery’ and shared hope and strengths in relation to their experiences of MHPs and disclosure.

2. Cain (2000) USA	To explore the professional experiences of psychotherapists who have histories of psychiatric hospitalization.	Psychotherapists **Sample size** (N=10) **Age range** 32 to 57 years **Gender** Female (N=7) Male (N=3) **Ethnicity** All White background Recruited using non-probability purposive and snowball sampling methods	**Qualitative** Semi-structured interviews and demographic questionnaire **Analysis** Thematic analysis	Actual experiences of disclosure/ non-disclosure of a psychiatric diagnosis/ hospitalisation and the impact within the workplace	**Lived experience** Primary diagnoses across sample varied, with some having accumulated several diagnoses along the way, however all had experienced MHP(s) at some point in their lives. **Prevalence of disclosure** Most participants disclosed to colleagues later in their careers. Participants were likely to disclose selectively, and some had never disclosed to anyone at work. **Choices related to disclosure or nondisclosure** Quality of supervision was related to whether someone had disclosed a MHP and/or hospitalisation. Those who disclosed judged their supervisors to be supportive and provide safety. Those who did not disclose, stigma was the main barrier to disclosure and individuals reported a lack of beneficial or quality supervision. All participants reported that the stigma of mental illness was perpetuated within the MH system and for some this hindered their advancement in the profession.

3. Cvetovac and Adame (2017) USA	To explore the various meanings of personal distress and how they relate to one’s relationships, family, and career	Psychotherapists **Sample size** (N=11) **Age range** N.R. **Gender** Female (N=9) Male (N=2) **Ethnicity** N.R.	**Qualitative** Published first person accounts **Analysis** Narrative	Actual disclosure experiences of emotional distress and psychiatric treatment	**Lived experience** All had experienced MHPs at some point in their lives. **Prevalence of disclosure** Varying levels of disclosure across sample. Exact levels N.R. **Choices related to disclosure or nondisclosure** All reported fear of stigma and professional repercussions related to disclosure. Themes related to concealment; loss of clinical privileges; being judged as incompetent by supervisors and colleagues. Conflict between desire to open up and being torn about disclosure was common. Some reported positive experiences of disclosing to a colleague or supervisor e.g., it aided capacity to self-reflect and prevented individuals from becoming overwhelmed by their distress.
4. Edwards and Crisp (2017) Australia	To investigate perceived barriers to disclosure and help-seeking among MH professionals	MH professionals (student, N=31, qualified, N=67). Psychologists (69.2%) Other (30.8%) **Sample size** (N=98) **Age range** N.R. **Gender** Females (N=82) Males (N=16) **Ethnicity** N.R. Recruited via snowball and purposive sampling methods	**Quantitative** Questionnaires **Analysis** Descriptive statistics	Anticipated disclosure/ barriers to help-seeking	**Lived experience** 40.8% reported experiencing MHPs at some point in their lives **Prevalence of disclosure** 64.3% reported that mandatory reporting requirements would prevent them from disclosing to their workplace if they were unwell; 57.1% reported that mandatory reporting requirement would also act as a barrier to seeking help if they were distressed. **Choices related to disclosure or nondisclosure** Participants reported that they would prefer to get help from friends/family. Concerns related to what people would say at work, embarrassment, and shame. 18.6% reported a barrier of not wanting a MHP on their medical records.

5. Grice, Alcock and Scior (2018) UK	To investigate the incidence of MHPs amongst trainees and to understand some of the mechanisms that may underlie their decisions about disclosure.	Trainee Clinical Psychologists **Sample size** (N=348) **Age range** N.R. **Gender** Female (N=299) Male (N=49) **Ethnicity** N.R. Recruited via email to 19 UK DClinPsy training course directors Purposive sampling method	**Quantitative** Questionnaires **Analysis** Exploratory factor analysis Multilevel linear model analysis	Anticipated disclosure of hypothetical MHPs Anticipated disclosure of actual lived experiences	**Lived experience** 67% reported experiencing at least one MHP. Anxiety (43%) and depression (39%) were most reported. **Prevalence of disclosure** Disclosure likelihood varied depending on disclosure recipient. Participants were least likely to disclose a hypothetical MHP to a placement supervisor or course staff member. CS*: Sup (-1.53 (MD), -1.68 (Schi), -1.83 (SF), course staff (-1.20 (MD), -1.32 (Schi), -1.84 (SF). Participants were more likely to disclose a current MHP, than a past one CS*: 0.23 (MD), 0.35 (Schi), 0.17 (SF), despite anticipating greater stigma with the former. For individuals with lived experiences of anxiety and depression, they were least likely to disclose these to placement supervisors and course staff. **Choices related to disclosure or nondisclosure** Participants with high levels of maladaptive perfectionism were less likely to disclose a MHP. CS*: -0.03 (MD), -0.03 (Schi), -0.43 (SF). People who indicated high levels of anticipated stigma with a past MHP were less likely to disclose a MHP. CS*: -0.02 (MD), -0.03 (Schi), -0.02 (SF).

6. Hassan et al. (2013) Canada	To assess the attitudes of psychiatrists towards preference for disclosure and treatment, should they develop a mental illness in addition to their own experience of mental illness.	Psychiatrists **Sample size** (N=487) **Age range** N.R. **Gender** N.R. **Ethnicity** N.R. Recruited via mailing list of CoP and Surgeons of Ontario Purposive sampling method	**Quantitative** Questionnaires **Analysis** Descriptive statistics	Anticipated disclosure of MHPs	**Lived experience** 31% reported experiencing a past or current MHP. **Prevalence of disclosure** 11.1% would disclose to a colleague and 41.9% would disclose to family **Choices related to disclosure or nondisclosure** Most important factors related to nondisclosure was commonly reported as 'career implications' (34.5%), followed by stigma (23.4%) and professional standing (16.4%)
7. Schroeder et al. (2015) USA	To assess psychologists' responses to a hypothetical situation in which they learn that a MH colleague is seeking personal therapy.	Psychologists **Sample size** (N=96) **Age range** N.R. **Gender** Female (N=35) Male (N=61) **Ethnicity** White (92.7%) Recruited via email using online listing of practising psychologists Purposive sampling method	**Quantitative** Vignette Questionnaire **Analysis** Descriptive and inferential statistics	Psychologists' reactions to fictional vignette with four conditions where colleague discloses; psychotherapy (no disorder specified; psychotherapy for bipolar disorder; psychotherapy for major depressive disorder and control (no psychotherapy/ disorder stated).	**Lived experience** N/A **Prevalence of disclosure** N/A **Choices related to disclosure or nondisclosure** Psychologists would continue to refer clients to a colleague who discloses being in personal therapy for MH disorders (depression and bipolar disorder), about as often to a colleague who mentions no disorder/ psychotherapy at all. Differences between means did not differ significantly. Referral rate change: (F (3, 91) = 2.40, *p*= *.073*), referral rate delay: (F (3, 89) = .57, *p*= *.639*)

8. Tay et al. (2018) UK	To assess the extent to which clinical psychologists report experience of self-defined MHPs, their views on disclosure and help-seeking, and to what extent stigma may affect disclosure and seeking help in relation to MHPs they experience themselves.	Qualified clinical psychologists **Sample size** (N=678) **Age range** Majority (84.2%) 30 to 50 years **Gender** Female (N=557) Male (N=121) **Ethnicity** White background (91.6%) Recruited via BPS, DCP mailing list. Purposive sampling method	**Quantitative** Questionnaires **Analysis** Descriptive and inferential statistics	Views about disclosure and actual disclosures of MHPs	**Lived experience** 62.7% reported experiencing one or more MHP. **Prevalence of disclosure** Participants most likely to disclose to family (68.2%) than within the workplace (44.5%) (χ^2 (1) = 26.22*). Most negative experiences of disclosing were to employers. 10.8% had not disclosed to anyone. **Choices related to disclosure or nondisclosure** Fear of judgement (71.7%), negative impact on career (67.4%) and shame (47.8%) were reported to be the main factors which prevented participants from disclosing MHPs. Those who had not disclosed to anyone showed higher levels of self-stigma (M= 21.860, SD = 6.462) than those who had disclosed at work (M= 17.414, SD = 5.571), d = 0.737).

9. Zold et al. (2020) USA	To explore faculty members' attitudes toward student disclosures of a history of MH concerns and psychotherapy use in application materials.	Faculty staff: Assistant Professor (28.3%); Associate Professor (37.0%); Full Professor (32.6%); and Other (2.2%), involved in evaluating student applicants for graduate doctoral programmes in clinical and/or counselling psychology. **Sample size** (N=184) **Age range** 30 to 72 years **Gender** Female (N=99) Male (N=85) **Ethnicity** White (91.7%) African American (3.9%) Hispanic/Latin(x) (1.1%) Asian (1.7%) Mixed ethnic background (1.7%) Recruited via email to faculty programmes. Purposive sampling method	**Quantitative** Vignette of fictional student applicant Questionnaires/rating scales **Analysis** Descriptive and inferential statistics	MH professionals receiving disclosure Disclosure of depression and/ or psychotherapy by a fictional applicant	**Lived experience** Fictional applicants disclosing either depression and/ or psychotherapy **Prevalence of disclosure** 69.8% of staff recommended against disclosing experiences of depression in applications; 64% recommended against disclosing experiences of psychotherapy. Staff from counselling programs and scholar-practitioner programs were more likely to report that applicants should disclose a history of depression in their application materials. There were no differences in the degree to which faculty recommended disclosing depression or psychotherapy use histories (χ^2 = 1.31, p=.25) **Choices related to disclosure or nondisclosure** Faculty members were less likely to accept an applicant who disclosed a history of depression, despite those applicants being rated as equally suited and likely to succeed. Acceptability: R=42, F (6, 113) 3.78, *p.=.01*, Suitability: R=39, F (6, 113) 3.11, *p=.01,* Likelihood of success: R=26, F (6, 112) 1.38, *p=.25*.

Note: Only data pertinent to review aims extracted
PTSD: post-traumatic stress disorder, MD: major depression, Schi: Schizophrenia, SF: specific phobia N.R: not reported, MH: mental health, MHPs: mental health problems, N/A: not applicable, BPS: British Psychological Society, DCP: Division of Clinical Psychology, DClinPsy: Doctorate of Clinical Psychology, CoP: College of Physicians, Sup: supervisor, CS: correlation strength, * = significant at p < .001

Quality appraisal results

Table 3 summaries the quality appraisal of all studies using the MMAT quality criteria. All nine studies reported on clear research aims/ questions and the data collected was appropriate to address the research questions and aims. However, none of the studies drew on existing models of disclosure or relevant psychological theories.

Quantitative studies (including the quantitative aspect of the mixed-methods study)

Studies 4, 5, 6, 7, 8 and 9 used non-probabilistic sampling strategies (purposive sampling) to address the research questions. One study additionally used snowball sampling method (4). A further study used a convenience sample (1). It was not possible to determine the representativeness of the sample for three studies (4, 5, 6) as the demographics and inclusion/exclusion criterion was not clear or present, or because the reasons why people did not respond or the differences between responders and non-responders were not known. Three studies (7, 8, 9) were judged to have a representative sample as the sample appeared broadly in line with the demographics of that population. The mixed-methods study (1) was judged to have a non-representative sample as the sample was sought from a pre-existing group of MH professionals and the author stated it was not representative.

Most studies used purposefully developed disclosure measures which appeared appropriate for the research aims and questions. Studies used single item questions (1, 4, 6, 7, 9) or Likert scales (5, 8). Four studies (4, 5, 8, 9) used validated measures relating to pre-established variables of interest e.g., concealment, stigma, or barriers to help-seeking. One study did not state a response rate (1), one study stopped collecting data at the point it met their power calculation (9) and the remainder of studies had response rates of less than 40%.

Qualitative studies (including the qualitative aspect of the mixed-method study)

All studies used sources of data (participants and recruitment settings) which addressed their research questions and aims and the approaches to data collection were relevant and appropriate. One study did not discuss their findings in relation to the context clearly (2) however the other two studies clearly discussed their findings in relation to the context. One study briefly mentioned their own subjective biases and its implication on the findings and interpretations of results (3). The other two studies did not mention how the author’s biases may have influenced the interpretations of findings.

Table 3

Mixed Methods Quality Appraisal

	Study number						Comments
Quality Criteria (Quantitative studies)	**4**	**5**	**6**	**7**	**8**	**9**	
1. Is the sampling strategy relevant to address the question?	Yes	Yes	Yes	Yes	Yes	Yes	All sampling strategies were appropriate
2. Is the sample representative of the target population?	CT	CT	CT	Yes	Yes	Yes	Representativeness of samples for half of the studies was unclear
3. Are the measurements appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	All studies used purpose developed measures for variables of interest
4. Is the risk of nonresponse bias low?	No	No	No	No	No	No	There were low response rates across all studies or reasons for nonresponse were not discussed
5. Is the statistical analysis appropriate to answer the research question?	Yes	Yes	Yes	Yes	Yes	Yes	Appropriate descriptive and/or inferential statistics generally used
Quality Criteria (Qualitative studies)	**2**	**3**					
1. Is the qualitative approach appropriate to answer the research question?	Yes	Yes					
2. Are the qualitative data collection methods adequate to address the research question?	Yes	Yes					
3. Are the findings adequately derived from the data?	Yes	Yes					Findings appeared to be logically derived
4. Is the interpretation of results sufficiently substantiated by data?	Yes	Yes					Direct quotes used in both
5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?	Yes	Yes					
Quality Criteria (Mixed methods study)	**1**						
1. Is there an adequate rationale for using a mixed methods design to address the research question?	Yes						
2. Are the different components of the study effectively integrated to answer the research question?	Yes						
3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes						
4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes						No divergences or inconsistencies apparent
5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	No						The sample was unrepresentative

Note: CT: Cannot tell

Synthesis of quantitative data

Lived experience

Studies 4, 5, 6 and 8 reported on the prevalence of MHPs or distress within their samples. Prevalence rates of current or past MHPs within the samples were 40.8% (4), 67% (5), 31% (6) and 67% (8). Studies 4 and 6 reported on future hypothetical likelihood of disclosure of distress. Study 5 reported on hypothetical disclosure of hypothetical MHPs (schizophrenia, depression, and specific phobia) and additionally hypothetical disclosure of lived experiences of anxiety and depression by those who had reported these difficulties. Within the study that investigated actual disclosure (8), MHPs commonly reported were anxiety, depression, phobias, and post-traumatic stress disorder. Interestingly, the study that reported lowest levels of MHPs had a sample of all psychiatrists (6), and the one with the highest had a sample of all psychologists (5). Within the two studies that focussed on recipients of disclosure (7, 9), the fictional applicant/ colleague was reported to disclose psychotherapy and/ or depression or bipolar disorder. The mixed methods study did not outline a specific level of prevalence of MHPs however stated that ‘most’ of their sample had lived experiences of MHPs.

Prevalence of disclosure

One study which focussed on hypothetical likelihood of disclosure (5), reported that recipient type was correlated with likelihood of disclosure. A further three studies on hypothetical disclosure reported that MH professionals would be more likely to disclose MHPs within their social circles, than their work circles (4, 6, 7). One study that focused on actual disclosure, reported that 37.9% of participants had disclosed their MHPs to colleagues or peers, and 25.6% to employers (8). Participants reported greater negative experiences of disclosing to employers, than to family/friends (8). Over half of the sample within this study had over 10 years of experience post qualification (54.3%). Another study which discussed hypothetical disclosure, reported that the Australian Health Practitioner Regulation Agency (AHPRA) mandatory reporting requirement, in which the agency need to be made aware if any practitioner is experiencing a MHP that may impact adversely on their practice, would prevent them from disclosing distress to their workplace if they were unwell (64.3%), and this would also act as a barrier to seeking help (57.1%) if they were distressed. It is difficult to make inferences on the general likelihood of disclosure for this study, as disclosure prevalence was not reported independently from the AHPRA mandatory requirement.

Choices related to disclosure or nondisclosure

From the studies that discussed hypothetical disclosures (4, 5, 6), fear of stigma and negative career implications were consistently reported as reasons for likely nondisclosure of MHPs. For actual disclosures participants reported that they had experienced stigma, exclusion, and discrimination and disclosure had a negative impact on their careers (1, 8). For participants with lived experiences, embarrassment, shame and being viewed as 'weak' was reported to prevent them from disclosing (1, 8). Participants who had not disclosed to anyone showed higher levels of self-stigma, than those who had disclosed (8). Study 5 showed similar results where high levels of self-stigma was associated with low levels of anticipated disclosure at work (5). Participants within this study were all trainee clinical psychologists, undertaking a doctoral psychology training programme.

Likelihood of disclosure of a current MHP was greater than that of a past one, despite their being greater anticipated stigma for the former (5). Participants reported higher levels of stigma for schizophrenia, than depression and specific phobia within this study. Anticipated disclosure of schizophrenia and depression to course staff or supervisors, was reported to be higher than specific phobia (5). The authors reported that this finding was consistent to previous evidence around greater willingness to disclose more heavily stigmatised conditions such as schizophrenia, than anxiety for example, which may be easier to conceal (Brohan et al., 2012).

Recipients of disclosure

Study 9 found that faculty members viewed applicants who disclosed depression on their application forms, as less likely to be accepted onto a psychology course, despite those applicants being rated as equally suited and likely to succeed (9). Faculty members advised against disclosure of a MHP and/ or psychiatric treatment on application forms for psychology doctoral programs (9).

Study 7 found that if a colleague disclosed a MHP and/ or psychiatric treatment to them, this disclosure would not change their behaviours in relation to how much and often they would refer clients to that colleague. Both these studies used hypothetical examples and the vignette and measurement used within one study (7) was brief (two questions). Respondents made comments about wanting more information about the colleague or having a discussion with a colleague to make a more informed choice about how they would respond (7).

Synthesis of qualitative findings

The participants within two studies all had lived experiences of distress, psychiatric hospitalisation and /or MHPs (2, 3). The third study reported that most participants had experiences of MHPs, but a figure was not reported (1). The following themes relating to disclosure choices were identified:

Differing levels of disclosure

Levels of disclosure differed across studies and was related to the type of recipient, trust in recipient, quality of support/ supervision, the ways in which distress was conceptualised and whether the difficulty was historic or current. In study 2 it was reported that psychotherapists disclosed their distress later in their careers rather than when they were distressed. This contrasts with the finding in the quantitative study where participants reported that they were more likely to disclose if the problem was current rather than historic (5).

Study 3 reported that when distress was described in relation to life trauma rather than illness, individuals were more likely to feel comfortable to talk openly with their manager about their distress. Within all studies participants were selective and cautious in disclosure (1, 2, 3). One person reported: “Be cautious about disclosure to administrators, there was little support in my experience” (1, p. 615). Another person reported: “I tell my three supervisors only a very small part of my story—that I have lost an important relationship in my life and have been through a time of intense grieving” (3, p. 355). Participants who disclosed their difficulties, stated that they received quality supervision and support, which helped them in disclosing. Those who did not disclose reported less beneficial supervision (2). The finding of recipient type being correlated with disclosure was consistent with quantitative findings, however the qualitative studies (2, 3) provide reasons as to why this may have been the case (e.g., trust in /support from recipient).

Perceived versus actual experiences of stigma, discrimination, and negative impact on career

Where reported, participants who chose not to disclose their difficulties at work, reported that fear of stigma and beliefs that stigma of MHPs was perpetuated within the MH system, prevented them from disclosing. One participant reported: “The culture is still to hide it” (1, p. 615). Other participants also reported fears of being judged as incompetent by their colleagues and supervisors as a barrier to disclosure (2, 3). This is consistent with findings from quantitative studies (5, 8). Participants also reported conflict between their desire to open up but feeling compelled to hide their difficulties. In addition, participants shared that they did not only have to manage the impact of their distress but also the distress of hiding part of their identities, which was reported within one study to be exhausting (3). One participant reported:

> I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide. One is what one is, and the dishonesty of hiding behind a degree, or a title, or any manner and collection of words, is still exactly that: dishonest. Necessary, perhaps, but dishonest. (3, p. 356).

Fears of exclusion, discrimination and negative impact on career were also reported in studies 1 and 3 and this was a barrier to disclosure. One participant reported: “I have concerns about how disclosure might impact my future when I decide to apply for other jobs” (1, p. 615). Similar fears were also reported in quantitative studies (4, 5, 6).

Within all three studies where participants had disclosed their difficulties at work, it was reported that disclosure impacted them negatively in their professional careers. One participant shared:

> I have already lost scholarships, fellowships, and clinical opportunities by being honest about my history. I am not naïve about truth-telling in a clinical context. I

> have learned well how important it is to keep the realms of wellness and sickness separate. (3, p. 355).

The need to keep wellness and sickness separate, may however perpetuate the ‘us and them’ dichotomy within the workplace. In addition, this may prevent integration of identities, (e.g., service user and professional (Richards et al., 2016)). Negative experiences of disclosure at work were also found in the quantitative study 8, however the specific reasons for why participants perceived their experiences of disclosure as negative was not reported. It is therefore unclear whether these negative experiences were related to specific negative outcomes or not.

One individual suggested how stigma may be reduced within the profession: “…administrators and university professors in the mental health fields should spend at least 4 hours a week interacting with patients.” (2, p. 27), however there was no evidence discussed in relation to how spending 4 hours with patients has an impact on reducing stigma. A further participant suggested that normalisation of MH difficulties can be helpful in reducing stigma, without specific reasons or evidence related to this: “Most people experience anxiety or depression at some point in their life. It needs to be normalized, reduce stigma.” (1, p. 615).

Disclosure as valuable

Participants in all studies discussed how disclosure was valuable, for example in helping to model hope and recovery to service users and colleagues in similar situations and being an asset to the profession. One participant reported: “We should embrace the additional skills this brings to VHA.” (1, p. 615). Some participants were hired specifically due to their lived experiences (2) and shared how they used their experiences within their work. For example, one person reported: “The most positive impact is… that I really know what’s going on for [clients] a lot more deeply than someone who hasn’t experienced [mental illness] (2, p. 26).

Similarly, it was reported that disclosure may inspire others to disclose and that perhaps disclosure to someone with similar experiences may be important:

> The most important part of my recovery was sitting with someone who I knew had gone that route before ...this can be one of the most critical differences in recovery, because basically, the message you [usually] get is that you can’t do

> it, and to actually see someone there who’s done it [is valuable]. So, I just say that sort of is my plea to the field, that it’s really important to reduce the stigma and open up this opportunity… (2, p. 27).

Discussion

This review aimed to synthesise the evidence on the prevalence and choices related to disclosure of psychological distress and/or MHPs among MH professionals within the workplace. This review has provided a critique of the existing literature and found that studies have been of varying quality. This review also found that the literature has lacked the depth and nuanced understanding of the complex processes involved in disclosure choices and decisions, which draws on relevant psychological theory (e.g., stigma, shame). Shame may activate approach or avoid behaviours (de Hooge et al., 2010) and disclosure may be mediated by approach or avoid motivations (Chaudoir & Fisher, 2010). Few studies discussed these complex processes, even though shame and stigma were found to be related to disclosure choices for MH professionals. There perhaps need to be specific investigations of the relevance and applicability of existing models and theories, to workplace MH disclosures by MH professionals. Most quantitative studies in the current review used survey methodology, which loses the context in which disclosure may or may not occur. The small number of qualitative studies also lacked discussion of findings within context, and how the authors’ biases may have impacted upon study findings and interpretations. Therefore, the results in relation to prevalence and choices of disclosure should be treated with caution. In addition, most studies did not seek evidence for actual disclosure experiences and used hypothetical likelihood of disclosure and/ or responses to disclosure scenarios. Whilst this evidence is useful, it is unclear whether this would reflect the actual choices and outcomes for MH professionals (Bell et al., 2011). The lack of research on actual disclosures may also reflect researcher bias, and potential assumptions of researchers that MH professionals are reluctant to talk about their distress and disclosure choices. It appears that within studies that included actual experiences, MH professionals were willing to talk about their experiences (1, 2, 8).

The review found that lived experiences of distress or MHPs among MH professionals were common, however this finding may be related to self-selection bias, as individuals who are more willing to talk about MH disclosure may be more likely to take part in MH disclosure research. MH professionals generally perceived that they would be least likely to disclose their distress within work circles compared to their social circles. In keeping with previous research (e.g., Corrigan et al., 2016, Peterson e al., 2011; Toth & Dewa, 2014), barriers such as anticipated stigma, discrimination and negative impact on career were commonly reported to prevent MH professionals from disclosing MHPs and/ or distress at work. For example, self-stigma was evident across many studies and participants reported that shame, embarrassment and perceiving MHPs as a 'weakness', were barriers to disclosure (4, 5, 8). This finding is consistent with previous MH disclosure literature within the general population, where self-stigma was commonly reported to prevent individuals from disclosing MHPs at work (Brohan et al., 2012; Corrigan & Matthews, 2003). Participants who had actual experiences of disclosing their distress at work, reported that the stigma of MHPs was apparent within the work culture and disclosure had a negative impact on their career (e.g., loss of clinical privileges) (3). This suggests that structural stigma within workplaces may exist and stigma toward MHPs may be perpetuated within the healthcare system. This may be particularly pertinent to address, given the potential impact of the COVID-19 pandemic on the mental health of clinical staff (Fernandez et al, 2021).

Stigma and labelling are complex processes (Goffman, 1963) and the review found a lack of discussion within studies, on how MH stigma within the workplace might intersect with other axes of disempowerment and marginalisation (e.g., race, class, gender) (Stangl et al., 2019). For example, for male MH professionals stigma of MHPs and help-seeking may be more profound due to dominant discourses and social norms around 'masculinity' (Möller-Leimkühler, 2002). Emphasis of these broader constructs within interventions that aim to help MH professionals to cope with stigma and make choices around disclosure, are important. In addition, interventions may seek to shift harmful norms through dialogue and engagement with local leaders.

When describing their distress in relation to life trauma rather than illness, participants were more likely to feel comfortable in talking openly with their manager about their distress (3). Therefore, it is important to consider how MH and distress conceptualisations may impact upon disclosure choices. In addition, there was greater stigma reported for more heavily stigmatised conditions such as schizophrenia (5). This finding is consistent with previous literature which suggests that greater stigma is associated with psychiatric diagnoses and type of MHP (Angermeyer & Dietrich, 2006). It was also apparent within the results that psychiatrists were less likely to report or disclose lived experiences of MHPs in the workplace, than psychologists. It may be that the differing training and MH conceptualisations within these professions impacts upon disclosure prevalence and choices.

Only a few studies provided insights into the positive outcomes and experiences of disclosure within the workplace. Whilst many studies reported on stigma, stigma may also foster resilience and fuel the formation of advocacy groups (Stangl et al., 2019). Whilst the theme of disclosure being valuable was apparent in the qualitative literature, researchers generally did not specifically look for positive experiences. There is a risk that stigma may be perpetuated due to researcher bias. Whilst some studies suggested some ways in which stigma may be contended with, such as normalisation of disclosure of distress (1), there is little evidence to support how this might help reduce stigma. It may be that further investigation into normalisation of disclosure and the different functions it might serve, for different people at different times, is warranted. In addition, there is a need to explore workplace disclosure structures that already exist, and support MH workplaces in developing guidance, structures, and pathways which enables opportunities for workplace disclosure if desired by an individual. MH professions may seek to draw upon support resources that are already available. For example, the Mind charity provide free workplace wellbeing plans and guidance for employers and employees in managing and responding to MHPs at work (Mind, 2020). Furthermore, innovations such as the HOP project (Corrigan et al., 2013; Scior, 2017) also exist to promote open discussions about workplace MH and disclosure. It may be that research has not yet caught up with existing innovations. Ongoing research and evaluations of existing innovations and how these may be adapted and utilised within the MH professions therefore seem important.

Limitations

The search process may have excluded relevant studies due to the search being limited to studies published in English and studies that included empirical data. It is also noteworthy that there was a lack of studies from low- and middle-income countries, which is not likely to be explained by restriction to English language publications alone. In addition, only two studies within the review were conducted within the UK therefore the findings may not be generalisable to the UK MH context. There was also an absence of qualitative studies within the review and thus the thematic synthesis was derived from a small number of studies, which may limit the conclusions drawn. Finally, whilst efforts were made to limit biases, inevitably author biases may have impacted upon inferences drawn. Nevertheless, this review has provided a critical insight into the methodological shortcomings of studies within the field and discussed aspects in relation to how the field may be developed.

Future research

Future research should seek to limit researcher and selection bias, given the lack of studies that focussed on positive experiences of disclosure. It is important to investigate the perspectives of MH professionals who have and have not chosen to disclose MHPs/ distress in future research, rather than researching views based on hypothetical disclosures. This may involve quantitative, qualitative, or mixed methodologies with a focus on actual disclosure experiences in the context of complex stigma processes. Such processes are arguably more likely to be captured within lived experience rather than hypothetical scenarios, and thus may help to further explain disclosure experiences among MH professionals.

Future research may seek to investigate the concept of normalisation of disclosure and the different functions disclosure may serve for different people at different times. The way in which MH distress is conceptualised and how this might impact disclosure choices, seems of particular importance. Further research is also needed in countries not represented by the papers in this review. Researching the specific context of the COVID-19 pandemic may provide additional understanding regarding disclosure decisions, given the wide recognition of consequently increased MH needs. Finally, it is important for future research to evaluate existing innovations and interventions that promote choices around disclosure.

Conclusion

The current review outlines the limitations and strengths of current research within the field and highlights the need for methodologically sound further research which explores and addresses the nuanced complexities around disclosure decisions and choices for MH professionals. The prevalence of disclosure of MHPs and/ or distress among MH professionals within the workplace, is much lower than the levels of distress or MHPs MH professionals report. However, these findings may be related to selection and researcher bias. MH professionals report experiences or expectations of stigma, exclusion and negative impact on career, which is consistent with previous disclosure research (Brohan et al., 2012). There was some evidence within the review that disclosure of distress was valuable however studies tended to generally focus on negative experiences. MH professions have an opportunity to learn from existing disclosure innovations. Whilst initiatives have started to develop specifically for MH professionals, that promote open conversations about MH distress among MH professions and disclosure (e.g. the HOP project (Scior, 2017)), research evidence does not align with these innovations.

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JOURNAL PAPER

“Isn’t it mad that we’re all psychologists and we can't talk about our feelings?”: A mixed-methods study exploring trainee clinical psychologists’ experience of (non)disclosure of psychological distress during training

Trainee psychologist: distress disclosure

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Abstract

Objective: Literature on trainee clinical psychologists' mental health has highlighted elevated levels of mental health difficulties and/or psychological distress among trainees, and low levels of disclosure within the workplace. The current study aimed to explore 1) trainee experiences of disclosure and/or concealment of psychological distress during their training, 2) beliefs, assumptions or predictions related to disclosure and 3) responses to disclosure.

Methods: A mixed-methods strategy was employed; 165 trainee or recently qualified clinical psychologists took part in an online survey. Thirteen of these were interviewed. Descriptive statistics and a reflexive thematic analysis were conducted to analyse the quantitative and qualitative data, respectively.

Results: The sample largely consisted of those who had disclosed distress. Six main themes were constructed: 1) Diagnostic or psychological conceptualisations 2) Worries about judgement complicate disclosure decisions; 3) Disclosure likelihood is determined by relationships; 4) Emotional support versus practical responses; 5) Desired changes that could increase disclosure; and 6) Legacies of disclosure experiences.

Conclusion: There is a need for training programme staff to prioritise emotional support, increase permission giving, and enhance disclosure guidance. Further research, including those receiving disclosures, those who do not disclose and from underrepresented groups, is required.

Keywords: psychological distress, disclosure, concealment, trainee clinical psychologists, stigma

Introduction

Previous research on disclosure of a mental health difficulty and/or psychological distress within the workplace, suggests that employees face complex decisions about whether to disclose their difficulties at work (Brohan et al., 2014; MacDonald-Wilson, 2005; Toth & Dewa, 2014). Prior evidence has mainly gleaned from research among the general population however, and mental health providers, including (trainee) clinical psychologists, are not immune to experiencing psychological distress[1] and/ or mental health difficulties (Grice et al., 2018; Hassan et al., 2013; Tay et al., 2018; Victor et al., 2021). A recent study exploring lifetime mental health difficulties within a sample of 1,959 applied psychologists, which included predominantly trainees, found that over 80% of respondents had lived experiences of mental health difficulties, with nearly half reporting a formal diagnosis (Victor et al., 2021). Another survey study of 348 trainee clinical psychologists (TCPs), found that 67% reported a mental health difficulty (Grice et al., 2018). In both studies, commonly reported difficulties were anxiety and depression. These figures however, may be impacted by the greater likelihood of those with lived experiences of distress being drawn to working within mental health fields (Aina, 2015; Huynh & Rhodes, 2011). These studies may also be subject to self-selection and response bias, whereby professionals who experience distress, may be more likely to respond to research exploring lived experiences of mental health difficulties.

Additionally, the literature to date has mainly been conducted using survey methodology (e.g., Grice et al. 2018; Tay et al., 2018; Victor et al., 2021). Whilst this method allows for a large-scale sample to be obtained, it has limitations. For example, the use of survey methodology limits the opportunity to clarify participant responses and as such, any ambiguity or misunderstandings of survey questions are not possible to detect. Tay et al. (2018) also recruited through a mailing list of subscribed clinical psychologists to the British Psychological Society (BPS), and therefore may have excluded experiences of those who are not members of this society. Therefore, the findings from these survey studies should be treated with caution. Indeed, TCPs may be exposed to high levels of stress during training, which may both contribute to and exacerbate levels of psychological distress (Cushway, 1992; Pakenham & Stafford-Brown, 2012). Trainees report main stressors during

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[1] See extended paper section 1.1 for further discussion on psychological distress

training as: poor supervision; extensive travelling; deadlines; moving house; separation from partners and the ambiguous nature of clinical work (Cushway, 1992; Pica, 1998). Whilst these studies give insight into the range of stressors for TCPs, these studies are dated, and stressors may have changed. A more recent unpublished thesis study highlighted training stressors for TCPs as: challenging supervisory relationships; difficulties on placement; discrimination; coursework; commuting; and presentations, and personal stressors as: relationship difficulties; traumatic experiences; and family illness (Willets et al., 2018). Trainees also have dual roles in which they are required to cope with stressors, while developing knowledge and skills related to clinical work (Myers et al., 2012). Additionally, given the emergence of coronavirus (COVID-19) in 2020/21, it is likely that distress among mental health workers is exacerbated, given the significant disruption COVID-19 has posed, to service provision and daily life (Byrne et al., 2021).

Disclosure[2] of a mental health difficulty (i.e. a ‘concealable stigmatised identity’[3]) (Quinn & Earnshaw, 2013) at work, may enable workplace adjustments and support, but may also risk stigma and discrimination (Brohan et al., 2012; Toth & Dewa, 2014). One systematic review of studies with 1,891 participants, who were mental health professionals, found that fear of stigma inhibited disclosure and levels of disclosure was related to recipient, trust, quality of supervision, how distress was conceptualised, and type of problem (Zamir et al., 2022). This review however included a range of professional backgrounds including TCPs, psychiatry, psychotherapists, and mental health nurses. This may limit the applicability to the clinical psychology professions, due to the differing ways in which mental health difficulties may be understood and described within these professions. For example, psychiatry generally uses a more medical model of mental health, in comparison to clinical psychology professions. Of the few studies, that have focussed on clinical psychology, one found that qualified clinical psychologist participants, were unlikely to disclose their difficulties at work, due to fears of negative impact on self and career, shame, and beliefs that they need to be emotionally ‘resilient’ (Tay et al., 2018). Another found that TCPs’ were least likely to disclose their difficulties to

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[2] See extended paper section 1.2 for further discussion and theories of disclosure
[3] See extended paper section 1.3 for explanation on concealable stigmatised identities

supervisors, mentors and tutors (Grice et al., 2018). This study however focussed on hypothetical disclosure, which may differ from actual disclosures (Bell et al., 2011).

There has been growing recognition of the importance of valuing and supporting lived experiences of mental health difficulties among TCPs (BPS, 2020), tackling stigma, and supporting mental health professionals in making disclosure decisions ('Honest, Open, Proud for Mental Health Professionals' (HOP-MHP) (Scior, 2017)). Whilst employers are prohibited to discriminate against anyone who discloses mental health difficulties, under the Equality Act 2010, this relies on employees voluntarily sharing ‘impairment’ with employers, which employees may be reluctant to do, due to fears of stigma or discrimination (Brohan et al., 2012). Additionally, individuals may not identify with terms such as ‘impairment’ (Irvine, 2011), or seek a psychiatric diagnosis for distress (Stein, 2018), which is often required for legal protection against discrimination, and for workplace reasonable adjustments to be made. As such, not all employees are protected by these laws, making disclosure more complex.

The Disclosure-Processes Model (DPM; Chaudoir & Fisher, 2010) outlines when and why disclosure, of a concealable stigmatised identity may be beneficial. Five key factors are suggested to be important in the process of disclosure: antecedent goals; the disclosure event itself; mediating processes; outcomes; and a feedback loop (Chaudoir & Fisher, 2010). This model highlights that disclosure is an ongoing process, and previous disclosures impact subsequent disclosures. Other models of disclosure suggest that individuals hold a default position of non-disclosure at work, due to the attribution of being stigmatised by their colleagues, supervisors or managers, and the likelihood of disclosure is suggested to be determined by the purpose, and a cost versus benefit analysis (Toth & Dewa, 2014). These models have, however, focussed on the general population, as opposed to the mental health provider context.

Within the clinical psychology population, some of the factors associated with (non)disclosure of mental health difficulties during training, were reported to be: having past and/or current mental health difficulties; having specific reasons to disclose (e.g., wanting support); anticipating negative outcomes (e.g., due to stigmatising course culture); or anticipating supportive responses (e.g., due to having suitable recipients); and feelings of shame and fear, or acceptance and comfort (Willets et al., 2018). However, this was an unpublished thesis study, which consisted of recently qualified clinical psychologists, who were asked to recollect their experiences during training, which may be subject to recall bias. The findings of this thesis, appeared to be consistent with a recent qualitative study, which found that trusting relationships, safety, and having an ‘in road’, enabled disclosure, whereas worries about impact on training, internalised stigma, and fears of voicing the ‘unspoken’, were barriers to disclosure (Turner et al., 2021). This study however only included participants who had disclosed distress, limiting representation of individuals who choose not to, or feel unable to disclose distress.

Considering the risks associated with mental health stigma and disclosure is important, as stigma[4] (not living up to society-imposed norms of one’s identity) may invoke feelings of inferiority, self-hate and shame[5] (Overton & Medina, 2008). Stigma has been suggested to be intertwined with how power[6] is exerted within society, for example, through processes of labelling, stereotyping, separating from “us” and discrimination (Link & Phelan, 2001). Within the training context, power differentials between TCPs and course trainers, may further exacerbate concealment of distress, due to possible adverse impact on training (Turner et al., 2021). Concealing part of one’s identity has high emotional costs, including an increase in isolation and demoralisation, depressive symptoms, and feelings of being different (Link et al., 2001), further exacerbating psychological distress and mental health difficulties (Brohan et al., 2012; Goldberg et al., 2005; Toth & Dewa, 2014). Shame theories suggest that shame may activate both approach and withdrawal behaviours, whereby approach behaviours, may act to restore the threatened sense of self, by for example, making amends, whereas withdrawal behaviours, may act to protect self from further damage, by desire to hide or disappear (de Hooge et al., 2010). Thus, experiences of shame may both increase or decrease the likelihood of disclosure of distress, however, it is unclear what may influence whether an individual is more likely to engage in disclosure or concealment.

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[4] See extended paper section 1.4 for further discussion and theories of stigma
[5] See extended paper section 1.5 for further discussion and theories of shame
[6] See extended paper section 1.6 for further discussion and theories of power

Rationale and aims[7]

The current study was in line with the workplace health and well-being priorities, highlighted by Public Health and Office for Health Improvement and Disparities (OHID, 2022) for health and care professionals, working within the National Health Service (NHS). Despite growing recognition of attending to mental health difficulties among employees in the workplace, including TCPs, there is limited empirical evidence regarding TCPs' disclosure experiences, and the beliefs and assumptions the decisions about disclosure are based on. Additionally, it is unclear what responses TCPs get, from recipients (e.g., cohort peers, placement supervisors, academic/course tutors, line managers or mentors), if they do disclose. This was considered important to explore, as it could inform how training programmes can support disclosure and appropriate responses, which do not inhibit further disclosure. The current study therefore aimed to answer the following questions:

1) What are trainee clinical psychologists' experiences of disclosure and/or concealment of psychological distress during their training?
2) What beliefs, assumptions or predictions are decisions about disclosure based on?
3) What responses did trainees get if they disclosed?

Methods

Epistemological stance[8]

The research was conducted from a critical realist epistemological position. It was acknowledged that an observable reality exists, but this reality is constructed through individual contexts and experiences (Pilgrim, 2019).

Design[9]

The study followed a mixed-methods sequential explanatory design (Creswell, 2014); this enabled widespread data to be obtained via a survey, and then for a smaller sample of participants to be interviewed, for an in-depth exploration of the nuances related to psychological distress and disclosure, for TCPs. The study

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[7] See extended paper section 1.7 for further discussion on study rationale and aims
[8] See extended paper section 2.1 for further discussion on epistemological stance
[9] See extended paper section 2.2 for further discussion on design and methodology

received ethical approval from the University of Nottingham's Division of Psychiatry and Applied Psychology Research Ethics Committee (ref:1662)[10].

Instruments[11]

An online survey was created for the purpose of this study, based on previous literature and theory (Chaudoir & Fisher, 2010; Grice et al., 2018). The survey asked TCPs about their experiences of psychological distress, disclosure and/or concealment during training, beliefs, and assumptions about (non)disclosure, and responses to disclosure. The survey was generated and refined through discussion with research supervisors and piloted with two TCPs.

It was made clear to participants, that the term 'psychological distress' referred to the experiences which are sometimes called 'mental disorder' or 'mental illness' within literature (Cromby et al., 2013). The term 'psychological distress', included, but was not limited to, overwhelming emotional states that disrupt everyday functioning, believing, seeing or hearing things, that others may view as out of the ordinary (Cromby et al., 2013).

The questions were answered using a mixture of multiple-choice options and free-text boxes. Questions shown, were controlled by skip-logic on Qualtrics. For example, if participants had not disclosed their distress, the survey skipped to the 'did not disclose' questions. At the end of the survey, participants were asked if they wished to opt in for phase two of the study. Participants who had disclosed and had more than one experience of disclosure, were asked to report these experiences separately. To obtain a range of experiences, those who shared more than one disclosure, were asked to consider contrasting disclosures.

The interview schedule was based on the questions asked in the survey and developed, through discussion in research supervision. The schedule was refined following scanning of the themes that emerged within the survey, and through piloting the schedule with a TCP.

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[10] See extended paper section 2.3 for the ethical approval and considerations

[11] See extended paper section 2.4 for further discussion and explanation of study instruments

Participants and Recruitment[12]

Online survey

Current or recently qualified (last two years) TCPs were eligible to take part if they:

- Studied on (or had recently qualified from) a UK BPS accredited Doctorate of Clinical Psychology (DClinPsy) programme, so that findings could be analysed within this context.
- Self-identified as having experienced significant psychological distress (past or current, with or without diagnosis), which impacted upon their functioning.

Recruitment occurred via social media (Twitter and Facebook) and via email to all DClinPsy courses (N=29), via purposeful and snowball sampling methods. The researcher's course of study was excluded from emails, to avoid direct recruitment of participants the researcher knew. The survey was live for six weeks.

Semi-structured interviews

Sixty participants opted in to take part in the interview and 13 completed the interviews. A minimum of 10-12 participants were required based on literature on thematic analysis (TA) (Ando et al., 2014). To identify participants, a maximum variation sampling strategy was employed, enabling obtainment of participants that varied from each other as much as possible, and to provide a broader understanding of TCPs' (non)disclosure experiences (Patton, 2014). Variables such as type of recipient and difficulty, year of training, positive/negative experience of disclosure, and those who had and had not disclosed, were selected. Eligible participants were contacted via the email address they had provided. All interviews were conducted using telephone or via Microsoft Teams.

Analysis[13]

Survey data was analysed on an Excel spreadsheet using descriptive statistics. To establish common patterns of experience across the data, relevant to the research aims, qualitative free-text box data and interview data, were analysed

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[12] See extended paper section 2.5 for further discussion and participants and recruitment

[13] See extended paper section 2.6 for further discussion on analysis method

using a reflexive TA (Braun & Clarke, 2006; Braun & Clarke, 2019), separately. It is acknowledged that the use of a TA, when the researcher is part of the community that they are researching is a limitation, however, this was managed by continuous reflexivity throughout the study and transparency of processes, biases, and assumptions.

Interview data was transcribed using the University of Nottingham's automated transcription service, however transcriptions were checked and edited for accuracy, by the first author. A hybrid inductive-deductive approach was used (Fereday & Muir-Cochrane, 2006), allowing first, the generation of data-driven codes and unexpected ideas or patterns, and subsequent integration of theory-driven codes. Initial codes were generated inductively on Microsoft Word using a semantic focus (e.g., explicitly stated concepts, meanings, ideas, and experiences). A deductive framework using relevant theory and literature (e.g., DPM model (Chaudoir & Fisher, 2010), stigma (Link & Phelan, 2014) and shame (de Hooge et al., 2010) theories), was then used to code the data again. Themes were developed, refined, and labelled, through continuous discussion and reflection with the wider research team.

Synthesis of results

Survey and interview data were recorded, analysed, and are reported separately. Survey TA themes were synthesised within the interview themes as these were comparable to each other.

Reflexivity[14]

Reflexivity is an important aspect to consider, as the researchers' beliefs, experiences, values and assumptions, may impact upon study analysis and interpretations (Willig, 2008). The researcher acknowledged their current role as a TCP and biases related to their own experiences of distress pre and during training, including how these may influence the analysis and interpretations. To address these biases, the researcher kept a reflexive diary and used research supervision, to challenge and check interpretations.

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[14] See extended paper section 2.7 for further discussion on reflexivity

Results

Phase one (survey)[15]

A total of 165 participants completed the survey. Participant demographics were broadly in line with the TCP population (Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2020); however minority groups (ethnic and male) were underrepresented in the sample. Table 4 highlights participant characteristics.

Disclosure experience(s)

The 165 participants gave 328 responses regarding individual disclosures. Of these 328 response counts, 30% (*n*=99) were related to disclosure to cohort peers, 27% (*n*=87) to an academic/course tutor, 23% (*n*=75) to a placement supervisor, 9% (*n*=31) to a line manager, and 5% (*n*=17) to a mentor. Six percent (*n*=19) of these responses, related to those who did not disclose their experiences.

Because participants were able to report more than one disclosure experience, within Table 5, disclosures 1 and 2 are broken down for each disclosure, rather than each participant, and summarised separately. Out of 100 response counts for disclosure 1, 45% (*n*=45) were for cohort peers, 30% (*n*=30) to academic/course tutor, 19% (*n*=19) to a placement supervisor, 4% (*n*=4) to a line manager and 2% (*n*=2) to a mentor. Out of 46 response counts for disclosure 2, 33% (*n*=15) were to a placement supervisor, 30% (*n*=14) to an academic/course tutor, 22% (*n*=10) to cohort peers, 13% (*n*=6) to a line manager and 2% (*n*=1) to a mentor.

As participants could choose more than one response, Table 6 summarises the total response counts for the highest endorsed responses for TCPs' prior beliefs and assumptions related to non-disclosure, and what might have enabled disclosure. For prior beliefs and assumptions that prevented disclosure, the total overall response counts were 469, and for what might have enabled disclosure were 264.

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[15] See extended paper section 3.1 for further phase one results

Table 4

Phase one (survey) participant characteristics

Sample characteristics	Response options	*n*	%	TCP general proportions %
Gender	Female	148	90.24	82
	Male	15	9.15	17
	Other	1	0.61	
	Total	164	100	100
Age range (years)	20-30	112	68.29	75
	31-40	49	29.88	21
	41-50	3	1.83	4
	Total	164	100	
Ethnicity	White British	131	79	Ethnicity group totals %
	White Irish	11	6.6	White: 82
	Other White Background	8	4.8	Asian/Asian British: 4
	British Asian Indian	4	2.4	Mixed: 4
	Mixed Ethnic Background (White and Asian)	3	1.8	Black/Black British group: 4
	British Black African	3	1.8	Other: 3
	Mixed (White and Black Caribbean)	1	0.6	
	Other British Asian	1	0.6	
	Prefer not to disclose	1	0.6	
	Total	165	100	
Current or recently qualified trainee	First year	51	30.91	
	Second year	40	24.24	
	Third year	43	26.06	
	Recently qualified (1 year or less)	17	10.30	
	Recently qualified (2 years or less)	13	7.88	
	Prefer not to say	1	0.61	
	Total	165	100	

Sample characteristics	Response options	*n*	%
Diagnosis/es received[1]	No diagnosis	56	28.43
	Depression	51	25.89
	Anxiety disorder (social/generalised)	29	14.72
	Post-traumatic stress disorder	14	7.11
	Eating disorder	12	6.09
	Other anxiety disorder	6	3.05
	Bipolar disorder	4	2.03
	Obsessive compulsive disorder	4	2.03
	Borderline/ emotionally unstable personality disorder	2	1.02
	Psychosis	1	0.51
	Schizophrenia	1	0.51
	Specific phobia	1	0.51
	Other:	16	8.12
	Attention deficit hypersensitivity disorder	2	
	Physical pain/ chronic fatigue syndrome	2	
	Seasonal affective disorder	1	
	Post-natal depression/ birth trauma	1	
	Complex post-trauma stress disorder	1	
	Exhaustion	1	
	Chose not to seek diagnosis	1	
	Prefer not to say	1	
	Total	197	100
Distress arising pre or during training	Both pre-existing and arose during training	64	45.39
	Pre-existing	61	43.26
	Arose during training	16	11.35
	Total	141	100

Note 1. [1] = participants could select more than one diagnosis. TCP= trainee clinical psychologist.

Note 2. General TCP proportions are based on Clearing House for Postgraduate Courses in Clinical Psychology equal opportunities data published for entry 2020. Age range percentages may slightly differ due to the differences in how the clearing house records this.

Note 3. Totals for ethnicity groups have been provided however details of these broken down further, can be found on the clearing house website and in the extended paper.

Table 5

Summary of disclosure experience(s)

Disclosure experience(s)	Response options	Disclosure 1		Disclosure 2	
		Response count *n*	%	*Response count* *n*	%
Disclosure recipient	Cohort peers	45	45	10	22
	Academic/ course tutor	30	30	14	30
	Placement supervisor	19	19	15	33
	Line manager	4	4	6	13
	Mentor	2	2	1	2
	Total	100	100	46	100
Prior beliefs and assumptions*	I was anxious/fearful	48	5.42	-	-
	I would be judged negatively	46	5.2	23	5.1
	I was embarrassed	45	-	-	-
	I would be judged as incompetent	-	-	27	5.99
	I was unsure if I could trust the person	-	-	23	5.1
	I would be perceived as weak	-	-	23	5.1
Disclosure outcome**	I was supported by the person I disclosed to	69	13.64	22	9.61
	I felt understood	56	11.07	-	-
	I experienced increased anxiety	-	-	18	7.86
	I did not feel safe	-	-	17	7.42
Disclosure response***	The recipient listened to me	83	13.26	28	11.11
	The recipient was non-judgemental	80	12.78	23	9.13

Note 1. The table summarises the highest endorsed responses and is not a comprehensive summary of all the findings. The full dataset is included in the extended paper.

Note 2. Disclosure 2 is not necessarily sequential to disclosure 1.

*Total overall response counts were 885 for disclosure 1 and 451 for disclosure 2.

**Total overall response counts were 506 for disclosure 1 and 229 for disclosure 2.

***Total overall response counts were 626 for disclosure 1 and 252 for disclosure 2.

Table 6

Summary of non-disclosure experience(s)

Non-disclosure experience	Response options	Response count *n*	%
Prior beliefs and assumptions*	Disclosure would be too exposing	44	9.38
	Concealment was easier	34	7.25
	I would be judged as incompetent	30	6.4
	I feared that I would be perceived as 'unfit'	28	5.97
What might enable disclosure**	Open conversations about mental distress during training	31	11.74
	Normalising of distress during training'	30	11.36
	Specific guidance surrounding process and potential outcomes of disclosure	29	10.98

Note 1. Non-disclosure data includes participants who chose not to disclose at all, and those who chose not to disclose to specific people but may have disclosed to others.
Note 2. The table summarises the highest endorsed responses and is not a comprehensive summary of all the findings. The full dataset is included in the extended paper.
*The total response counts for this question were 469
**The total response counts for this question were 264

Phase two (interviews)[16]

Thirteen participants were interviewed: Table 7 highlights the characteristics of this sample.

Themes

Six main themes were developed; 1) Diagnostic or psychological conceptualisations 2) Worries about judgement complicate disclosure decisions; 3) Disclosure likelihood is determined by relationships; 4) Emotional support versus practical responses; 5) Desired changes that could increase disclosure; and 6) Legacies of disclosure experiences. Four of these had subthemes which are described below.

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[16] See extended paper section 3.2 for further phase two results

Table 7

Phase two (interviews) participant characteristics

Pseudonym	Self-identified distress experiences	Year of training *Age Range (years)*	Disclosure details			Interview format (length -minutes)
			Disclosure(s)	Disclosure recipient(s)	Did not disclose to	
1.Alex	Anxiety difficulties, Diagnosed with depression and anxiety disorder (generalised/social)	1st year *20-30*	2	CP PS	Some PS	Video call (69)
2.Pat	Anorexia diagnosis. Bereavement, relationship difficulties, lack of coping strategies due to COVID-19	1st year *31-40*	3	AT PS	N/A	Video call (70)
3.Rowan	Low mood and depression, high levels of anxiety related to course pressures, isolation due to COVID-19	1st year *20-30*	2	PS CT	N/A	Video call (63)
4.Charlie	Bipolar disorder diagnosis, low mood impacting concentration/ emotion regulation	Recently qualified (1 year) *31-40*	Several	CT PS	N/A	Telephone call (62)
5.Stevie	Trauma (flashbacks, anxiety), PTSD and eating disorder diagnosis	3rd year *20-30*	Several	CT PS	Some PS	Video call (85)
6.Bailey	Depression diagnosis. Eating difficulties. Bereavement during training leading to low mood and high anxiety	2nd year *20-30*	Several	CP CT	N/A	Telephone call (73)
7.Andi	Childhood trauma, disordered eating, anxiety and relational difficulties	Recently qualified (2 years) *20-30*	2	Mentor CT	N/A	Video call (84)

Pseudonym	Self-identified distress experiences	Year of training *Age Range (years)*	Disclosure details			Interview format (length -minutes)
			Disclosure(s)	Disclosure recipient(s)	Did not disclose to	
8.Billie	Anxiety, panic, depressive episodes, self-harm, periods of dissociation/derealisation	3rd year *20-30*	Several	CT	CP	Video call (82)
9.Frankie	Childhood trauma, bereavement, course pressure and high anxiety	1st year *20-30*	None	N/A	Anyone	Telephone call (49)
10.Sam	Social anxiety, trauma, relational difficulties.	Recently qualified (1 year) *31-40*	Several	CT PS	Some CP	Video call (69)
11.Ray	Low mood, depression, anxiety, trauma, and relational difficulties with PS on course	3rd year *20-30*	Several	PS CT	N/A	Video call (77)
12.Taylor	Moderate/severe depression related to workplace stress, anxiety, exacerbated by course pressures	2nd year *20-30*	2	CT PS	Some PS	Video call (79)
13.Jordan	Low mood, anxiety, and periods of derealisation. Relational difficulties and bereavement during COVID-19	2nd year *20-30*	Several	CP PS	Some PS and AT	Video call (83)

Note: CP = cohort peers, PS = placement supervisor, CT = clinical tutor, AT = academic tutor, N/A = not applicable

Theme 1. Diagnostic or psychological conceptualisations

Participants conceptualised their distress using diagnostic categories, or in relation to life and/or relational trauma. Alex reported: “I think I’ve always been quite an anxious person and then I’ve related that to my childhood experiences”. Additionally, several described that the pressures of clinical psychology training, exacerbated their distress. Taylor reported: “It was mainly the academic components of the course that were triggering that [distress]”. Where diagnostic categories were discussed, it was often shared that these labels supported other people’s understanding of their distress, as well as their own. However, it was acknowledged that this was different to what clinical psychology may teach:

> And I know with like clinical psychology, you’re kind of thinking about the narrative and the formulation. But I guess when I apply it to myself, I think of it in the diagnosis terms which I think is quite ironic. (Charlie)

This suggests that whilst TCPs may have the knowledge and skills in alternatives to diagnoses, they may not always make sense of, or apply these ways of thinking to their own distress.

Theme 2. Worries about judgement complicate disclosure decisions

Subtheme 2a. Self-stigma and shame

All participants highlighted feeling self-stigma and shame about psychological distress, which impacted their disclosure choices. Charlie described: “I didn’t share it [distress] very often… I was quite ashamed of it most of the time”. Self-stigma was specifically related to participants’ own views about their competence and worth as a mental health professional:

> As a trainee or as a psychologist, I think it’s a huge thing to get into, but I think, the idea that well, if you have all of these strategies and all of these tools and all of this knowledge, yet you still need help and support yourself, then does that make you a really bad psychologist. (Bailey)

Over half acknowledged, that many TCPs may experience distress, despite this, felt that they could not be open about their experiences, due to stigma. Stevie described: “…something similar has happened to me and I've felt like I can't talk about it, and isn’t it mad that we’re all psychologists and we can't talk about our feelings?” Participants appeared to perceive that as mental health professionals, they should be able to maintain their own mental wellbeing, regardless of any precipitating or present contributory factors. All acknowledged how self-stigma and shame, impacted upon likelihood of disclosure and sometimes increased distress.

Subtheme 2b. Expected stigma and fears of competency being questioned

All participants highlighted expected stigma and fears of their competency and ability being questioned. This was particularly intertwined with self-stigma as well as external stigma:

> When you're starting the course, you already have a bit of kind of an imposter syndrome and I didn't want to start this really busy kind of course, on that note of being like ‘oh hey also, I'm really struggling at the minute’, for them to go ‘oh gosh, who have we recruited in here?’ (Frankie)

As well as beliefs, some reported actual experiences of their competence being questioned: “…and she was like, well, if you need a little bit of extra help now, are you gonna be able to manage the job?” (Billie). This suggests that for some, worries about judgement, are embedded within actual experiences of stigma, rather than being irrational.

One highlighted disparity of esteem, between mental and physical health and perceptions that these experiences, result in different outcomes, highlighting that stigma toward mental health difficulties and distress, continues to exist: “If I had never told him and I just like had a couple of weeks off and said that I've got like food poisoning or something, I know that he would not have questioned my competence…” (Ray). However, it was acknowledged that this was a perception and could not be factually proven.

Subtheme 2c. Power between trainee-staff member

Almost all participants commented on the inherent power imbalance between them and programme staff, and perceived that power differentials increased their worries about disclosure:

> This is a person with great, power, rank and seniority over me, and she can pass or fail this placement and maybe there’s a fear in me somewhere, that it would not have been helpful for my progress on the placement to disclose. (Alex)

Whilst relevant to specific staff roles, such as clinical tutor or placement supervisor, power may also be evident within the different layers of the system and the training context, as Charlie described: “It's a very assessment-based environment so you feel like everything you do is being assessed”.

Overall, worries about judgement, and the real and perceived impact of stigma, shame, and power, complicated disclosure decisions and at times further exacerbated psychological distress. However, it is interesting to note that TCPs talked about competence as a binary concept (competent or not competent), when in fact competence may be more likely to be judged on a task-by-task basis, within the workplace. Additionally, any response to a disclosure requires some level of judgement from the recipient, to enable a course of action. Judgement therefore may be out of genuine concern and desire, to support and make adjustments, as opposed to stigma alone.

Theme 3. Disclosure likelihood is determined by relationships

Subtheme 3a. Existing relationship and trust

Many participants reported disclosing their distress despite prior worries. These disclosures appeared to be dependent on relationships and trust. As Billie reported: “I was a little bit more open about what happened when we built up that relationship.” Participants appeared to attribute relationships to personal qualities they observed within recipients, their demeanour, and previous interactions with them. Sam reported: “she's just very like warm and seems to… genuinely care about how you’re doing.” These relational qualities appeared to enable disclosure.

Many described that the nature of placements, meant transitory relationships with placement supervisors, and thus less opportunity to develop strong relationships and feel comfortable to share distress: “…when you have sort of fleeting relationships through training, where you might have a supervisor for six months and then that's it. You know there is no way I was going to kind of go there with some of them" (Andi). Alternatively, several shared that peers knew the pressures of being on the course, and so would have greater understanding of their distress: "If they've not done the dclinpsy themselves… I don't think they have a sense of how difficult it is" (Taylor). This appeared to enable stronger relationships with peers and increase disclosure likelihood.

Subtheme 3b. The Goldilocks zone of distress

Several participants who felt required to disclose (e.g., due to ethical responsibility, or to gain support/adjustments) but did not necessarily wish to, shared presenting their distress in a 'tolerable' way. It was alluded to, that the tolerable amount of distress sits within a 'Goldilocks zone', however it was acknowledged, that was not realistic and TCPs may experience distress outside of this zone:

> Within training it feels like you're often sort of striving for this Goldilocks zone where you can have a little bit of distress…but it can't be too much, if it's too much then, it's not tolerable within our profession… actually sometimes people will have experiences that will be outside of that… (Stevie)

However, even when distress was perceived to be communicated in a 'tolerable' way, some reported receiving unhelpful responses. For example, in relation to experiencing bereavement it was shared:

> I made my distress so palatable and so tolerable and I still had a really difficult and unhelpful reaction. So if I hadn't have worked really hard within myself to like present in the very thoughtful, very reflective…understandable way, what would have happened? (Jordan)

What was perceived as tolerable also appeared to be dependent on specific types of distress, linked to specific reasons or events, or those which were previously disclosed under the protected disability titles:

> I guess because I did formally declare it as essentially a disability, although I don't really like that word… I was given an official kind of learning and development plan, which obviously just enabled me to have flexibility if I needed it. (Charlie)

This suggests that specific forms of distress may be responded to differently, which may increase or decrease disclosure.

Theme 4. Emotional support versus practical responses

Subtheme 4a. Support hoped for is not always a given

Over half of participants described that the support hoped for, was not always received. Particularly, the absence of emotional support, such as active listening, compassion and empathy, appeared to increase distress, self-criticism, self-stigma and reduce likelihood of disclosure: “it felt…that the response was non-existent…somebody not responding, or responding quite minimally, feels quite invalidating.” (Stevie). Some perceived that the lack of emotional support was exacerbated by there not being space to give to the disclosure, conveying that they needed to manage distress themselves: "I didn't feel like there was even any time to kind of properly give to it. I didn't feel like they wanted to talk about it. (Andi).

Despite emotional support not always being experienced, nearly all highlighted that their experiences of distress and disclosure were important, due to perceived personal and professional value: “Without those experiences I wouldn't be able to offer the support or think about things in the way that I do” (Jordan). It appeared that the absence of emotional support can develop TCPs’ own motivations, to avoid recreating their own experiences with their clients, and potentially with future TCPs they work with.

Subtheme 4b. Practical support is more readily available

Nearly all participants highlighted that practical support, such as gaining adjustments, was more available than emotional support. Practical support was however valued, as Ray reported: “because of that disclosure to [name]… in the placement planning session with the tutors, [name] was able to advocate for me… to say why I needed a different placement.”

Whilst the practical support was seen as important, this was not always what was desired. Sam reported: “she often goes into problem solving mode and like trying to find solutions…I don't always find that helpful.”

Overall, participants appeared to consider the practical support as important, which illustrates how power may be used in a supportive and positive way. However, this was considered less helpful in the absence of emotional support.

Subtheme 4c. Emotional support is dependent on existing relationship

Where emotional support was given, this was related to and dependent on the relationship with the recipient:

> She had shown me a lot of understanding and compassion… you know, even when I wasn't maybe as upfront… when I was talking about the work and stress levels, I really felt like she listened and she took me seriously. (Billie)

These instances appeared to have a positive impact and for some reduced shame and guilt, and developed confidence for future disclosure. However, some reported that the relationship was not always static. Ray described: "…I guess what had started as a disclosure that I'd chosen to do and felt safe, had turned into something that really wasn't safe, and it was really really unhelpful." This highlights the complex nature of relationships, that may be ruptured following disclosure and prevent further disclosure, in future relationships.

Theme 5. Desired changes that could increase disclosure

Subtheme 5a. Permission giving

Almost all participants shared that having the opportunity and permission to disclose their distress, if they wish, would be beneficial. Participants gave practical examples of what this may consist of: "I mean she could have asked me… like is there anything else that you'd like to bring to our supervision?... Once that [supervision] had been set… I had never really considered it [disclosure] to be honest." (Alex)

Additionally, permission giving was not only considered important within the supervisory relationship, but also within the training curriculum and within staff interactions, as Charlie reported: "Like just sharing lived experiences as part of the training, discussing maybe in groups and valuing that in all its forms, might have enabled me to feel more comfortable earlier on to disclose with peers."

Subtheme 5b. The four C’s – clarity, confidentiality, consent, and choice

Over half of participants highlighted the importance of clarity, for example, around the processes, actions and outcomes of disclosure, confidentiality, consent and choice, and prioritising these, to enable disclosure:

> When it’s gone a little bit wrong it’s been not privileging trainees as anything but students…I guess consent and sharing information, and I wish… if it had been privileged in the same way as a client had, you would be really mindful about who am I passing this information to? What am I saying? What am I repeating? (Billie)

Whilst clarity around processes, actions and possible outcomes of disclosure was described by many as extremely important, clarity in communication and validation of disclosure, was also considered to be important, to help manage and counteract worries:

> Like just clearly communicating that we don't think that this is gonna make you an awful practitioner or that you’re not competent or… I think just, just actually naming that, rather than being left wondering and second guessing is that what their thinking… (Stevie)

Participants’ perceptions of recipients not privileging the four C’s, appeared to not only increase distress, but also adversely impact upon relationships, reducing the likelihood of disclosure. Ray shared: “in supervision he’d bring it up more, rather than letting me being able to bring it.” Privileging the four C’s, was suggested could have enabled relational safety, consisting of trust and security, and enabled future disclosure.

Subtheme 5c. Prioritising emotional support

Whilst practical responses were deemed to be valued, emotional support was considered important to prioritise over these:

> Listening and reacting with empathy and understanding. Not jumping into action, so not jumping into what do we need to fix in terms of like placement expectations. Reassurance that it was okay to feel what I was feeling…and asking me how she could help…(Jordan)

Another highlighted the importance of verbal and non-verbal communication: “I guess it’s not always what somebody says, it’s their body language it communicates so much.” (Stevie). These relational factors were considered as highly impactful in future likelihood of disclosure and levels of distress in the moment, thus important for future recipients to prioritise when receiving disclosures.

Theme 6. Legacies of disclosure experiences

Most participants described that their disclosure decisions and experiences had a personal and professional impact, which not only influenced future likelihood of disclosure, but also feelings toward the work and their role:

> I just gradually gave a lot less of myself overtime… it sort of grated away at my love for the profession…it just made me feel as though… if we can’t care for ourselves, if we can’t witness distress in our own profession then how are we going to be effectively able to do that within services and our work with others? (Stevie)

For some, whilst not all disclosure experiences were positive or went how they had hoped, they still took value from them:

> The accumulation of the good and the bad, makes me feel like I can tell people going forward… I’ve just filled in an occupational health form for my first qualified job, I put it on there, and not been like oh I need to hide this. (Ray)

This suggests that negative experiences do not inevitably result in future concealment. Additionally, Andi reported that the one positive disclosure to their mentor, prevented them from leaving training: “All my experiences weren't good until the point at which I was with my mentor… had I not had that really good experience… my whole training would have been different.” This suggests that having at least one perceived helpful experience may be a buffer, against the negative.

Discussion[17]

Barring one unpublished qualitative thesis (Willets et al., 2018), this project is the first to explore TCPs' actual disclosure and non-disclosure experiences. The sample was overrepresented by TCPs who had disclosed distress, compared to those who had not, which may be due to self-selection bias and the potential worries for TCPs who have not disclosed, in taking part in research that requires disclosure as part of the research. Additionally, the sample whilst broadly in line with the demographics of TCPs, based on Clearing House data (CHPCCP, 2020), was underrepresented by men and Black Asian and Minority Ethnic backgrounds. TCPs with minority intersectional backgrounds may have additional concerns about disclosure (Oexle & Corrigan, 2018), and as such, further research that explores the experiences of these groups is warranted.

In line with previous research (Grice et al., 2018; Victor et al., 2021), anxiety and depression were most commonly reported distress experiences. TCPs described their distress experiences diagnostically, whilst others in relational and trauma terms, which may reflect the nature of DClinPsy training, which does not primarily focus on diagnostic categories (Johnstone, 2014), compared to psychiatry, for example. Additionally, it may be that participants choose to hold onto diagnostic categories, as under the Equality Act 2010, these are protected terms, that may enable adjustments and support, in comparison to experiences defined as psychological distress, however this warrants further research.

Consistent with previous research on the impact of COVID-19, on the mental health of employees (Gilleen et al., 2021; Kar & Singh, 2020), the pandemic appeared to adversely impact TCP distress, however distress was pre-existing. As well as exacerbating distress, for many COVID-19 and subsequent measures (e.g., online/ remote working), meant reduced opportunity to talk about distress, and reduced support to manage the pressures of clinical training. Programme staff therefore need to acknowledge the context of the pandemic, the additional barriers this poses for disclosure, and support mitigating against these barriers. For example, by having explicit discussions about the impact of COVID-19 within teaching, in

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[17] See extended paper section 4.1 for an extended discussion

meetings, supervision, and collaboratively developing plans with TCPs on what support they might need.

(Non)Disclosure experiences

The integrated quantitative and qualitative results, suggest that TCPs disclose to a range of recipients, however, these disclosures are dependent on relationships and trust, which is consistent with previous literature highlighting the importance of relational factors (e.g., emotional support) and likelihood of disclosure at work (Rollins et al., 2002; Turner et al., 2021). Trust is underpinned by attachment patterns, which allows one to be vulnerable in interpersonal relationships (Harms et al., 2016). Where relationships did not exist, disclosure of vulnerability consisted of modifying one’s expression of distress to a perceived ‘tolerable’ level. Showing a modified version of oneself, however, is linked to increased distress and powerlessness (Richards et al., 2016), and may risk perpetuating the narrative that distress in all its forms is not acceptable. Clinical psychology, like many other professions, such as physiotherapy and occupational therapy, is regulated by the Health and Care Professions Council (2019); these standards of proficiency highlight the need for practitioner psychologists, to be able to manage the emotional, psychological, and physical impact of one’s own practice. TCPs appeared to acknowledge the ethical responsibilities to clients, however, appeared to worry about ‘fitness to practise’ concerns, and possible negative impact on training and subsequent qualification and assessment. However, fitness to practise concerns are more likely to be raised through an absence of disclosure, whereby client care and clinical practice is adversely impacted, as opposed to when one is experiencing distress in itself. By disclosing distress, TCPs have the opportunity to gain the support they require, which for some within the current study, enabled continuation and completion of the course.

Beliefs and assumptions

Consistent with previous research on disclosure of stigmatised identities at work (Brohan et al., 2014; Brohan et al., 2012; Toth & Dewa, 2014), the integrated findings highlighted that shame and stigma (external and self), were commonly reported worries that complicated disclosure decisions. TCPs’ worries were specifically embedded within fears of competency being questioned, and being perceived as ‘unfit’, within the context of a pressured, assessment-heavy training environment. Despite shame and stigma, disclosure however, still occurred. Shame threatens the universal human desire to have a positive self-view (Lewis, 1971). At times of scrutiny and evaluation, the threatened self may activate approach behaviours, that function to restore this threatened self, or avoid behaviours which may serve to protect one from further damage (de Hooge et al., 2010), making disclosure more or less likely. Despite stigma and shame, TCPs were still disclosing distress to others, which may relate to a desire for individuals to restore the threatened self. Additionally, disclosures were motivated by specific purposes, and the perceived responses and outcomes, increased or decreased the likelihood of future disclosure. This finding fits with the DPM model, which suggests that disclosure does not end with the outcome, but is an ongoing process (Chaudoir & Fisher, 2010), however the current study gives further nuance, by highlighting that this process is related to relationships.

Whilst for some, prior worries were not borne out of experience, for others, the beliefs were reinforced through experiences of stigma and their competency being questioned. This highlights that worries about disclosure may relate to self-stigma, but structural and external stigma may also operate within the system. A limitation, however, is that TCP perspectives are not corroborated by disclosure recipients. Whilst participants seemed to see questions relating to competency as being grounded in stigma, there is a possibility that they were grounded in genuine concern for the TCP, rather than having an undermining motive. Additionally, the ways in which competency was talked about by TCPs, suggested that this was perceived as a binary concept – that you are competent, or you are not – rather than a day-to-day, or task-to-task judgement to make. It is important therefore for programme staff, supervisors, and TCPs, to develop a nuanced approach to understanding distress and competency, on a case by case, or task-by-task basis.

Disclosure experiences and beliefs appeared to also be impacted by power differentials, including legitimate and expert power (French & Raven, 1959). It is possible that TCPs perceive that legitimate power that programme staff hold, may be exerted negatively, due to stigma and fears of competency being questioned, however power may also enable resources, adjustments and support (Johnstone & Boyle, 2018). It seems that further exploration of how power may be perceived by

TCPs and different recipients of disclosure, and the different ways in which it may operate within the training context, is warranted. Due to the limited data from minority groups, it is also unclear how aspects of power and privilege, may impact upon distress experiences and disclosure for people with multiple intersecting minority identities. Therefore, further exploration of the experiences of intersecting minority groups is warranted.

Responses from recipients

Quantitative results show that TCPs perceived support was available following disclosure, however the qualitative findings give further nuance; highlighting that support was more readily available in practical ways. Additionally, desired emotional support was not always a given and was dependent on the existing relationship with the recipient. This finding is somewhat consistent with previous literature, whereby disclosure enabled support and adjustments at work (Brohan et al., 2012), however goes further to highlight that just practical support is not enough, or always desired. This suggests that practical responses may be of value, but how these are communicated or achieved need to be carefully considered. It may also be that support is perceived differently by TCPs and recipients. For example, time off work, may be perceived as stigmatising by TCPs, however as a supportive or compassionate strategy, by programme staff, which removes additional course stressors and provides opportunity for self-care. Differences in perceptions, due to the lack of data from the other side of the dyad (i.e., the disclosure recipient), are unclear however, which future research should seek to address.

As well as permission giving, clarity of processes, actions and outcomes, confidentiality, consent, and choice, were highlighted as crucial factors, that could enable disclosure. TCPs suggested that permission giving may occur within day-to-day interactions with placement supervisors or academic tutors, or within wider training processes and curriculum. An absence of permission giving appeared to prevent disclosure, consistent with previous literature (Turner et al., 2021) which highlighted, that TCPs perceive lived experiences of mental health difficulties as the ‘unspoken’. Programme staff should seek to consider formal or informal ways in which mental health and distress among TCPs, may be talked about and welcomed, thus permitting TCPs to share. This may include specific discussion of distress within supervisory meetings, academic or personal tutor meetings, incorporating the relational approaches that TCPs value, for example, emotional support, empathy, compassion, confidentiality, and consent. It is possible that confidentiality may need to be broken, if programme staff have genuine concerns for the well-being of TCPs, their clients, or practice. Where this needs to happen, it is important that this is in line with the BPS (2020) recommendations, whereby programme staff seek to discuss worries with TCPs, in the first instance, and agree a mutual plan of support. Programme staff and TCPs are encouraged to also consult their local university policy and procedures when co-developing support plans.

Whilst permission giving does place an emphasis on what training institutions can change, it is important to acknowledge that TCPs may still choose not to disclose despite this, based on their own motivations and experiences (Turner et al., 2021). Whilst permission giving does not inevitably mean guaranteed disclosure, it can support communication that distress is okay to talk about, perhaps shifting the narrative that distress within clinical psychology, is the unspoken. This shift is considered important in workplaces, to prevent adverse individual and organisational outcomes, and supports the view that it is not just about talking about mental health, but creating a culture and environment, in which employees feel able to disclose distress (Farmer & Stevenson, 2017).

Strengths and Limitations[18]

To the researcher's awareness, this is the first study that has employed a mixed-methods strategy, obtaining a large quantitative survey sample and smaller qualitative interview sample, to understand and provide nuance to TCP distress (non)disclosure experiences, during clinical psychology training. This study adds to the growing literature, highlighting the importance of attending to provider mental and increasing disclosure opportunities, within clinical psychology training.

The study, however, has some limitations which are important to consider. The project only explored experiences from one side of the dyad (TCPs); further research that triangulates data and explores experiences from different recipients of disclosure is required. This is important as those receiving disclosures, in various

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[18] See extended paper section 4.2 for further discussion on the strengths and limitations

positions and roles, in the workplace, may have different concerns, priorities or interpretations. For example, future research may seek to analyse interview data using the non-dyadic (when members of the dyad are interviewed separately) Framework method (Collaco et al., 2021). However, it must be considered that TCPs may be concerned about participating in dyadic research, which includes those involved in evaluating them during training, even if confidentiality is assured.

There was a small number of TCPs captured within the study, who had not disclosed their experiences. It is important for further research to seek participants who do not disclose, as they may have different concerns about disclosure. Additionally, the study lacked participants from minority intersectional backgrounds, who may perceive (non)disclosure in different ways. Obtaining participants from a diverse range of minority intersectional backgrounds is important, as these groups may have different experiences of power and privilege, and thus, experiences of distress and disclosure.

Whilst efforts were made to reduce researcher bias, through ongoing reflection in research supervision, reflective diary keeping, and transparency of process, the findings unavoidably, may have been impacted by the researchers' own assumptions and experiences.

Finally, the study design was cross-sectional in nature. Future research may seek to employ a longitudinal design, which follows up TCPs post-qualification and into their first supervisor roles, to consider if this influences views about their disclosure experiences, or whether future disclosure decisions were influenced.

Practice implications and future research[19]

The findings from the study fit the national priorities of Public Health England; highlighting the need to promote workplace health and well-being, among health and care professionals (OHID, 2022). This includes managing workplace health risks, preventing staff sickness, and using a 'health first' approach. Given this, and based on current study findings, it is important for DClinPsy programme staff, to further prioritise relational approaches when receiving disclosures, such as emotional support, clarity around processes, actions and outcomes of disclosure, consent,

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[19] See extended paper section 4.3 for further discussion on practice implications and future research

choice, and confidentiality. Additionally, it is important to acknowledge, that TCPs may not have had prior experience of disclosure, may be fearful of disclosing, and worry about negative impact on training and subsequent qualification. Employers have a legal duty to recognise and respond to mental health difficulties and to make necessary adjustments; for this to occur it is recognised that some judgement is required. However, adopting a sensitive and compassionate approach within these processes, may mitigate against TCPs' worries, and enable greater disclosure.

Additionally, plentiful opportunity for TCPs to disclose distress during training in formal ways (e.g., within supervision, curriculum and meeting structures) and informal ways (e.g., by communicating an ethos of valuing lived experience of distress during training (BPS, 2020)), is required. Increased opportunity for disclosure may enable TCPs to access the support they require, reduce the likelihood of greater distress, staff sickness and risk to service user care, all important priorities for employers and universities.

Notwithstanding the existing efforts to support TCPs, training institutions should seek to enhance their structures, processes, and guidance, to support TCPs in navigating disclosure decisions, and accessing support. Guidance should seek to include process of disclosure, support available, and emphasise that disclosure in fact is a “competency in action” (BPS, 2020). This may support reducing the worries and fears TCPs have about disclosure. Existing initiatives already exist that DClinPsy courses may wish to consider, in further developing supportive practices, for example, the Thriving at Work guidance (Farmer & Stevenson, 2017), the BPS valuing and supporting lived experiences during clinical psychology training guidance (BPS, 2020), In2gr8mentalhealth (2017), MIND employee toolkits (Mind, 2020) and All Our Health Resource (OHID, 2022)

Further research should seek to triangulate data by including different recipients of disclosure, TCPs from multiple intersecting minority identities, and those who do not disclose, as these groups may have different experiences and concerns related to disclosure and psychological distress. Additionally, future research may seek to adopt a longitudinal design and follow up TCPs post qualification, to consider any changes in perceptions of disclosure experiences and future disclosure decisions.

Conclusion

This project further adds to the growing literature relating to psychological distress within clinical psychology and extends it, by exploring experiences of TCPs, who have and have not disclosed distress during their training. Consistent with previous disclosure research, worries about judgement, particularly expected stigma and competency being questioned, and self-stigma and shame, complicated disclosure decisions, within the workplace. This study further highlights that power and relationships impact upon disclosure decisions, and that practical support, whilst valued and more available, is not always helpful when not accompanied with emotional support. This project highlights the need for training institutions to increase permission giving for TCPs, who may wish to disclose distress. Additionally, programme staff may further prioritise relationships and emotional support, by focussing upon consent, confidentiality, clarity of processes, and consent within these relationships. Further research that includes the other side of the dyad (those receiving disclosures), TCPs from multiple intersecting minority identities, and those who do not disclose, is required.

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EXTENDED PAPER

1. Extended Introduction

1.1. Psychological distress

There is a lack of consensus on the definition of psychological distress (American Psychological Association [APA], 2006, p.6). Within the western culture, the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5, American Psychiatric Association, 2013) and the International Classification of Diseases 11th edition (ICD-11, World Health Organisation [WHO], 2019), are two classification manuals, used to diagnose and categorise various mental health difficulties and symptoms. Neither of these manuals provide specific definitions of psychological distress and the term is used as a stand-alone symptom, as a qualifier of other symptoms, and as a general measure of severity (Phillips, 2009). The dominant medical model of mental health, suggests that psychological distress arises as a result of faulty genes and developmental vulnerabilities, exposed by stress in life (Johnstone, 2014). Munsey (2006) however, describes that psychological distress is an experience of intense stress, which is not readily resolved, affecting well-being and functioning, or disruption of thinking, mood and other health problems, that intrude on professional functioning. Other psychological definitions of psychological distress exist and are described based on their psychotherapeutic approach (e.g., cognitive, psychodynamic and systemic) (Beck, 1976; Dallos & Draper, 2015; Schroder et al., 2016).

When talking about their emotional distress and its causes in general terms, individuals do not necessarily discuss their mental health in medicalised language (Irvine, 2011; Stein, 2018). Furthermore, polarised debates on psychiatric diagnosis exist within psychology, and so psychologists may be less constricted by medical language, when talking about their mental health (Kinderman et al., 2013). Given the differing ways in which individuals may describe their mental health, constraining the current project to the inclusion of those with just diagnosed conditions, and through use of psychiatric language, would be problematic. With this in mind, ‘psychological distress’ was explored and discussed within the current project. Given the dominance of the medical model however, and for some, diagnoses being important to open up access to services, and a helpful way of understanding their difficulties (Perkins et al., 2018), it was considered important to include within the definition of psychological distress, experiences which are often called ‘mental disorder’ or ‘mental illness’ within literature (Cromby et al., 2013). For the current study, the term ‘psychological distress’ included overwhelming emotional states, that disrupt everyday functioning, believing, seeing or hearing things, that others may view as out of the ordinary (Cromby et al., 2013). This meaning of distress situated human suffering, as reactions to everyday life, and allowed opportunity to understand personal meanings of distress, as influenced by one’s own values, beliefs, experiences, relationships and social contexts (Johnstone & Boyle, 2018).

1.2. Disclosure

Disclosure, or ‘self-disclosure’ is defined as behaviour that reveals personal information about oneself verbally, for example, through use of language, either written or spoken (Cozby, 1973). Disclosure may also, however, occur non-verbally (e.g., through body language or gestures), whereby others may observe information that reveals something about oneself (Omarzu, 2000). For the current project, disclosure was defined as verbal communication about oneself (Cozby, 1973), as this allowed for focus and clarity. Whilst non-verbal communication is important, arguably all social communication may be defined in this sense. Therefore, limiting disclosure to verbal communication and behaviour either through written or spoken words, was considered to allow for a boundary and specificity. It is understood that limiting disclosure to verbal behaviour, is however, not all encompassing and a limitation, and it is acknowledged that disclosure may occur in a non-voluntary manner, or signs may be picked up by the recipients (e.g., when one is in distress it may not be possible to hide this).

The literature on disclosure is extensive and diverse; within the mental health field disclosure is complex, because mental health difficulties and psychological distress, continue to be stigmatised within society (Peterson et al., 2011). Disclosure is defined as an ongoing process (Reis & Shaver, 1988), with specific decision-making decisions (Omarzu, 2000) and outcome processes (Greene et al., 2006). Models of disclosure have gleaned from research within varying populations, however common processes and principles may occur, when making a disclosure decision. For example, the breadth, depth, and duration of disclosure, has been highlighted to be common factors within models (Omarzu, 2000). Breadth refers to the number of different topics covered, duration may be the amount of time spent disclosing, and depth, the level of intimacy involved (Omarzu, 2000). What is defined as intimate however has been contested, and may constitute information that is potentially perceived as embarrassing, or private (Howell & Conway, 1990).

One disclosure model is the Disclosure Decision Model (DDM) (Omarzu, 2000) which highlights that disclosure is a cognitive process, which results in decisions related to the content, depth, breadth, and duration of disclosure. The DDM suggests that disclosure must be motivated by a specific goal, and a specific person to disclose to, must be identified. The perceived benefits and risks of the disclosure are then assessed, which may increase or decrease disclosure. The authors suggested that this model could be used as a framework, to understand and predict disclosure, in different situations. However, a limitation of this model, is that it is generic in nature and does not include the specific complexities, that may be inherent for people who experience mental health difficulties, particularly in the context of professional training. For example, disclosure may also be affected by the perceived responses of the recipient and the interaction between two sides of the dyad (Kenny, 1996), which may thus impact the trajectory of disclosure.

A further model, the Disclosure Processes Model (DPM), has been posited by Chaudoir and Fisher (2010), who sought to include more causal predictions about how factors associated with disclosure are interrelated. The DPM posits that five key factors are important in the process of disclosure: antecedent goals; the disclosure event itself; mediating processes; outcomes; and a feedback loop. Antecedent goals may be approach-focussed (e.g., to pursue positive outcomes/emotions) or avoidance-focussed (e.g., to prevent negative outcomes/emotions). It is suggested that an understanding of these goals, may lead to an understanding of when disclosure may be beneficial. The disclosure event itself may occur at once, or over longer periods of time, where an individual discloses small parts of their identity in smaller chunks. The reaction of the recipient of disclosure, is characterised within the model, as either supportive or unsupportive. The mediating processes; alleviation of inhibition, social support and changes in social information, are suggested to affect long-term individual (e.g. psychological), dyadic (e.g., intimacy/trust) and social contextual (e.g., disclosure norms/cultural stigma) outcomes (Chaudoir & Fisher, 2010). This model goes beyond other models of disclosure (Greene et al., 2006;

Omarzu, 2000) and can be applied to stigmatised identities, and is hypothesised to be part of a larger ongoing process of “stigma management” (coping with psychological and social consequences of holding a stigmatised identity) (Chaudoir & Fisher, 2010). Whilst useful at a universal level, the model included data from a wide range of stigmatised identities, potentially limiting its applicability and understanding, of the specific concerns that mental health professionals such as psychologists, may be faced with.

A more recent published disclosure model, within the context of trainee clinical psychologists (TCPs), has been proposed by Turner et al. (2021). This model suggests that six related elements increase or decrease the likelihood of disclosure for TCPs. The first stage is: ‘motivations, enablers and barriers’. These aspects were suggested to interact together to determine whether a disclosure may take place. The second stage was hypothesised to include ‘the features of disclosure’ and the ‘responses received’, which influence each other. A final aspect of the model was hypothesised as ‘impact of disclosure’, which may lead to increased or decreased likelihood of disclosure. Whilst this model appears to coincide with factors associated with the extant disclosure literature, it goes further to highlight the specific worries and barriers within the TCP context, which may increase or decrease disclosure. Given this model is new, it is yet to be tested. Whilst the model includes overall impact of disclosure, the data within this was derived from generally positive outcomes, which may not encompass differing disclosure experiences, in which disclosure does not go to plan or is harmful to the individual, and/or the relationship with the disclosure recipient. In addition, whilst the model focussed on specific disclosure experiences, it did not include data from TCPs who had not disclosed their difficulties. It may be that those who have not disclosed have differing perceptions of the barriers and possible impact of disclosure. Lastly, the data within the study was cross-sectional in nature, therefore it is not possible to ascertain if perceptions of disclosure experiences change over time or differ, post qualification and into TCPs own supervisory roles.

1.3. Concealable stigmatised identities

For people who experience mental health difficulties and/ or psychological distress, these experiences are generally invisible and concealable. Whilst it is acknowledged that these experiences may become more visible at times of distress, a person with a ‘concealable stigmatised identity’, often has a choice of whether to disclose their identity to others. Stigmatised identities are not limited to mental health difficulties and/or psychological distress. While not an exhaustive list these include sexuality, HIV/AIDS, political beliefs and values and/or chronic illness (e.g., epilepsy, chronic fatigue syndrome) (Green et al., 1999; Herek et al., 2009; Rutledge et al., 2011; Smith et al., 2009). These identities are considered ‘stigmatised’ as they are often viewed as inferior and/ or are discredited within society (Goffman, 1963) (more on stigma below). Whilst for people with concealable stigmatised identities, decisions about disclosure may not be taken lightly, some people may choose not to disclose and a having a “private sense of self”, whereby private information, feelings, thoughts and desires are kept to oneself, may be a positive aspect of ego development (Kelly & McKillop, 1996). In addition, not all people with concealable stigmatised identities will exhibit distress or experience negative outcomes due to concealment, and as such, concealment may be more comfortable and the desired option (Quinn & Chaudoir, 2009). It is needless to say however, that this should not be confused with the collusion of stigmatising and discriminatory practices, which should continue to be challenged and omitted (Flett, 2012).

1.4. Stigma theory

Stigma has been defined by Goffman (1963), as a discredited or disfavoured attribute within the society in which one lives. Attributes are cognitively constructed and linked to stereotyped (often negative) beliefs (Corrigan et al., 2003). For an attribute to be discredited or devalued, first there needs to be an awareness of difference. Once difference is identified, Goffman (1963) highlighted that the devaluation of the differing attribute, results in a ‘spoiled social identity’, and individuals employ different strategies for identity management. Stigma may not only lead to negative stereotypes but also prejudice (viewing stereotypes as real) and discrimination (avoidance or exclusion) (Corrigan et al., 2003). One of the criticisms of the early stigma literature, is that it side lined concerns relating to where stigma derives from, by whom and for what purposes (Link & Phelan, 2001; Tyler & Slater, 2018). However, literature on stigma has been extended to include different types of stigma at a societal, interpersonal, and individual level (Bos et al., 2013; Link & Phelan, 2014). For people with mental health difficulties, public stigma, self-stigma and structural/institutional stigma may occur (Corrigan et al., 2003). Public stigma refers to negative or discriminatory attitudes that others may have about a person's identity. Self-stigma is suggested to occur when the public stigma is accepted to be true and thus internalised, and institutional stigma consists of systemic level stigma, within organisational policies and procedures, that may limit people's opportunities or advancements in society or work (Corrigan et al., 2013; Corrigan & Rao, 2012).

Stigma is a complex process and it is suggested that it cannot be separated from how power is exerted within society (Link & Phelan, 2001). Stigma research has been extended to include Goffman's original work, but is defined as the co-occurrence of four processes; 1) labelling human differences; 2) stereotyping of differences; 3) separating those labelled from "us"; and 4) status loss and discrimination against those labelled (Link & Phelan, 2001). Stigmatisers may obtain certain gains by holding onto stigmatising views; keeping people 'down', by higher social status or dominance in society, monetary gains, keeping people 'in' by enforcing certain written and unwritten rules, or keeping people 'away', through for example, avoidance of disease, based on an evolutionary motivation (Link & Phelan, 2014). Stigma reflects an evaluation of value and worth by stigmatisers and as such was hypothesised by Bourdieu (1987), a form of symbolic power. Symbolic power refers to the imposition on others, a legitimised vision or view of the social world. People who are in receipt of symbolic power, may be impacted by other people's perceptions about their worth and value, and internalise this, which is often referred to as self-stigma, within the stigma literature (Corrigan & Rao, 2012). Additionally, misrecognition of stigma or symbolic power, may serve to facilitate stigmatisers interests, by keeping these hidden and thus keeping them powerful (Bourdieu, 1990).

Applying these principles to stigma toward mental health difficulties, it has been hypothesised that first a motivation of stigma is to 'keep people in' (Link & Phelan, 2014); for example through enforcement of social norms. If that does not work then motivations to 'keep people down' (e.g., through domination or exploitation) or ‘away’ (e.g., through avoidance or withdrawal) may also play out (Link & Phelan, 2014). For example, within society individuals who may be experiencing distress and display non-normative behaviours, may be reassured by others, to “think positive” or “look on the bright side”, which may be attempts to keep people within the normative society (Link & Phelan, 2014). When distress or mental health difficulties may be so profound (e.g., in the form of acute psychosis, ‘bizarre’ behaviours), keeping people away or down may be more prominent.

The ‘in concern’ may lead to suppression and concealment of the stigmatised identity by the individual themselves, as they are aware of the negative stereotypes about having a mental health difficulty (Link & Phelan, 2014). This links with the possible desire for individuals to stay within the ‘in group’ (us), rather than the ‘out group’ (them), to maintain a sense of social identity and self-esteem (Tajfel et al., 1979). Additionally, people with stigmatised identities may expect rejection and this may result in increased withdrawal from others, or interactions that may be potentially threatening. It is suggested that when withdrawal is effectively enacted, the goals of keeping people away are achieved. Additionally, due to negative beliefs and stereotypes about people with mental health difficulties, these individuals may be placed lower in society, which the stigmatised individuals may themselves believe to be true of their character and worth (self-stigma), leading to low self-esteem and increased psychological distress (Corrigan & Rao, 2012). Whilst the re-conceptualisation of stigma in relation to power, helps to critically engage in broader concerns related to social inequalities, this work is still limited by focussing on the ‘aims of stigmatisers’, rather than conceptualised in relation to the motives of institutions and states, within a broader political economy of neoliberal capitalist accumulation (Tyler & Slater, 2018).

1.5. Shame

Shame is a universal, primitive and adaptive human emotion, which alerts individuals to when they behave in ways that may alienate them from a social group, or inconsistencies between aspects of the self (Gausel et al., 2012; Gilbert, 2003). In this respect, shame is rooted within a self-focused, social threat system (Gilbert et al., 1994). Shame may trigger automatic defences to protect oneself, by escaping the situation, concealment, anger, or submissive behaviour (Gilbert, 2003). Shame may be misperceived as having a similar function to other emotions, such as guilt, however, shame and guilt are distinct. Guilt may elicit a reparative response through a negative emotional response, in which one perceives they have harmed others (e.g., “I feel bad about hurting another person”). Whereas shame may evoke beliefs that “I am bad”; perceptions that one is inherently flawed, resulting in self-protective strategies to be employed (Gilbert, 2003). Whilst shame is an uncomfortable emotion, at its core, it is derived from an innate human drive to seek care, approval, love, and belongingness (Brown, 2006). In this sense, it is arguable that to manage shame, one might first engage in approach behaviours that act to restore the threatened sense of self (de Hooge et al., 2010). However, when restoration may not be possible, or may pose greater risk to self, then a person may avoid or withdraw to prevent the self from being further damaged (de Hooge et al., 2010).

Shame Resilience Theory (SRT) (Brown, 2006) highlights that whilst we cannot remove shame altogether, a person can learn to be resilient in the face of shame. Brown (2006) proposed four elements within developing this resilience: 1) recognising and understanding shame; 2) critical awareness surrounding shame (e.g., cultural and social expectations); 3) forming empathic relationships that enable reaching out and; 4) speaking shame by desconstructing and discussing shame. While shame is considered and seen to arise idiosyncratrically, it is acknowledged that it does not occur in isolation from one’s social context (Brown et al., 2011). Although mental health difficulties are not the only category that may elicit shame (Brown, 2006), evidence suggests that shame may worsen mental health and is associated with negative mental health outcomes and well-being (Arnink, 2020; Duarte et al., 2017). Shame may also impact interpersonal relationships, encompassing increased aggression, hostility, lack of empathy, and intense self-focus (Dearing & Tangney, 2011; Ferguson et al., 2000).

Shame is suggested to be fuelled by the social and reflective nature of humans, which result in internalised devaluation of one’s worth and esteem (Hinshaw, 2007). Stigma in itself may be described as ‘a deep mark of shame and degradation carried by a person, as a function of being a member of a devalued social group’ (Hinshaw, 2007, p.26). However, shame is not always an inevitable part of stigma. For example, self-esteem may be preserved in those who are stigmatised, by attributing the negative evaluation of one’s worth in the stigmatiser rather than in one’s inherent flaws, perceiving attributes discounted by stigmatisers as unimportant to oneself, or identifying with the stigmatised and activism (Hinshaw, 2007). However, for people with mental health difficulties, low self-esteem and shame are more likely to occur, than not (Kotera et al., 2021; Wood et al., 2017; Yakeley, 2018).

1.6. Power

Whilst power was discussed in relation to stigma earlier, it is important to further consider the ways in which power may operate. The definition of power has often been contested; power may be described dialectically, as the (in)capacity of actors to mobilise means to achieve ends (Avelino, 2021), or may be seen as an action, rather than something located within an individual (Foucault, 1980). Types of power have been suggested by French and Raven (1959): coercive; reward; legitimate; expert; referent; and information. Coercive includes operation of power by threats or punishments; reward by resources or incentives; legitimate via a superior role or responsibility; expert via knowledge or skill another needs; referent via being liked or admired by another; and information via holding, knowing or providing information to change another’s thoughts, or actions. Lukes (2005) further highlighted that power has an observable dimension, whereby it is exercised though open decision making, exclusion of possibilities by controlling agendas, and manipulation of identities and expectations, thereby power being a mechanism for influence. By considering these ideas of power, it is important to then not only consider an individual who may ‘hold’ power, but how, when and if, this is exerted, and in what ways.

1.7. Further rationale

1.7.1. Further literature on psychological distress among psychologists

Research evidence investigating the prevalence of psychological distress and/or mental health difficulties among psychologists, has historically been a neglected area, however, has gained increased recognition in recent years. An early survey study found that 57% of mental health professionals, including psychologists, had experienced depression (Deutsch, 1985). In another study, over 10% of psychologists reported experiencing psychological distress (Thoreson et al., 1989), and in another, 62% of counselling psychologists identified as being depressed and 42% reported suicidal ideation or behaviour (Gilroy et al., 2002). All three of these studies used survey methodology and are likely subject to self-selection and response bias. There was also a lack of consensus on how distress was defined, limiting direct comparison between studies. A more recent large-scale study conducted within the UK, with a sample of 678 qualified psychologists, found that 62.7% reported lived experience of a mental health difficulty, with depression and anxiety being most commonly reported (Tay et al., 2018). This study however recruited through a mailing list of subscribed clinical psychologists to the British Psychological Society (BPS), and therefore may have excluded experiences of those who are not members of this society. One study that included both trainee and qualified mental health professionals, of which 69.2% were psychologists, found that 40.8% of their sample, reported that they had experienced mental health difficulties at some point in their lives (Edwards & Crisp, 2017). Psychologists may also construct their identity as a practitioner as being relatively powerful and as a client as being relatively powerless (Richards et al., 2016). These power dilemmas and conflicting identities, may also contribute to distress and subsequent disclosure choices (Rhinehart et al., 2020).

1.7.2. Trainee clinical psychologists

TCPs are just as likely as other mental health professionals, and the general population, to be impacted by mental health difficulties and/or psychological distress. Cushway (1992) found that psychological distress was significantly higher (59%) for TCPs, than that found for comparable groups. Exposure to high levels of stress during training, may both contribute to and exacerbate levels of psychological distress (Cushway, 1992; Pakenham & Stafford-Brown, 2012). Poor supervision; extensive travelling; deadlines; moving house; separation from partners and the ambiguous nature of clinical work (Cushway, 1992; Pica, 1998), were reported as significant stressors for TCPs. More recent findings from an unpublished thesis study highlighted, however, main stressors for TCPs were: challenging supervisory relationships; difficulties on placement; discrimination; coursework; commuting; and presentations, and personal stressors as: relationship difficulties; traumatic experiences; and family illness (Willets et al., 2018). A recent survey including 348 TCPs, found that 67% reported experiences of mental health difficulties (Grice et al., 2018). Trainees also have dual roles in which they are required to cope with stressors, while developing knowledge and skills relating to clinical work (Myers et al., 2012), adding a further layer of complexity. A more recent survey study drawn from almost 2,000 primarily applied psychology graduates (59.8%) and faculty staff (27.6%), found that 82.2% reported experiencing a mental health difficulty (Victor et al., 2021). Depression, generalised anxiety disorder, and suicidal thoughts or behaviour were most reported, which was consistent with previous studies. Most studies, however, have used survey methodology, and there is a lack of understanding of the specific nuances of distress and disclosure, within the TCP population.

Considering and attending to distress among TCPs is an ethical responsibility, as universities have a duty of care to their students, to protect their health, safety and well-being (BPS, 2020). Failing to respond to mental health difficulties if known, and make reasonable adjustments, can lead to significant adverse consequences. For example, as highlighted by the recent tragic suicide of Natasha Abrahart, in April 2018. Natasha was a student at the University of Bristol. It was found that the University had breached its duties to make reasonable adjustments to the way in which it assessed Natasha. The primary stressor and cause of her distress and subsequent death, was deemed to be an oral assessment, and direct discrimination and unfavourable treatment by the university, despite the university being aware of Natasha's mental health difficulties, and social anxiety. It is vital that universities respond to the mental health of their students, to prevent from such devastating events from occurring in the future. It is important to also note, that as well as being postgraduate students, TCPs are paid National Health Service (NHS) employees. Employers, just like universities, are legally required under the Equality Act 2010, to make reasonable adjustments for people with a disability, which includes mental health difficulties.

Furthermore, Public Health England recognise the importance of prioritising workplace health and well-being and outline within the 'All Our Health' policy, that workplaces should take action to address workplace health issues. This includes addressing health and safety risks, preventing staff sickness, and adopting a 'health first' approach (Office for Health Improvement and Disparities [OHID], 2022). The current study was therefore considered an important part of this wider, national health priority, within NHS settings.

1.7.3. Self-disclosure among psychologists

Distress disclosure research, specifically within the psychological and trainee populations is sparse, however there is emerging literature for factors associated with disclosure of distress, within the mental health professions, in the workplace. A recent systematic review, with a sample of 1891 mental health professionals including psychologists, exploring the evidence relating to disclosure of psychological distress at work, found that participants were less likely to disclose their distress within their work circles, than social circles and fears of stigma inhibited disclosure (Zamir et al., 2022). Another scoping review found that workplace culture, a “us and them” divide, and direct and indirect messages of disclosure being “inappropriate”, was related to nondisclosure of emotional distress within the workplace (King et al., 2020). These reviews provide insightful information related to disclosure specific to the mental health professions, however, included a wide range of professions (e.g., psychiatry, nursing), which may limit the applicability to TCP context and training, as distress may be perceived differently across these professions.

One survey study found that TCPs were least likely to disclose a mental health difficulty at work if it was a past, rather than a current difficulty (Grice et al., 2018), however, this study focussed on hypothetical likelihood of disclosure, which may not reflect actual disclosure experiences. Concerns relating to how one’s difficulty or distress may be perceived, may be exacerbated by often explicit recommendations that psychologists should avoid disclosing experiences of distress (Appleby & Appleby, 2006), as these disclosures risk being perceived as “unprofessional” or “inappropriate” (Devendorf, 2022). One study conducted in the USA, found that 69.8% of faculty members of clinical and counselling doctoral psychology courses, recommend against applicants disclosing experiences of depression on application forms, and 64% recommend against disclosing receiving psychotherapy (Devendorf, 2022). Clinical faculty members, over counselling faculty members, were found to be less favourable to disclosure. This was a similar finding to that of Zold et al.'s (2020) study. It may be that the differences between clinical and counselling psychology, lie within the different emphasis placed on lived experiences of distress within these training courses. For example, within the UK, to receive accreditation to become a counselling psychologist, a minimum of 20 hours of personal therapy is required (BPS, 2018). There is no such requirement for clinical psychology. Whilst personal therapy does not equate to lived experience of distress per se, it implies a level of disclosure of personal and emotional information. However, both these studies were conducted in the USA and so these course requirements may differ, to those in the UK.

1.7.4. Study rationale

Previous studies regarding psychological distress and disclosure during clinical psychology training, barring one recent qualitative study (Turner et al., 2021), have often used survey methodology (Grice et al., 2018; Victor et al., 2021). Whilst survey methodology has its strengths and may allow retrieval of information from a larger number of participants, and may be more cost-effective, this method often negates the nuanced understanding of the area of interest, with it not being possible to ask follow-up questions (Robson & McCartan, 2016). In addition, the study by Grice et al. (2018), which focussed upon TCP disclosure, which is relevant to the UK clinical psychology training context, used hypothetical likelihood of disclosure. Arguably, actual disclosure experiences, the decisions related to these and factors that impact on disclosure, may vary in a real-life setting.

There is already growing recognition of the importance of attending to psychological distress among mental health professionals (BPS, 2020; *In2gr8mentalhealth*, 2017). Additionally, the 'Honest, Open, Proud for Mental Health Professionals' (HOP-MHP) self-help project (Scior, 2017), adapted from the Honest Open Proud (Corrigan et al., 2013) project within the general population, was implemented by University College London (UCL) in 2017. This project aims to support mental health professionals, including psychologists, in making decisions about disclosure of distress within a workplace setting. The HOP-MHP project highlights the need for support systems to be in place for mental health practitioners. The current study therefore aimed to add to these existing initiatives, helping to develop an understanding of disclosure within the clinical psychology training context. In particular, an individual may make predictions about future experiences and predictions may be based on past experiences and knowledge, or assumptions and beliefs (Beck, 1976; Johnstone & Dallos, 2014). It was unclear what predictions TCPs made, what assumptions and beliefs these predictions were based on and how assumptions may have influenced disclosure choices and behaviours. Are TCPs' choices about disclosure grounded in experiences or are they primarily assumptions or predictions? It was also considered important to focus on what responses TCPs received from psychologists within the workplace (e.g., cohort peers, placement supervisors, academic/course tutors, line managers or mentors), if indeed they had disclosed, as this could inform how training programmes can support disclosure and appropriate responses, that do not inhibit further disclosure. Given that qualitative data is lacking, a mixed-methods approach was indicated to obtain a wide-range of experiences related to (non)disclosure, with a smaller sample to be followed up, for in-depth exploration into the specific nuances of disclosure, and to contextualise the quantitative data.

1.7.5. Researching trainee clinical psychologists

Narrowing down the sample to TCPs was a decision taken following discussions within supervision, considering research literature and gaps in research. While other post-graduate psychology courses may have been included (e.g., counselling and/or forensic psychology), it was considered that this would significantly increase heterogeneity of the sample, thus limiting the conclusions that can be drawn within the context. In addition, counselling psychology doctoral courses have a requirement to take part in personal therapy throughout their training; whilst this does not automatically imply a psychiatric diagnosis and/or distress disclosure, to seek therapy, one must disclose personal experience of distress to an extent. As such, it was considered that there may be different issues around disclosure within this population.

2. Extended Methods

2.1. Epistemological stance

Approaches to social research include quantitative, qualitative and mixed-methods strategies. The two traditional paradigms of social research are quantitative and qualitative methodologies, however the mixed-methods paradigm started to emerge from the 1990's, establishing itself as a third methodological paradigm (Creswell, 2014). Quantitative methods seek to circumscribe the variables of interest, using prescriptive techniques of measurement, and outline relationships between variables, prior to investigation of them (Robson & McCartan, 2016). Additionally, quantitative methods are interested in objective, mechanistic analysis using statistical inferences (Robson & McCartan, 2016).

Qualitative methodologies are interested in experiences of people as they are felt and lived in their contexts. This paradigm emphasises that 'objective reality' cannot be known, and there are as many realities as there are people. In this sense, within research, the researchers' own interpretations and subjectivities are acknowledged, and the task is to understand the multiple constructions and meanings of reality, as lived by the participants (Johnson & Onwuegbuzie, 2007; Robson & McCartan, 2016).

A critical realist position was adopted for this study, which acknowledges an observable reality however posits, that these realities are value-laden, and influenced and shaped by one's own positions, privileges, meanings, thoughts, emotions, and social factors (Creswell & Plano Clark, 2011). Historically, quantitative research was predominantly concerned with and linked to positivism, however, this was superseded by postpositivist stances, due to criticisms relating to science only dealing with observable phenomena, rather than abstract or hypothetical concepts (Phillips & Burbules, 2000). Postpositivist views of research acknowledged that evidence is imperfect and fallible, facts and values cannot be completely separated, and methods can seek to reduce bias and establish reliability and validity (Phillips & Burbules, 2000). Alternatively, qualitative research was originally concerned with social constructionism, which suggests that there is no one known 'truth', and 'truth' is constructed through interactions between people (Johnson & Onwuegbuzie, 2007). Critical realism is an alternative to the traditional positivist versus social constructionist epistemologies, and considered an appropriate method for conducting mixed-methods research (Pilgrim, 2019). Critical realism allows psychologists to think critically and reflectively about theories and practice, and has fundamental assumptions related to ontological realism, epistemological relativism and judgemental rationalism (Bhaskar, 2016; Pilgrim, 2019).

Ontological realism refers to the world existing regardless of what we may think or perceive about it; and our subjective experiences being part of a world that existed before we were born, and that will continue after we die (Pilgrim, 2019). However, how we think about the world is important, as these perceptions, thoughts, or notions about the world and experience, are, in themselves, part of reality that has evolved through time (Pilgrim, 2019). Epistemological relativism is the premise that we construct the world around us, and reflect and talk about it, but these construal's change, as we live in a culture which changes over time, and varies between places (Pilgrim, 2019). Construal's are suggested to be dependent on the context in which they came about. Finally, judgemental rationalism is the notion, that based on ontological realism and epistemological relativism, we are able to weigh up truths and likelihoods, in a cautious manner, knowing that knowledge is fallible, however these judgements nevertheless are important to make (Porpora, 2015).

2.2. Rationale for design and methodology

One myth regarding using quantitative and qualitative research methods together, has been the 'incompatibility thesis', which suggests that quantitative and qualitative methods are separate paradigms and interested in different phenomena, and so they cannot be combined (Sale et al., 2002). Whilst there are differences within quantitative and qualitative methodologies, in terms of their ontological practices and epistemological stances, there are also similarities (Howe, 1988). It is argued that quantitative methods also call for prior qualitative judgements, as what is 'objective' within social research, is not straightforward (Kurtoglu, 2010).

Using a mixed-methods approach by means of a critical realist position was suitable for this study, as it allowed for acknowledgement that TCPs' experiences of psychological distress exists, however these may differ based on the influences of each individuals' own experiences, knowledge, and meanings (Creswell & Plano Clark, 2011). In this way, the current study did not seek to obtain one 'truth' about psychological distress and disclosure, but understand the multiple realities and ways in which this may be viewed.

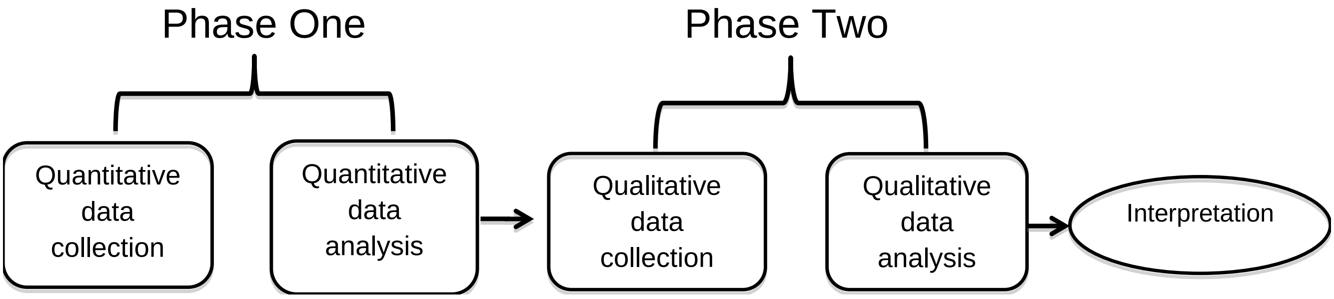
It was first hoped that the collection of quantitative data would allow for wide-ranging data to be obtained, and then the second qualitative phase would allow to contextualise findings, and provide greater nuance and meaning to (non)disclosure experiences. By using a mixed-methods design, data could be triangulated, giving it greater validity and a comprehensive understanding of TCPs' experiences (Robson & McCartan, 2016). Additionally, the use of quantitative methods first, could allow for selection and recruitment of participants for the qualitative phase (Fetters et al., 2013). This was considered important within the current project, as interviewing a range of participants with diverse experiences, could allow for an understanding of a range of distress and (non)disclosure experiences.

Mixed-methods strategies have been criticised for being time-consuming, lacking integration of findings or knowledge, and skills of the researcher (Bryman, 2004; Mason, 2006). The time-consuming nature of research, arguably, is determined by the specific research questions posed, specific analysis strategies, and researcher skill and expertise, however. In relation to the lack of integration of findings, Mason (2006) highlights that the tensions between the two paradigms, provides opportunity for thinking 'outside the box', creativity, and multidimensional ways of understanding. Therefore, throughout the project, ideas, reflections, and viewpoints, were continually reflected upon within supervision, via use of a reflective diary, and holding in mind how the two paradigms may co-exist together. Similarly, to manage the criticism of the skills and knowledge of the researcher, the primary researcher sought appropriate supervision through both qualitative and quantitative research supervisors, creatively debating ideas, which facilitated and enhanced the researcher's knowledge and skills in mixed methods approaches. A final criticism of mixed-methods approaches has been that it may prioritise quantitative methods over qualitative ones (Giddings & Grant, 2007). This, however, risks undermining one approach over the other. Whilst the qualitative section forms a larger part in the write up of the results, as inevitably the quotes used to illustrate findings are longer, the quantitative and qualitative findings were equally weighted, and formed the discussions and conclusions of the study. Additionally, the qualitative themes from the survey and interviews were integrated together in the write up, representing both quantitative and qualitative findings.

The study followed a sequential explanatory design, following a two phase, mixed-methods design (please see Figure 2 below) (Creswell & Plano Clark, 2011). The overall purpose of using this design was that the qualitative data would help to build upon and explain the quantitative results. This design was advantageous as it allowed for one type of data to be collected at a time. It was also considered useful as it was hoped that the researchers could tailor the interview schedules for the second phase if required, based on the themes that arise in phase one of the study. Additionally, it was thought that the quantitative participant characteristics, can guide purposeful sampling for the qualitative phase (Creswell & Plano Clark, 2011).

Figure 2

Explanatory mixed methods design



2.3. Ethical approval and considerations

The project followed ethical procedures stipulated by the BPS (2021). The study was reviewed by the University of Nottingham's Research Ethics Committee (Appendix A). Amendments based on reviewer feedback was submitted on 2nd February 2021 and Ethical Approval was granted on 5th February 2021.

2.3.1. Informed consent

A participant information sheet was developed for study (Appendix B) which included information about the nature and purpose of study. It also highlighted the types of questions that might be asked in the first phase (survey), and that a smaller sample would be selected for phase two of the study. It was made clear that the study was voluntary, and researcher and supervisor email addresses were provided, so that participants could discuss the study further and ask any questions. On accessing the survey link, the information sheet was downloadable so that the participants could save a copy, and consider whether they wanted to participate. Consent was obtained via ticking of the relevant boxes in the online survey (Appendix C). For the second phase, consent was implied if the participant opted in for the interview, and responded to the interview invite via email, confirming their interest and preferred date/ time for interview.

2.3.2. Right to withdraw

Participants were informed within the information sheet that they were free to withdraw at any time from the study, without giving a reason. Following completion of the survey, it was made clear that participants had two weeks to withdraw their data and they could do so by contacting the researcher with their unique code, which they were asked to create and make a note of, at the start of the survey. It was also outlined in the information sheet, that following completion of the interview, if they choose to take part, they could withdraw their data up to two weeks after the interview, after which point data may have been analysed and could not be withdrawn.

2.3.3. Confidentiality and anonymity

The participant information sheet highlighted that all participant data would be confidential. Minimal demographic information was collected in the survey to protect confidentiality and anonymity. Participants were also reminded in the interview about confidentiality and given space and time to ask any questions about this.

2.3.4. Data storage

All researchers followed privacy and guidelines for data protection and storage in line with the Data Protection Act (2018) and General Data Protection Regulations (2018). It was made clear in the information sheet, that if participants chose to opt in the interview, that their email address would be stored separately to their survey data, via a separate survey link. All online survey data was held within Qualtrics which is the approved University of Lincoln's online survey software. All survey and interview data were only accessible by the researchers and relevant regulatory organisations. All data was held securely, and password protected, on the University of Nottingham's OneDrive. Research data will be kept securely by the university for seven years, after which point it will be disposed of securely. Only members of the research team were given permission by the data custodian to have access to participant personal data.

2.3.5. Risk to participants

As the study explored disclosure and concealment of psychological distress, participants may have experienced some discomfort when talking about their experiences. It was advised that if they were currently feeling distressed or felt as though they would be distressed by the questions in the survey or interview, to not take part. At the start of the online survey introduction, participants were encouraged to look after their own well-being and close the survey should the questions cause any discomfort. It was also advised that they could return to the survey later (within seven days), if they wished. If they wanted to return after seven days, they could do so by following the survey link again and starting the survey from the beginning. During the interview, signs of distress were monitored throughout, and steps were taken to support participants. For example, stopping the interview, taking a break, and giving the participant time and space. In addition, participants were given details of a range of sources of support within the information sheet and the debrief sheet, after completion of the survey and the interview (Appendix D).

2.4. Instruments

2.4.1. Online survey

The survey was designed for the purpose of the study; the specific questions included were based on previous research on disclosure (Brohan et al., 2012; Grice et al., 2018; Tay et al., 2018). For example, literature highlighted features of disclosure, including type of disclosure (full/ partial), recipients, purposes/functions, expectations, beliefs and assumptions and outcomes of disclosure, and concealment and so questions related to these were included. In addition to questions related to previously identified factors relating to disclosure, specific questions relating to the aims of the research and the research teams' interests, were included. This included, specific questions relating to beliefs, assumptions and predictions related to disclosure, responses to disclosure, and what may have enabled disclosure. Additionally, what, if anything could have made the experience 'better'. The survey was created on Qualtrics, University of Lincoln's online survey tool. Participants were asked to create a unique code at the start of the survey, so that their data could be identified should they wish to withdraw after completion of the study.

Questions were answered with a mixture of multiple-choice questions and free text boxes. Participants were asked a few demographic questions at the start of the survey, to help contextualise the sample and establish representativeness. For example, participants were asked whether they were a current trainee or recently qualified clinical psychologist, their age, gender, and ethnicity. Participants were given the choice of 'prefer not to say', respecting participant choice, and addressing possible fears TCPs may have, related to anonymity. No further demographic information was obtained, and participants were not asked which course they studied on, to maintain anonymity and confidentiality. At the end of the survey, participants were asked if they wished to opt in for phase two (interview) of the study.

Survey question wording differed slightly based on whether the participant had or had not disclosed their distress during training. Depending on participant experience, they were directed to the relevant sections of the survey based on skip logic as part of the Qualtrics software. In addition, it was identified that participants may have more than one disclosure that they may wish to share, therefore an option to include a second disclosure was added to the survey, with the same disclosure questions and answer options. When completing this, participants were asked to clarify who this disclosure was related to. Responses to disclosure one and two, did not necessarily mean that these were participants' first or second disclosures overall; these simply related to the order in which they chose to report them in the survey. At the end of phase one, participants were asked if they wished to opt in for phase two of the study. If they chose to opt in, they were asked to include a contact email address via a separate link, so that their data was not stored with their email address. The time to complete the questionnaire and length varied for each participant, based on their specific experiences and number of disclosures; this ranged from 18 to 62 items and 15 – 45 minutes to complete.

2.4.2. Pilot of questionnaire

Feedback from two current TCPs was also sought and this feedback was used to tailor the survey questions. For example, it was highlighted that the 'nature of difficulties' question was broad and adding a couple of examples of what could be included here could be helpful, therefore further detail for this question was added. In addition, it was highlighted that amount of 'time off work' may be different at different times, therefore based on this, the question was adapted to include a free text box for anything that did not fit with the multiple-choice answers. Additionally, the answer choice, 'to seek help', in relation to the purpose of disclosure, was changed to 'seek professional help (e.g., in the form of medication or therapy)' for greater clarity, based on TCP feedback. The questionnaire used can be found in Appendix E.

2.4.3. Semi-structured interview schedule

The semi-structured interview schedule (Appendix F) was developed through discussion within research supervision and aimed to elicit further detail related to the questions asked within the survey. The interview schedule first asked about participants' experiences of psychological distress, before and/or during training. Prompts, such as how they felt they understood these experiences and how it impacted them personally or professionally, to help contextualise the results further was included. Participants were then asked about their experiences of disclosure; purpose; expectations; prior beliefs or assumptions about self or others; outcome of disclosure; disclosure impact; if they or others could have done anything differently; whether they would still choose to disclose if they were in that situation again; and anything they would say to others who might be in a similar situation. Participants were also asked if they wanted to discuss more than one disclosure, or if there was anyone, they wanted to disclose to but did not. For those who had not disclosed at all or to some, were asked the ‘concealed’ questions which were similar to the ‘disclosed’ questions, but slightly differed in wording. For example, as well as beliefs and assumptions, participants were asked what stopped them from disclosing and what would have enabled them to disclose.

2.4.4. Pilot of interview schedule

The interview schedule was piloted with one TCP and refined following feedback. For example, it was highlighted that it was unclear whether the ‘disclosure experiences’ question was targeting disclosure experiences as a whole, or specific experiences. Therefore, the researcher made a note of this for future interviews, starting with an open question about disclosure experiences and following this with asking the participant to identify specific disclosure experience(s) to discuss. Additionally, it was made clear to participants that if they had more than one disclosure experience to share, then they would be asked about this separately. It was also highlighted that it would be useful to capture diverse experiences, so if they wanted to share more than one experience, they were asked to consider two contrasting examples.

As part of the mixed methods design, the researcher scanned the findings from the quantitative phase and used the findings to consider tailoring the questions for the interview phase. It was evident within the quantitative findings that participants highlighted specific fears and beliefs about their competency being questioned, and self-stigma. To prevent looking for specific findings, participants were not asked specific questions in relation to stigma, however, when talking about their beliefs and assumptions related to themselves and others, they were asked to give explicit examples of these, to understand the specific concerns or worries. Apart from this, the questions in the interview schedule appeared consistent with the themes emerging within the survey, therefore specific questions in the interview schedule were not changed.

2.5. Participants and recruitment

2.5.1. Online survey

There was no target number of participants required for phase one of the study and a total of 165 participants took part in phase one (survey). The survey was open for six weeks between 05/02/2021 and 19/03/2021. The study was advertised through a broad range of methods and as such, it was not possible to ascertain the total numbers of participants that were approached to take part, or to know reasons for why participants may have chosen not to take part. Over 216 participants initially accessed the survey, however, 51 responses were deleted as they did not progress past the consent page. This was not considered unusual, as in order to access the information sheet, which they could download or read online, the participant was required to click on the survey link. They could then decide whether they wanted to take part. It may be that following reading of the information sheet and/or the consent form, the participant chose not to take part due to not meeting the criteria; however specific reasons are not possible to ascertain.

Based on the Leeds Clearing House for Courses in Clinical Psychology, for 2021 entry, there are 979 TCP places. For 2020 entry and 2019 entry, there were 770 and 614 places respectively; with approximately 2,363 TCPs across the typical three-year course (this excludes numbers of TCPs who may have dropped down a year or be training for longer than three years). Additionally, the study included recently qualified clinical psychologists, which based on the clearing house data increased the possible pool of participants to 3,550 TCPs (593 for 2018 and 594 for 2017). One in four people are suggested to experience mental health difficulties within their lifetime (Independent Mental Health Taskforce, 2016), resulting in 888 possible TCPs with lived experiences of psychological distress and/or mental health difficulties. The sample of respondents are therefore approximately 18.6% of possible TCPs, who may have had lived experiences of distress (across a five-year period). This is important to take into account when considering the generalisability of the findings.

For 2020 equality monitoring data from the Clearing House (CHPCCP, 2020) the sample was broadly in line with the TCP demographics; predominantly White backgrounds - 90.4% in current sample (82% usually overall in clearing house sample), female aged between 20-30 years old. However, participants from an Asian background (usually 6% based on clearing house data), mixed-ethnic backgrounds (usually 4%), Black backgrounds (usually 4%) and males were underrepresented, within the sample. This underrepresentation may be related to possible worries about taking part in research that requires disclosure of distress as part of the research, and anonymity and/ or confidentiality, and the different concerns different groups, for example men, may have around talking about their mental health (Stein, 2018).

Participants were included within the study if they were:

- Current trainee clinical psychologists or recently (within last two years) qualified clinical psychologists.
- Studying on (or had recently qualified from) a UK BPS accredited clinical psychology doctorate course so that findings could be analysed within the context in which clinical psychology training take place (e.g., National Health Service (NHS)).
- Identified via self-report as having experienced significant psychological distress (past or current and with or without diagnosis) which impacted upon their functioning.
- Disclosed or concealed their psychological distress during training. If disclosed this disclosure was within the workplace to cohort peers, placement supervisor, academic/ course tutor, line manager and/or mentor.

2.5.2. Semi-structured Interviews

Semi-structured interviews were considered appropriate for the second phase of the study, as it was thought that these would allow flexibility, which other methods of interview (e.g., fully structured interviews) do not allow. Additionally, it was deemed that the semi-structured interview schedule could help to guide the questions, and the specific prompts and structure of questioning used, could be tailored based on what the participant brings up (Clarke & Braun, 2013).

Originally, it was hoped that a mixture of telephone, face-to-face or video interviews would be conducted to allow participant choice. Telephone interviews are advantageous if a participant wishes to remain anonymous. An online video (e.g., Zoom or Microsoft Teams) and telephone interview, also helps to overcome practical issues related to the wide geographical locations that TCPs may be based, and costs of travel. It was acknowledged that telephone and online video interview methods may have limited observation of cues, which may be picked up within face-to-face interviews (e.g. body language) (Robson & McCartan, 2016). Due to the coronavirus pandemic, it was not possible to conduct face-to-face interviews, and as such all interviews, were conducted either via Microsoft Teams, or telephone.

For qualitative research, there is a lack of consensus for the numbers of participants required, however, it is often useful to consider previous literature within the area, to estimate how many participants may be required for a meaningful analysis to be conducted. Given the lack of qualitative literature on TCPs, it was not possible to draw on previous literature, however, it has been argued that 12 interviews may be sufficient to produce themes and over 90% of codes, within thematic analysis (TA) (Ando et al., 2014). Given this, 10-12 participants were aimed for, and 13 took part in total.

All interviews were audio recorded via an encrypted digital dictation device. Video interviews were also recorded via Microsoft Teams Software, using the University of Nottingham's email account. This video recording was a back-up and participants were made aware of this at the start of the interview. All audio recordings were then uploaded to the University of Nottingham's approved automated transcription service, after which each transcription was checked and edited for accuracy by the lead researcher (A.Z).

2.5.3. Recruitment (online survey)

Recruitment for the online survey took place via emails to all Doctorate of Clinical Psychology (DClinPsy) courses, apart from the lead researcher's own university, to avoid directly recruiting TCPs that the researcher knows, and via advertisement to social media (Twitter and Facebook).

An email (Appendix G) was first sent to 29 DClinPsy courses using their admin email contacts, obtained from their website and/or the Clearing House for Courses in Clinical Psychology, on 10/02/2021 and subsequently on 23/02/2021.

The study recruitment poster (Appendix H) was attached, alongside the ethical approval confirmation from the University of Nottingham's Research Ethics Committee. Of these, 10 courses confirmed that they had circulated the research participation request to their TCPs, one responded by stating that they were not permitted to circulate the request, and the rest did not respond.

A project specific Twitter handle was created for advertisement of the study. For Facebook, the page admins for the 'UK based Clinical Psychologists' and 'Trainee Clinical Psychologists' groups were approached online and requested to post the study recruitment poster and information, on their Facebook Groups. These were posted once, whereas the study was tweeted on five occasions. The original study tweet was re-tweeted 105 times. Table 8 below outlines the dates each of these were posted and/or re-posted. Within all advertisements, interested participants were asked to pass on the study details to anyone else they think may have been eligible and interested, via snowball sampling methods. The short tweet, which included the Qualtrics survey link and study poster, read:

> *"I am recruiting trainee or recently qualified (last 2 years) clinical psychologists with experiences of psychological distress to take part in an anonymous survey investigating experiences of disclosing or concealing distress during training".*

The Facebook post read:

> *"Hi everyone, as part of my DClinPsy research I am inviting trainee or recently qualified (within last two years) clinical psychologists, who have experiences of psychological distress and/ or mental health difficulties, to take part in an anonymous online survey. We are interested in hearing about your experiences of disclosing or concealing your distress during clinical psychology training. The survey should take around 15-45 minutes depending on your experiences. This is mixed-methods study with the option to opt in to take part in the second phase (interviews) at the end. For more information or to take part please click on this link: https://unioflincoln.eu.qualtrics.com/jfe/form/SV_6fD6KMXtlF3YCTr*
>
> *Please share this with anyone else who you think may be interested."*

Table 8

Social media recruitment dates

Recruitment location	Twitter	Facebook – Clinical Psychologist Group	Facebook – Trainee Clinical Psychologist Group
Date(s) posted	05/02/21	05/02/21	05/02/21
	17/02/21		
	25/02/21		
	09/03/21		
	16/03/21		

2.5.4. Recruitment (semi-structured interviews)

A total of 60 participants opted in to take part in the second phase (interview) of the study. Purposeful sampling methods were used to select the sample of interest, from those who had opted in. Purposeful sampling is a method of sampling that allows for participants to be recruited, who may have the experiences required to fulfil the aims and research questions of the project (Robson & McCartan, 2016). There was an interest in gaining participants who reported a range of experiences in relation to disclosure and concealment of distress. For example, those who reported positive experiences, negative experiences, those who had concealed and those who had disclosed. This enabled selection of a range of experiences (Palinkas et al., 2015).

To obtain the sample, using the Qualtrics software filter options, participants who had opted in were chosen. From this, participants were further filtered down to those who had disclosed and those who had not. Only four participants who did not disclose their experiences opted in for phase two. Therefore, all four of these participants were contacted and invited to take part in the interview, via email. Of these, one responded and agreed to take part in the interview. For those who had disclosed, responses were filtered to obtain a range of participants, for example, a mixture of first, second, third or recently qualified TCPs, those with a range of psychological distress experiences (e.g., those who reported anxiety, depression, post-traumatic stress experiences, psychosis, bereavement, self-harm, birth trauma and eating difficulties). From this, participants were further filtered to include those who had disclosed to a range of recipients, those who reported positive and negative experiences, those who disclosed to some but concealed from others. Initial interview emails were sent out to over 15 participants, of which several did not respond. As interviews were planned, further emails were sent to participants whose range of experiences were missing from the sample. An overall sample of 13 participants was obtained.

2.5.5. Demographics

The survey asked TCPs a very small amount of demographic information to maintain anonymity and confidentiality. The demographics obtained were considered useful to contextualise the data, establish representativeness of the TCP population and generalise the findings within the context of clinical psychology training. Demographics obtained included: whether they were a trainee or recently qualified clinical psychologist; age; gender; and ethnicity.

2.6. Analysis methods

2.6.1. Survey data

Survey data was analysed on an Excel spreadsheet using descriptive statistics, to highlight the frequency of selected responses. The purpose of the quantitative data from the outset, was to describe participant experiences of distress and disclosure. All the data from the free-text boxes from the quantitative survey was grouped together on a word table, and analysed using a reflexive TA (Braun & Clarke, 2006; Braun & Clarke, 2019). This included the same steps as the analysis of the interview data below.

2.6.2. Interview data

The interview data was analysed using a reflexive TA (Braun & Clarke, 2006; Braun & Clarke, 2019). The procedure followed the six-steps of TA as described in Table 9. A hybrid inductive-deductive approach was used; initial codes were first produced inductively by reading and re-reading the transcripts. A deductive coding framework (Table 10) was then used to again code the data, considering whether the initial codes provided support for or against the deductive framework, which was derived using relevant theories and literature on disclosure.

2.6.3. Qualitative methodologies

In choosing a suitable qualitative methodology several methodologies were considered, appraised, and discussed within research supervision. A summary of the methodologies considered and the decision-making around excluding these is described below.

2.6.4. Grounded Theory

A grounded theory approach seeks to generate a theory relating to a particular area of interest, predetermined by the researcher. The theory is suggested to be ‘grounded’ in data and the particular interactions, processes and actions of the people who are involved (Glaser & Strauss, 1967). This method allows for in-depth and rich data surrounding complex phenomena to be generated (Robson & McCartan, 2016). Glaser and Strauss (1967) originally posited that the researcher enters the field, without theoretical preconceptions, however, this was often described as more positivist in stance (Charmaz, 2008). Grounded theory was later revised by Corbin and Strauss (2008) to include more constructivist thinking, as it was criticised that a researcher cannot enter the field of research without theoretical preconceptions (Charmaz, 2008). Grounded theory is particularly useful in novel areas of research, where little theoretical knowledge may be known.

Although there was limited literature on TCP experiences of disclosure and theory within the TCP population, and grounded theory may have been suitable, it was considered inappropriate given the other relevant theories regarding disclosure, that could be drawn upon, for example, within the general population (Chaudoir & Fisher, 2010; Greene et al., 2006), theories of stigma (Corrigan & Rao, 2012; Goffman, 1963; Link & Phelan, 2014) and shame (Gilbert, 2003). As such, a new or novel theory was not aimed to be derived, which is a central feature of grounded theory. It was considered that the pre-existing theories may support the understanding of psychological distress and disclosure within the TCP context.

2.6.5. Discourse Analysis

Discourse analysis is concerned with how reality is constructed through the use of language within a particular context (Georgaca & Avdi, 2012). It may seek to consider for what purposes and how, language is used, including focus on pauses, utterances, to understand the meaning behind spoken or written words (Hodges et al., 2008). Discourse analysis was considered however deemed inappropriate for the project, as it did not align with the project aims of understanding TCPs' experiences of psychological distress and disclosure. Additionally, discourse analysis is usually conducted using a social constructionist stance and differed from the critical realist position adopted by the researcher.

2.6.6. Interpretative Phenomenological Analysis

The primary focus of interpretative phenomenological analysis (IPA) is meaning-making of the unique experiences of each participant, and how these meanings relate to participants individual and cultural contexts, within their specific context (Willig, 2008). This method relates to the double act of interpretation (double hermeneutics), whereby the researchers are making sense of people, who are making sense of their own experiences, to get an 'insiders perspective' of the phenomena in question (Willig, 2008). The sample of data used in IPA studies is usually small, and analysis is idiographic and intensive, where one case is analysed at a time (Smith et al., 2009). This method was considered, however excluded, as the researchers in the current project were seeking to establish patterns of experience across the experiences of TCPs, rather than exploring TCPs' sense-making of the phenomena of disclosure in greater, ideographic detail.

2.6.7. Thematic Analysis

Thematic analysis (TA) (Braun & Clarke, 2006) is a method of analysis that helps to uncover a collection of themes and patterns across data. TA is often misunderstood as a single method, with one set of method for analysis, however, it is considered to be more of a family of methods (Fugard & Potts, 2020). TA acknowledges both inductive (data-driven) and deductive (theory-driven) approaches to coding, and semantic (explicit or overt) and latent (implicit, underlying; not necessarily unconscious) processes and meanings for coding and development of themes (Braun & Clarke, 2019). In addition, TA also allows use of a hybrid inductive-deductive approach (Joffe, 2012) and flexibility in the theory that drives the research, allowing it to be applied to wide-ranging research interests and populations, in a variety of different ways, based on the aims of the research and the stance of the researcher (Braun & Clarke, 2012). This approach was relevant for the current study as, whilst prior theoretical models surrounding disclosure exist, applying inductive coding first, would allow for the researcher to not be constrained by the theory from the outset.

The procedure for identifying, analysing and interpreting patterns within the qualitative data is systematic and so it allows for explicit structure and processes for the researcher, that can be followed flexibly as opposed to being considered as rigid rules (Braun & Clarke, 2012). For the current project, a reflexive TA was chosen, as it places a larger emphasis on the researcher's own biases, standpoints and experiences, and invites researchers to be reflexive throughout the process of analysis (Braun & Clarke, 2019, 2021). Coding is acknowledged to be a subjective process and the researcher engages with their subjectivities through writing reflections and acknowledging all that they bring to the process (Braun & Clarke, 2019). Given that the lead researcher was a TCP themself, reflexively engaging with the analysis was considered even more so important, allowing interpretations to be critically debated and challenged.

Whilst the flexibility of the approach is appealing, and makes TA a popular method of analysis, the method has been criticised by some for being too vague, lacking transparency, and specific decisions being poorly described within literature (Nowell et al., 2017). To overcome these limitations, explicit decisions related to the approach were discussed and made within research supervision, including the use of inductive-deductive methods and semantic codes. To manage the limitations around transparency the specific decisions and processes are discussed, including a reflexive section by the lead researcher, which discusses the reflexive process throughout the stages of analysis.

Table 9

Six steps of analysis for TA

Phase	Description of procedure
1.Becoming familiar with the data	Transcription and reading the data several times
2.Generating initial codes	Noting initial ideas on the data and reducing large chunks of data into manageable segments
3.Generating initial themes	Looking for patterns within the data and coding them into themes
4.Reviewing and developing themes	Going over themes to ensure they fit with initial codes
5. Refining and defining themes	Deciding on names that best describe each theme
6.Producing the report	Writing up the analysis illustrated by extracts from the data

2.6.8. Data Analysis

Familiarisation with data occurred when the researcher carefully listened to each audio recording and checked each transcript for accuracy, editing the transcript, so that it was in line with the participants words. All interview transcriptions were derived from the University of Nottingham's automated transcription service, which was not highly accurate, therefore the listening back process was important, which also increased familiarisation. The researcher then read back each interview transcript at least twice and made initial notes and reflections, in their reflective diary.

Generating initial codes was first conducted inductively, whereby the researcher systematically hand coded each dataset using the participants' language wherever possible. The object descriptor method (e.g., disclosure impact: able to reflect and learn) was used as required, and where this helped to retain the meaning and context of what was being discussed. To address any potential biases within initial coding, coding labels were discussed in research supervision. Following feedback in supervision, the researcher was mindful around not sanitising experiences and keeping participant language. For example, initially when the participant said "really terrible", this was first coded as "bad", however this was re-coded and rephrased to maintain the salience and importance of what was being discussed, following feedback in supervision.

Following completion of inductive coding, each dataset was then re-coded using a deductive coding framework developed by the lead researcher, which was discussed and refined within supervision. The deductive framework was based on relevant theories and literature (see Table 10). The recent disclosure model proposed by Turner et al. (2021) was not drawn upon in the coding framework or data analysis, as this model was published after data analysis for the current project had commenced. The researcher did not read the paper until after all data had been analysed and themes had been defined.

Generation of initial themes involved creation of a Microsoft Excel spreadsheet, in which all inductive and deductive codes from each dataset were copy and pasted. These codes were then grouped together, and initial themes were noted by the researcher within an initial thematic map (Appendix J). A theme was developed when it related to the research questions or aims, rather than the researcher focusing exclusively on prevalence and frequency (Braun & Clarke, 2006). Following inductive coding, the deductive coding framework was applied to the transcripts (Appendix I). The ideas that emerged from applying the deductive framework were noted by the researcher, including any reflections on inconsistencies and similarities. The deductive coding framework provided greater nuance and theoretical support to the initial theme names, rather than to significantly alter thematic map categories. For example, support was provided for the theme of stigma and shame, however, this was further nuanced as it highlighted that shame may evoke both approach and avoid behaviours, and thus increase or decrease disclosure. The researcher made notes in their reflexive diary to manage biases, debated initial themes within research supervision, challenging interpretations.

Table 10

Deductive Coding Framework

Coding Framework	Link to Literature
Does the data show evidence for or against…	*Research suggests that…*
1.Disclosure impacts subsequent (non)disclosures	It is suggested that disclosure is a process (Dindia, 1998; Reis & Shaver, 1988). The Disclosure-Process Model (Chaudoir & Fisher, 2010) further posits that disclosure does not only consist of a cost versus benefit analysis, or end with outcomes of disclosure events, but disclosure impacts upon subsequent disclosure processes through a feedback loop.
2.Self-stigma and shame related to psychological distress/ mental health difficulties can impact disclosure decisions.	Research suggests that disclosure of psychological distress/ mental health difficulties can elicit feelings of shame (Link et al., 2001). Shame may evoke both approach and avoidance behaviours thereby impacting disclosure decisions (de Hooge et al., 2010). Additionally self-stigma related to stigmatised identities, may be a barrier to disclosure (Corrigan & Rao, 2012).
3.Fears of stigma, exclusion and discrimination inhibit disclosure	Mental health difficulties are highly stigmatised within society, including among mental health professionals (Boyd et al., 2016; Edwards & Crisp, 2017). Disclosure of distress is associated with fears and experiences of stigma, exclusion and discrimination (Brohan et al., 2012) which may therefore impact decision making process, beliefs, assumptions and experiences.
4.Power imbalances between trainee-staff/supervisor	Within the clinical psychology training environment there are inherent power imbalances between trainee-staff/supervisor (BPS, 2020). Theories of power (Foucault, 1980; French & Raven, 1959) suggest that different types of power may exist including coercive, legitimate, reward, expert, referent and information, and power is more about observable behaviour than located within an individual. It would be interesting to see how power relates to (non)disclosure.
5.Personal and professional identity integration and impact on disclosure	Research suggests that mental health professionals with lived experiences of distress may face identity dilemmas related to the personal and professional self (Richards et al., 2016). Identity is associated with self-esteem and distress (Tajfel et al., 1979). It would be interesting to see how TCPs might consider their personal and professional identities as someone who has experienced distress and a professional and how/ if this impacts upon disclosure.

Reviewing and developing themes was an ongoing process through several supervision sessions, where the original thematic map developed by the lead researcher was tailored; based on suggestions by supervisors about themes that appeared to overlap, themes that could be grouped together or any themes or subthemes, that did not have sufficient data to support them. The research questions were kept in mind throughout the process, to ensure that themes were answering the questions. To improve the credibility of each theme, each theme was referred back to the original raw data and initial codes, to ensure they adequately reflected the participant data.

Refining and defining themes were conducted by the lead researcher and these were checked within research supervision. The researcher wrote a narrative around each theme and subtheme, with reference back to original raw data, to ensure these narratives were representative of raw data. The themes were written in such a way that they followed logically from the research questions, relating to distress experiences, prior beliefs and assumptions, the disclosure itself, responses to disclosure, desired changes and impact of disclosure. The themes and subthemes were tailored, and participant words were included: for example, ‘fear about judgement’ was rephrased to ‘worries about judgement’, and the ‘Goldilocks zone of distress’ was a metaphor used by a participant which related to the theme narrative accurately and thus, was named this way. The themes were also discussed with a peer with expertise and knowledge in qualitative methods and analysis, to further enhance credibility.

Producing the report occurred once the final thematic map (Appendix K) was completed following reflection and agreement with the themes by the research team. The researcher used direct quotes to illustrate the themes, and interpreted findings within an analytic narrative. Pseudonyms were used throughout the narrative to demonstrate a range of participant data being used and reflected, within the write up. The report included both quantitative and qualitative findings, and areas of similarities and differences were noted and discussed within the discussion section, using extant literature.

2.6.9. Quality Monitoring

With mixed-methods research quality assurance is just as important as it is in quantitative and qualitative research alone, given it is a paradigm which has been criticised for being poorly planned and integrated (Mason, 2006). Mixed-methods research quality can be appraised using its own quality criteria. One method is via use of the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) which includes five subsections and has good reliability and validity (Pace et al., 2012; Pluye et al., 2009). The MMAT can be used for quantitative (randomised control trials, non-randomised comparative studies, and descriptive studies), qualitative and mixed-methods studies. Quality assurance for the current study was conducted through assessment of the final write up of the study, using the mixed-methods section of the MMAT, by the lead researcher, and by another independent TCP, who has published research in peer-reviewed journals. Details of these are included in Appendix L and M.

Quality was further assured by ongoing discussions and reflection with both research supervisors and two TCPs, who were also conducting a mixed-methods study and a qualitative study. This included discussion about initial theme generation and checking of the narrative, and whether this was perceived to appropriately reflect data and quotes. Supervision sessions were written up by the lead researcher and sent to the University of Nottingham’s admin team for their records, and the lead researcher wrote ongoing reflections in their own diary for reference and quality assurance. This included writing of thoughts, feelings and emotions that arose, as well as decisions made and reasoning behind this.

2.7. Reflexivity

2.7.1. Reflexivity in qualitative research

Qualitative research by definition is subjective in nature; this subjectivity is valued and not ignored. It is important to be aware of one’s own biases, assumptions, and perspectives within qualitative research, and take steps to manage and limit these, to promote rigour of research. Through continuous reflexivity of one’s own influence on the research, whether intentional or unintentional, quality of research can be enhanced (Jootun et al., 2009). Hertz (1997) argued that this reflexivity requires the separation of ‘what I know’ and ‘how it is’ through detachment, internal dialogue, and constant scrutiny. This idea suggests that the researcher enters the field without preconceived ideas, however, it is acknowledged that the researcher had prior knowledge in the field, had conducted a literature review on the topic, and as such, could not have truly entered the field without pre-conceived ideas. To mitigate against biases reflective diaries may often be used (Ortlipp, 2008); to maintain reflexivity the researcher used this method, considering their own biases and assumptions related to distress and disclosure (Braun & Clarke, 2019). Additionally, the researcher continuously used research supervision to check their interpretations and assumptions, by asking ‘what would a disclosure recipients’ perspective be?’, ‘might they experience the disclosure in the same way?’, and ‘how might course trainers or placement supervisors view the situation?’. This allowed for a critical discussion in supervision, reflective dialogue, and scrutiny of assumptions, enhancing the quality and rigour of interpretations, results, and findings.

2.7.2. Researchers’ statement of perspective

To facilitate transparency and provide readers with an understanding of how to interpret and read the research analysis and findings, a statement of perspective is included (Elliott et al., 1999).

This research was undertaken as part of the partial requirements of the Trent Doctorate in Clinical Psychology. My interest in the topic was facilitated by my own experiences of psychological distress pre-training and during training, and knowing other peers with lived experiences. My prior beliefs about the topic were that mental health professionals and developing trainee clinical psychologists, just like others, are human first. I had perceived that there were myths about clinical psychologists and that they are somehow immune to life adversities and stressors. Due to my own beliefs about the value of lived experiences in the helping professions, such as it enables greater understanding, empathy, and sensitivity to other people’s suffering, I started the project with the view and hope that within the clinical psychology profession, course staff and peers, must value lived experiences of psychological distress. However, I had some doubts about how able TCPs may feel to disclose distress, due to the highly competitive nature of clinical psychology and stigma related to mental health difficulties, and thus, how welcomed their disclosures may be by others. I had prior hopes that given that psychologists receive training on empathising and person-centred approaches, which I most aligned with, they would have positive responses to disclosure. On reading around the topic and searching the literature I learned, however, that there was a mismatch between distress experiences and disclosure within the workplace. I started to wonder why this was and the factors related to these experiences and choices. As I went through training myself and had experiences of disclosing my own distress, and witnessing peers also contemplating disclosure, I wondered how the training environment and context, may make disclosure more or less likely. Additionally, how different individuals or experiences may be responded to or not by different recipients. I was aware throughout the study process, that I was unlikely to hold a neutral stance due to my prior beliefs and assumptions, however, at all stages of the study, I noted down my assumptions and reflected on these via research presentations, obtaining feedback on the project, and through critical discussion in research supervision.

3. Extended Results

This section provides further detail on the survey and interview findings. The main findings of the survey were highlighted in the journal paper, however, to further elaborate on the findings, summary tables including all the quantitative results are included below. For the interviews, further quotes from participants to illustrate the themes that were not included in the main journal, are included.

3.1. Phase one (survey) results

In relation to responses related to distress experiences, help-seeking, and time off work, 88% (*n*=125) of participants reported seeking professional support for their distress and 11% (*n*=16) shared that they had not. In terms of help-seeking and a total of 244 responses endorsed, 27.4% (*n*=67) stated they sought medication through their general practitioner (GP), 26.6% (*n*=65) shared they sought talking therapies via their GP, 0.82% (*n*=2) sought medication privately, 29.9% (*n*=73) sought talking therapies privately and 15% (*n*=37) stated 'other'. From 123 respondents, 30.9% (*n*=38) stated they sought professional support before training, 24.4% (*n*=30) during training and 44.7% (*n*=55) both before and during training. Out of 139 responses, 49% (*n*=68) stated that their distress resulted in time off work (pre- and during training) and 51% (*n*=71) stated that it had not. From a total of 68 responses, the following were reported in relation to time off work; 5.88% (*n*=4) each responded with 1-2 days and 1 week, 2.94% (*n*=2) stated 2 weeks, 8.82% (*n*=6) stated 1 month, 7.35% (*n*=5) stated 2-3 months, 2.94% (*n*=2) stated 4-6 months, 7.35% (*n*=5) stated over 6 months and 58.82% (*n*=40) stated 'other'.

The survey responses from participants who shared one or more disclosure are summarised in Table 11. This includes details of the level of disclosure, whether this was planned or unplanned, purposes of disclosure, beliefs, thoughts or assumptions about disclosure, outcomes, and responses to disclosure. Disclosure 1 and 2 are reported separately. It is worth noting that the disclosure 1 and 2 are not necessarily sequential disclosures.

Table 11

Disclosure experience summary

Disclosure experience	Response option	Disclosure 1		Disclosure 2	
		Response count *(n)*	%	Response count *(n)*	%
Level of disclosure	Fully disclosed	25	25	10	21.74
	Partially disclosed	46	46	19	41.30
	Selectively disclosed	29	29	17	36.96
	Total	100	100	46	100
Disclosure planned or unplanned	Planned	36	36	22	47.83
	Unplanned (e.g., occurred in the moment)	44	44	12	26.09
	I had no choice in the disclosure (e.g., due to significant distress at the time)	20	20	12	26.09
	Total	100	100	46	100
Purpose of disclosure	To gain/ seek support	54	27.14	29	33.72
	To seek professional help (e.g., in the form of medication or therapy)	5	2.51	1	1.16
	To be a role model for others	8	4.02	5	5.81
	To normalise experiences of distress	35	17.59	10	11.63
	To be honest and open about your mental health	71	35.68	32	37.21
	Other	26	13.07	9	10.47
	Total	199	100	86	100
Prior beliefs, thoughts, or emotions	I would be judged negatively	46	5.20	23	5.10
	Disclosing would have a negative impact on my relationship with the person	26	2.94	18	3.99
	Disclosing would help me to integrate my personal and professional identities	27	3.05	13	2.88
	I would be judged as incompetent	40	4.52	27	5.99
	I was unsure if I could trust the person	29	3.28	23	5.10
	I would feel better by disclosing	31	3.50	17	3.77
	Disclosure would have a negative impact on my self-esteem	11	1.24	7	1.55

Disclosure experience	Response option	Disclosure 1		Disclosure 2	
		Response count *(n)*	%	Response count *(n)*	%
Prior beliefs, thoughts, or emotions	I trusted the person, I assumed I would have a positive experience of disclosing	43	4.86	11	2.44
	Experiencing distress is a weakness	20	2.26	8	1.77
	Disclosure would help me to build strength and resilience in my personal and professional life	34	3.84	17	3.77
	I would be discriminated against	13	1.47	7	1.55
	I would feel less burdened by my difficulties	27	3.05	17	3.77
	I would be stigmatised	16	1.81	9	2.00
	I would be perceived as weak	29	3.28	23	5.10
	Disclosing would help me to manage my distress	40	4.52	15	3.33
	I feared disclosing would impact negatively on my training experience	32	3.62	22	4.88
	I feared I would be ‘kicked off’ the course	18	2.03	8	1.77
	I was ashamed	30	3.39	9	2.00
	I was embarrassed	45	5.08	18	3.99
	Lived experience of distress is an asset to the work and disclosure would be beneficial during my training and clinical work	31	3.50	10	2.22
	I would feel inferior to others on my cohort/ other psychologists	33	3.73	17	3.77
	My previous experience of disclosing was negative, so I feared future negative experiences	15	1.69	4	0.89
	I would be perceived as ‘unfit’	32	3.62	21	4.66
	I was anxious / fearful	48	5.42	17	3.77
	Disclosure would have a negative impact on my mental health and well-being	8	0.90	7	1.55
	I was worried about the outcome	40	4.52	21	4.66
	I would be viewed as a 'client' and therefore less powerful	14	1.58	6	1.33
	My previous experience of disclosing was positive so I assumed this experience would also be positive	12	1.36	5	1.11
	Support would not be available or provided	16	1.81	8	1.77
	I thought disclosing would give me a sense of relief	32	3.62	15	3.33

Disclosure experience	Response option	Disclosure 1		Disclosure 2	
		Response count *(n)*	%	Response count *(n)*	%
Prior beliefs, thoughts, or emotions	By disclosing I thought I would receive the care and support I needed	26	2.94	21	4.66
	Disclosure would help me with my confidence with considering disclosure within client work	11	1.24	4	0.89
	Other	10	1.13	3	0.67
	Total	885	100	451	100
Disclosure outcome	I received the help that I needed	27	5.34	11	4.80
	I was supported by the person I disclosed to	69	13.64	22	9.61
	I did not receive the help that I needed	7	1.38	13	5.68
	I was not supported	7	1.38	13	5.68
	Disclosure adversely affected my training	4	0.79	9	3.93
	Disclosure helped me to manage my distress	24	4.74	11	4.80
	My clinical work was limited by supervisors due to my disclosure	2	0.40	5	2.18
	I was referred to Occupational Health	11	2.17	4	1.75
	My line manager was informed	10	1.98	9	3.93
	My mental health worsened	6	1.19	10	4.37
	I was relieved	37	7.31	11	4.80
	I felt understood	56	11.07	15	6.55
	I felt safe	45	8.89	11	4.80
	I did not feel safe	12	2.37	17	7.42
	I developed confidence for future disclosure	48	9.49	14	6.11
	I was able to connect with others in similar situations	25	4.94	5	2.18
	I was able to integrate my personal and professional identities	28	5.53	9	3.93
	Disclosure aided self-reflection	46	9.09	15	6.55
	I experienced increased anxiety	26	5.14	18	7.86
	Other	16	3.16	7	3.06
	Total	506	100	229	100

Disclosure experience	Response option	Disclosure 1		Disclosure 2	
		Response count *(n)*	%	Response count *(n)*	%
Recipient response	Listened to me	83	13.26	28	11.11
	Did not listen to me	3	0.48	7	2.78
	Were sensitive towards me	77	12.30	22	8.73
	Were non-judgemental	80	12.78	23	9.13
	Were judgemental	5	0.80	7	2.78
	Did not pressurise me to share more than I wanted	66	10.54	21	8.33
	Were helpful	53	8.47	17	6.75
	Provided containment	55	8.79	15	5.95
	Were unhelpful	9	1.44	15	5.95
	Provided safety	35	5.59	10	3.97
	Normalised my experiences	63	10.06	16	6.35
	Were clear about any actions they were going to take	33	5.27	16	6.35
	Were unclear about confidentiality and/or information sharing	3	0.48	9	3.57
	Provided useful resources for support	20	3.19	7	2.78
	They pressurised me to share more than I wanted	1	0.16	6	2.38
	Did not provide clarity about next steps/actions	4	0.64	8	3.17
	Provided support	26	4.15	13	5.16
	Other	10	1.60	12	4.76
	Total	626	100	252	100

For the first disclosure, 59% (*n*=59) reported that the recipient could not have done anything differently, 17% (*n*=17) were unsure and 24% (*n*=24%) stated ‘yes’. For the second disclosure, 26.8% (*n*=12) stated ‘no’, 17.8% (*n*=8) stated unsure and 55.6% (*n*=6) stated yes. For disclosure 1, out of 99 respondents, 86.9% (*n*=86) stated that they would still choose to disclose if they were in the same situation again, 9% (*n*=9) stated they would not, and 4% (*n*=4) were unsure. For disclosure 2, out of 44 respondents, 56.8% (*n*=25) stated that they would still choose to disclose, 29.6% (*n*=13) stated they would not, and 13.6% (*n*=6) were unsure. In terms of regrets for disclosure 1, 96 participants responded, 17.7% (*n*=17) stated they did have regrets, 77% (*n*=74) stated they did not, and 5% (*n*=5) were unsure. For disclosure 2 and 45 respondents, 31.1% (*n*=14) reported having regrets, 46.7% (*n*=21) reported having no regrets, and 22.2% (*n*=10) were unsure.

For overall experience (0=very negative, 10=very positive) of disclosure 1, 97 participants responded (*m* = 7.32, SD 2.31), and for disclosure 2, 46 responded (*m* = 4.93, SD 3.28). When sharing if anything could have made the experience better, for disclosure 1 and 99 respondents, 49.5% (*n*=49) reported nothing, 28.3% (*n*=28) were unsure and 22.2% (*n*=22) reported yes. For disclosure 2 and 46 respondents, 19.6% (*n*=9) reported nothing, 15.2% (*n*=7) were unsure and 65.2% (*n*=30) stated yes. A summary of the results for participants who did not disclose their experience to anyone, or to some are summarised in Table 12 below.

Table 12

Non-disclosure experience summary

Non-disclosure experience	Response options	Response Count *(n)*	%
Beliefs, thoughts, or emotions that prevented disclosure	No, I chose not to disclose because I saw no purpose in disclosing	6	1.28
	Disclosure would be too exposing	44	9.38
	Concealing would protect me from potential damage to my self-esteem/ worth	16	3.41
	I feared further emotional strain and stress	20	4.26
	Disclosure would have a negative impact on my training	25	5.33
	I would be judged as incompetent	30	6.40
	I would be stigmatised	18	3.84
	I would be discriminated against	10	2.13
	I feared that I would be perceived as ‘unfit’	28	5.97
	I feared I would lose opportunities on placement	13	2.77
	I feared I would be ‘kicked off’ the course	7	1.49
	I was ashamed	18	3.84
	I was embarrassed	25	5.33
	Concealment was easier	34	7.25

Non-disclosure experience	Response options	Response Count *(n)*	%
Beliefs, thoughts, or emotions that prevented disclosure	I was not ready to disclose	19	4.05
	I was anxious/ fearful	24	5.12
	I feared that disclosure would raise ‘fitness to practise’ concerns	15	3.20
	Disclosure would have a negative impact on my mental health and well-being	12	2.56
	I would be perceived as a 'client' and thus less powerful	13	2.77
	I would feel inferior to others on my cohort/ other psychologists	20	4.26
	Experiencing distress is a weakness	3	0.64
	I would be perceived as ‘weak’ or ‘inferior’	16	3.41
	I did not feel safe to disclose	18	3.84
	The culture on the course prevented me from disclosing	13	2.77
	My previous negative experiences prevented me from disclosing	10	2.13
	Other	12	2.56
	Total	469	100
What would have enabled disclosure	Nothing, I saw no purpose in disclosing	6	2.27
	Open conversations about mental distress during training	31	11.74
	Normalising of distress during training	30	11.36
	Specific guidance surrounding process and potential outcomes of disclosure	29	10.98
	Clarity around support available	15	5.68
	Clear guidance on confidentiality and limits in relation to own mental health difficulties	27	10.23
	Guidance on the processes and outcomes of disclosure	17	6.44
	Support from staff in considering decisions surrounding disclosure	18	6.82
	Opportunity to speak to others in a similar situation	24	9.09
	Quality supervision	17	6.44
	Building good relationships with trusted psychologists	22	8.33
	Resources to support decision surrounding disclosure (e.g., peer support, online resources)	18	6.82
	Other:	10	3.79
	Total	264	100

From 53 responses, 5.6% (*n*=3) stated they regretted not disclosing, 69.8% (*n*=37) had no regrets, and 24.5% were unsure. Out of 55 respondents, 54% (*n*=30) reported that they would still choose not to disclose, 7% (*n*=4) stated they would not, and 38% (*n*=21) stated they were unsure.

Themes from free-text boxes for survey

All data from the free-text boxes were collated and a TA was conducted separately. From this, seven main themes were initially constructed, which are highlighted and demonstrated with relevant quotes in Table 13. It was important to note that, for many participants, distress and disclosure opportunities appeared to be exacerbated by the emergence of the COVID-19 pandemic, and feelings of isolation, low mood, and lack of connection due to this, whilst managing a demanding course. It is possible that this was more prevalent for first year TCPs who started training during the pandemic, who also may have had less opportunity to disclose their distress experiences. Each of the survey themes were synthesised with the constructed themes from the interview data, as these were similar in nature. For example, survey theme 1 integrated into interview theme 1, theme 2 into interview subtheme 2a, theme 3 into interview theme 2 and 2b, theme 4 into interview subtheme 2c and 5, theme 5 into interview theme 3a, theme 6 into interview theme 4 and theme 7 into interview theme 6. The following describes the narratives of the initial survey themes:

1. **Differing conceptualisations of distress:** When describing their experiences of distress in their own words and the impact of this on them personally and professionally, some participants used diagnostic categories to make sense of and label their experiences, whilst others viewed diagnostic labels as hindering and not reflective of their experiences. For these participants, they often referred to earlier experiences of life trauma and relational difficulties, and/or recent experiences of trauma and stress. The impact of the COVID-19 pandemic was referred to by many participants, resulting in them having less resources that may have otherwise helped them to cope with their distress, and the demanding nature of clinical training. This suggests that whilst the COVID-19 pandemic may have exacerbated distress

for TCPs, impacting not only levels of distress and coping resources, but also opportunities for disclosure, distress was pre-existing.

2. **Self-stigma and shame:** This theme was consistent with the findings of the interview results, whereby shame and self-stigma was reported to exist, and prevent disclosure, however, this was often discussed in relation to clinical training. It was unclear whether this was related to clinical psychology training, or more widely related to being a mental health professional. Feelings of shame, embarrassment, and distress being seen as a weakness, were common factors related to participant lived experiences.

3. **Fears and experiences of judgement and discrimination:** This theme was also consistent with the interview findings and highlighted that many participants had fears about being judged or had had experiences of being judged and discriminated against. For example, participants shared that disclosing distress would mean that their name would be ‘flagged’, and they did not want this, in case this impacted upon their progress with the course and/or opportunities for the future. Some TCPs gave explicit examples of when they viewed that they had been discriminated against, by being told to take time off work, or that they should not have disclosed their experiences. Some reported that disclosure negatively impacted upon their relationship with the recipient, and they felt that this changed the way in which they were seen and treated. These adverse experiences appeared to prevent disclosure. It is important to note, however, that recipients of disclosure may have had different perceptions and reasons for why time off work was required, for example, if work was being impacted in such a way where there was a risk to service user care. Additionally, it is possible that taking time off work may sometimes be intended as a compassionate response, for example, as means of removing stressors and allowing for greater self-care.

4. **No space for distress within the culture of clinical psychology:** Many participants highlighted feeling, that within the culture of clinical psychology, there was no space to talk about distress and that they perceived distress was not valued or welcomed. It was important to note that these experiences

appeared to be more wider beliefs about the culture of clinical psychology, as well as some specific experiences where participants reported that they felt there was no space within the structures of the course (e.g., placement meetings, supervision), that provided the opportunity to disclose. These opportunities may also have been reduced by the pandemic, given that for many teaching was moved online. Participants often reported that within these online formats, they had little informal discussions with other cohort members, staff and lecturers, and as such the opportunity to disclose was reduced.

5. **Safety, trust, and relationships increase or decrease disclosure:** Again, fitting with the results from the interviews, participants reported that safety, trust, and relationships with the recipients, were important factors in whether they were likely to disclose their experiences or not. These also impacted upon their prior beliefs, outcomes and responses from recipients. Participants who reported positive experiences of disclosure, shared experiencing a safe relationship with the recipient, who listened to them, were empathic, and created space to explore difficulties. However, for those who felt they needed to disclose to specific people to gain the adjustments or for practical support, and often did not have a strong relationship with this person, perceived these disclosures increased distress, feelings of unsafety, judgement, and stigma. This highlights the important role of relationships and emotional responses within disclose experiences.

6. **Emotional and relational responses require prioritisation over practical ones:** Positive experiences appeared to be evident when emotional responses and support, over practical responses were prioritised, although the practical responses appeared to be needed, alongside the emotional support. There were some examples where support was spoken about but did not transpire into action, or implemented, which TCPs reported to be unhelpful. Where support desired was received, this appeared to also increase trust in the recipient and belief that their disclosure had been heard. This suggests the importance of training courses having clear and specific plans in place, highlighting how TCPs may be supported, what they might

require, and for this to be a collaborative process in which TCPs are able to share what they feel they need and require.

7. **Lasting legacies of disclosure experiences:** Disclosure experiences, whether these were perceived to be positive or negative, ultimately all had an impact on TCPs, both personally and professionally. What was interesting was that even when disclosure had not gone as hoped, or when prior negative assumptions and beliefs had been confirmed, TCPs still shared developing learning from the experiences. This suggests and supports evidence that individuals can thrive from adversity, and adversity may not necessarily prevent future disclosure or have a negative impact on self. However, this needs to be taken cautiously, as whilst it is evident that TCPs may thrive despite negative experiences, continuing to emphasise the creation of safe and supportive environments, where TCPs feel able to disclose and talk openly about distress, is important.

Table 13

Themes and relevant quotes from phase one (free text boxes)

Themes	Quotes
1. Differing conceptualisations of distress	*“Experiencing challenges of navigating training and COVID”* *“Bipolar disorder - episodes of mania and depression”* *“Post-traumatic symptoms in response to trauma prior to starting training”* *“Recent difficulties with accommodation, bereavement, relationship breakdown and not being able to access all of my normal coping strategies”* *“I don't necessarily believe in diagnosis or talking explicitly about my "problems".”* *“Framing this as disclose when for me my difficulties are ongoing life work (probably) as they related to early life experiences as well as past”*
2. Self-stigma and shame	*“I'd be keen to avoid any kind of narrative of being anxious/stressy/ emotional on the course”.* *“I was worried (and still am) about my anxiety being seen as a weakness”* *“I feel embarrassed that I was so upset/distressed at the time”* *“I was ashamed, as though it [distress] was something I shouldn't be talking about or sharing”* *“I do still carry a lot of shame and admitting what feels to me like a weakness is difficult and feels uncomfortable”.*
3. Fears and experiences of judgement and discrimination	*“Not wanting to have a particular 'flag' when it comes to monitoring my wellbeing as a trainee”* *“All the issues that later arose in our relationship were put down to my anxiety rather than the supervisor being quite abusive and very difficult”* *“I feel disclosing would jeopardise my future opportunities”* *“I had some subconscious anxieties around being judged or perceived differently”* *“I felt discriminated against, I was told that I should not have disclosed personal information to so many people”* *“I was told to take some time off from placement. I felt judged and stigmatised.”*

Themes	Quotes
4. No space for distress within the culture of clinical psychology	*"There have not been opportunities to open up about personal experiences"* *"Unhealthy culture on the cohort surrounding lived experience"* *"Clinical psychology is not safe. Under a thin veneer of professionalism there is a brutality and harshness toward any perception of weakness or vulnerability"* *"The culture around training continues to exhaust me, made doubly difficult beginning this work during a pandemic."* *"I wish I could [disclose] but I feel the culture of training doesn't permit it"* *"You don't feel that there is time for personal issues in clinical supervision or on placement"*
5. Safety, trust and relationships increase or decrease disclosure	*"Worry it [disclosure] would be passed onto course staff and am not sure how far the information would go and what the consequences could be"* *"I do not yet feel safe enough to disclose"* *"It [disclosure] depends on my relationship with the supervisor"* *"I wanted to share because we had developed a good supervisor-supervisee relationship and I felt able to share"* *"Supportive, kind and pragmatic. Felt very lucky that I had this individual as my assigned tutor"* *"I felt I could trust them. They listened to me. They validated my experiences."* *"Create a safe space to explore it within supervision, rather than pushing for answers/what I was going to do"* *"At times I felt as though several boundaries were being crossed, and I had not invited him to cross them. I came away from the meeting feeling unheard, unsafe, and as though he believed I was incompetent. I felt overwhelmed by his response, and very anxious about potential actions he might take."*
6. Emotional and relational responses first, over practical ones are needed	*"My placement supervisor gave me very helpful advice and signposting for where I could seek appropriate personal therapy"* *"After Occupational Health wrote a report, it was copied in to all the course staff, in violation of my rights to privacy"* *"I was disappointed that my supervisor jumped straight to problem solving"* *"Said that they heard how much I was struggling and in need of support but did not actually provide this (just told me how well I was doing given everything I was going through)."* *"Felt like the response was maybe reactive and anxiety-driven, so taking time to talk things through"*

Themes	Quotes
7. Lasting legacies of disclosure experiences	*“Although it was helpful at the time, I think the consequences and who else the information was shared with (and how they responded) had, and still has, a negative impact on my wellbeing.”* *“It helped me in the long term and has made me a better person and clinical psychologist”* *“My disclosure was treated safely and provided an opening for discussion about normalising distress”* *“I feel it [disclosure] has negatively impacted my experience of training”* *“Developed a reciprocal supportive relationship where we both knew we could turn to each other when needed”*

3.2. Phase two (interview) results

Theme 1. Diagnostic or psychological conceptualisations

Even though some participants who understood their distress and described it diagnostically, shared acknowledging that these experiences were not just internal to them, but contextual factors influenced these:

> I very much tried to see it [distress] in the context of… there are outside forces, there are things happening at work or there are things happening in my personal life, that make me feel this way, that triggered these feelings. (Taylor)

Many also highlighted the significant impact of COVID-19 on their distress and how this contributed to their distress. One participant when describing their experience of bereavement during COVID-19, shared that this was also adversely impacted by the nature of their clinical placement: “Losing her was always going to be distressing, but things I witnessed as well in connection with COVID, going into the wards… and that added, I think an extra level”. (Jordan).

This highlights that distress experiences were related to several factors pre and during training, and unsurprisingly adversely impacted by the emergence of the pandemic. Additionally, completing training during the context of COVID-19 added an extra layer of complexity, whereby witnessing the impact of COVID-19 with client groups, was distressing.

Theme 2: Worries about judgement complicate disclosure decisions

Subtheme 2a: Self-stigma and shame

This theme as discussed in the journal paper was evident across all participants. Charlie, however, differentiated between external stigma and self-stigma: “it's more a fear of being judged, rather than actually others judging, and I think a lot of it is self-stigma that I create for myself, ‘cause I feel embarrassed to some extent of some of my experiences.” This suggests that whilst some individuals may reflect on and separate out self-stigma from other types of stigmas, perhaps this is not always straightforward. One might argue that self-stigma is related to the self, but even this is related to how one perceives themselves in relation to others, as described by self-stigma theories, whereby external stigma is internalised. In this respect, external and self-stigma (specifically how one may be viewed) is intrinsically interlinked.

Subtheme 2b. Expected stigma and fears of competency being questioned

It was interesting to note that for some participants, disclosure was considered important because they felt this was the ‘right’ and ‘ethical’ thing to do, in relation to adhering to HCPC practice guidance:

> I was worried if I wasn’t well enough to work or something like that, then there would be negative consequences and that would be an unethical thing to do. I just wanted to make sure that I’d ticked all the boxes. (Pat)

This highlights that disclosure decisions are related to beliefs about responsibility and the impact of distress on clinical practice. This highlights that TCPs are likely to reflect on these factors; however, it is possible that this may drive disclosure when it might not be needed and wanted, as a personal choice, but due to perceived worries about the consequences of not doing so. Whilst the HCPC standards of proficiency, may be protective, enable boundaries at work, and support ethical clinical practice, these may also have a negative impact on TCPs and their confidence in disclosure. Often the worries were related to fitness and competency as a whole, rather than being judged on specific tasks or in specific situations, as Ray reports: “part of me thought that they will say that maybe I’m not fit to do it [work].” These all-encompassing perceptions appeared to increase worries and reduce likelihood of disclosure for many.

Subtheme 2c. Power between trainee-staff member

The power differentials and impact on disclosure decisions were highlighted by several participants. Sam reported: “I think that's why I felt so silenced a lot… she's like marking my placement and looking at my work and commenting on my performance and stuff, so I had worries about how she was gonna react.” This highlights the impact of legitimate power, whereby placement supervisors and course staff members have the power to pass or fail the placement, which were particular concerns for TCPs. In this context, power is not only held by an individual but also exerted by observable behaviour (e.g., by passing or failing the placement). These worries reflect rational worries for TCPs, however, it is unclear how exertions of power may relate to distress itself, or genuine concerns about competency, given that programme staff also have a gatekeeper role to the profession.

One participant further expressed how it is important for programme staff to hold in mind the power differentials between trainee and staff member, as this may impact upon how one presents or shares distress:

> I think that I was probably, under reporting how difficult I was finding things, but I was still sat there in floods of tears and I think maybe to just, to kind of hold that imbalance in mind… what it's like as a trainee who's never been through clinical training before. Who doesn't know what options there are, and all kind of standpoints. (Charlie)

Whilst this participant highlighted the importance of acknowledging power differentials, it was unclear how these differentials may be held in mind and whether there are specific ways in which they felt that power differentials may be addressed.

One participant described a specific experience of how they experienced power being used in an unhelpful way: “He’d like change the goal posts all the time, so like expect more of me that I know that all the trainees would not have to do”. (Ray). This highlights specific perceptions of unhelpful power use, however, it is not possible to determine, if indeed, there was differential treatment, as we do not know the experiences of the other TCPs the participant was referring to, and how these experiences differed. Nevertheless, it is important to acknowledge that this was experienced in this way by the TCP, suggesting that perhaps expectations were not transparent.

Theme 3. Disclosure likelihood is determined by relationships

Subtheme 3a. Existing relationship and trust

Several participants acknowledged that the support from one relationship is invaluable to disclosure likelihood, level, and experiences:

> I think it was lucky that my tutor was someone I got on with really well and that was, you know, she was the person, you know the right person to share that with anyway, and I think it would have been really hard if she didn’t feel like a supportive person. (Sam)

However, it was acknowledged and advised to others, who may be in a similar situation, to choose carefully who they disclose their distress to, and that those who need to be disclosed to, because of possible policies and processes in place, may not necessarily be the right people: “It's just got to be someone that you’ve got that relationship with… that relationship is key. Just because someone is your tutor that doesn’t mean they're the best person to go to about that.” (Billie).

It was important to note that despite possible power differentials, the quality of the relationship between the trainee and recipient, appeared to act to reduce these differentials and enable disclosure:

> It just, it felt okay to do that with her because I thought well, you know, yes, okay, as a psychologist she could voice her concerns to the University if she felt I was completely incompetent, but also within that mentor relationship, she didn't have a sort of a formal decision over whether I passed my training or not. (Andi)

This suggests that the inherent power differences between trainee and staff may be minimised, through development of trusting and supportive relationships. Seeking out recipients, who TCPs have a relationship with and sharing with those, may therefore increase opportunity for positive experiences.

Subtheme 3b. The Goldilocks zone of distress

It was highlighted that a significant amount of energy may be required to modify the expression of distress, and despite doing this, it may not necessarily result in the outcome hoped for:

> I made my distress so palatable and so tolerable, and I still had a really difficult and unhelpful reaction. So if I hadn't have worked really hard within myself to like present in the very thoughtful, very reflective like you know, understandable way, what would have happened? (Jordan)

To further highlight this theme, one participant reported disclosing distress early, to gain the help they needed and to prevent an escalation in their distress, however, they believed this was not recognised. It was suggested that their distress was not high enough or within the window in which support may be received:

> I think all they heard was… things aren't quite as bad for you right now as they could be, so we're gonna wait and see. Which I just think goes against all of what they are trying to teach us like preventative mental health programmes… and I know a lot of what psychology does is firefighting but that isn't always the best way you know, it's not always the best way to just kind of leave people until they're in crisis point so. I think, I felt really disappointed, that that wasn’t met. (Taylor)

Another highlighted: “It's almost like you have to reach a certain point before somebody says actually you need help. It feels very reactive sometimes rather than proactive”. (Frankie). This suggests that distress outside of the ‘Goldilocks zone’ for some TCPs, does not result in the support they require, can escalate distress further, and have a negative impact on training.

Theme 4. Emotional support versus practical responses

Subtheme 4a. Support hoped for is not always a given

Some participants reported that they had disclosed their distress and communicated specific practical aspects that they thought would help them to cope and manage, however, reported that these requests were not always met:

> …and I was trying to explain it and it just felt like the disclosure wasn't even important or relevant, and it was like it didn't matter, that all that stuff had happened, because it didn't fit with the rules of the training course. (Charlie)

For one participant who had disclosed their distress because they felt a reciprocal relationship with the person, reported that the response did not live up to their expectation and they felt increasingly judged:

> …like I was really hopeful that it would be okay and that he was someone who had disclosed that he’d had his own therapy, so like I thought he’d really get it.

> But he just… he just didn't. I think he thought less of me or that I wasn't competent. (Ray)

Another reported that their disclosure actually led to their competency being questioned, rather than them receiving the emotional and practical support that they had hoped for: "…the response was, you know we need to really think about whether you can cope with everyday work and normal job" (Billie)

This further supports the theme that for some worries about judgement are not just worries but evident in actual experiences of negative evaluation.

Subtheme 4b. Practical support is more readily available

There were several examples of where the practical support was helpful and valued by participants, as Pat reported: "We had an essay that was due in that weekend and she asked if I wanted any extenuating circumstances." This practical support enabled participants to continue with the demands of the course and was therefore important and welcomed.

Similarly, despite having prior beliefs about the recipient and their responses on an emotional level, the practical responses appeared to enable TCPs to get the support that they required:

> I believed that possibly my clinical tutor wouldn't really listen, but she is very good at putting action plans into place, so when there's a practical thing that needs to be done, I think she'd be very good at organising a meeting with the clinical director. (Taylor)

Another reflected that there were disparities between the practical aspects that they communicated they required, and the emotional responses that they thought would be available:

> I guess I gave them quite a direct request with that and they'd given quite a direct answer, but anything that was ambiguous… maybe in retrospect if I'd gone in with things that I wanted from them it might have been different, but I guess I didn't articulate those things with them because I didn't think I would need to, I have never done anything like that before so there wasn't really a

> framework to go with. I guess I trusted them to help me navigate and scaffold that a little bit. (Stevie)

This suggests that whilst TCPs may have prior ideas about what support they require, what may be helpful, and may be able to communicate this, this in reality may not always be possible, due to the level of distress one might be experiencing at the time. Additionally, anxieties and worries may make it harder to communicate specific requests, or know what support is available, if this is a first disclosure.

Subtheme 4c. Emotional support is dependent on existing relationship

Several participants reported that they had supportive relationships with some cohort peers and these relationships were different to other relationships and friendship groups, in that there was a shared understanding of what it is like to be on training. Taylor reported: “I think because we've had training in how to… how to listen. How to be genuine and importance of listening and being genuine.” Elaborating that:

> If they've not done the DClinPsy themselves, I don't think people, my other friends at least, I don't think they have a sense of how difficult it is and then to get news like I thought in that context, right around the time of an exam, yeah, I felt like they [cohort friends] would be the ones that understood the most. (Taylor)

One reported having a supportive relationship with a staff member, and felt that their distress was responded to helpfully and even valued:

> My personal tutor she was great, she said, ‘it’s great that you’ve got that experience…and is there anything you might need at that time’ and like ‘how about we meet like once a month’…or something like that. So, I already felt like it had been noted, it had been responded to in a helpful way. (Pat)

Another reported: “Because I’d had quite a lot of positive interactions with her, and I've been able to talk to her about some stuff and she had been supportive. I think that trust was there.” (Billie). Suggesting that trust and relationships may be built through several interactions and communications and may require time. Which within the context of training, particularly within supervisory relationships due to their short-term nature, may be more difficult to establish.

Theme 5. Desired changes that could increase disclosure

Subtheme 5a. Permission giving

Across the sample there was evidence that permission giving, within the differing structures of training, enabled disclosure or improved experience of disclosure. It was interesting to note that for one person, where this permission was given in the application form (e.g., where they had opportunity to declare a formal disability), this resulted in a quick response from course staff at the start of training: “I guess because I did formally declare it as essentially a disability, although I don't really like that word. So, the course director was aware and I met with her initially early on…” (Charlie).

It is important to note that declaring a disability within UK application forms for clinical psychology training may be advantageous, because some courses run the ‘disability confident’ scheme, whereby applicants who self-declare disabilities (physical and/or mental health) are offered an interview, if they meet the minimum standards for interview for that course. However, not all courses run this scheme, and the term used to define disability, is as defined within the Equality Act 2010 (as ‘impairment’), which does not represent the language TCPs may use to describe their distress, as highlighted within the results. Additionally, TCPs may have fears surrounding how disclosing a disability on application forms may impact upon their chances of getting onto the course, given the significant competition to get onto clinical training. Therefore, whilst declaring a disability on application forms may enable greater opportunity for explicit discussions of distress and support requirements to take place, TCPs may prefer not to declare this from the outset.

Several participants highlighted additional ways in which permission giving may be achieved: “I think nearly every trainee goes through distress or, you know, levels of stress and anxiety… I think there could have been more reflection on that really. You know the ups and downs of clinical training” (Charlie). In addition, it was highlighted:

> If there was allotted time within clinical supervision for personal stuff… that trainees get an hour a week to talk about clinical work, but if they also get half an hour a month or something, to reflect on how things are with the course. Their stress in relation to the course and their mood in relation to the course. That would definitely open up a window of opportunity for me to feel comfortable to talk about those things, because then it's kind of permitted. It's allowed. (Taylor).

These specific examples of how permission giving may be enacted may be drawn upon. It seems important to incorporate opportunities to talk about personal distress within the context of and pressures of training, as this was highlighted as an important factor. It is worth noting that there were a couple of examples, where participants reported that they had ‘well-being’ check ins. These check-ins may differ between-courses, between-staff and between-trainees, even with individual staff, and may be based on preference of staff and TCPs. However, not making such check-ins uniform, may reduce the likelihood of disclosure for those who say they do not want a check in. It was evident that such forums do exist and allow opportunity for disclosure, and so these practices could be further solidified and embedded.

Subtheme 5b. The four C’s – clarity, confidentiality, consent, and choice

Whilst clarity around processes, actions and possible outcomes of disclosure was described by many as extremely important, clarity in communication, and validation of disclosure was also considered to be important, to help manage and counteract worries:

> Like just clearly communicating that we don't think that this is gonna make you an awful practitioner or that you’re not competent or… I think just, just actually naming that rather than being left wondering and second guessing is that what their thinking… (Stevie)

One participant shared that the choice of what to do following the disclosure, was handed right back to them and this was a positive experience:

> …she handed it back to me and was like, I'm not going to tell you to go and talk to this girl. I'm not going to tell you to go and sort things out. I'm not going

> to tell you to tell everyone all of this stuff, but you know it's here. And if you want to, then that's a good way to move forward. (Andi)

Another reported regretting their decision to disclose because of the negative impact and lack of consent about the ways in which their disclosure they perceived was used: “I wish I just got on with the placement, perhaps been seen as a little bit lazy… and it never would have been brought into the room in ways that I never consented to”. (Ray)

Additionally, this participant hoped that their information would be treated with confidence, however, they did not experience this, which contributed to the feeling of regretting the disclosure:

> …when I got a new clinical tutor, so she came in and she was like ‘oh so I heard about some of the stuff that happened last year’ and I was like… I did find it like people have been talking about it [distress]. (Ray).

This further reinforces the importance of the four c’s and may mitigate against possible adverse experiences, enabling greater likelihood and willingness to disclose distress during training, if desired.

Subtheme 5c. Prioritising emotional support

Many participants acknowledged that emotional support and responses need to be recognised and prioritised. For example, Bailey reports: “I think taking the time to listen a bit more, to explore a bit more. Maybe a bit more proactive, it just felt quite reactive”.

One shared receiving emotional support within their relationship with their mentor and this being a significant turning point in their training, which prevented them from leaving training:

> She was very good and very able to kind of be clear about the purpose of it [disclosure] being around my training, rather than unpacking all that stuff and that I would need to go on and do that myself. (Andi)

This highlights that positive relationships and emotional support can not only have a positive impact on the trajectory of disclosure for TCPs, but also their overall trajectory and experience of training.

Similarly, when considering what advice to give to others who may be in a similar situation, it was highlighted by many, that the relationships and emotional support are significant factors to consider:

> My top advice would be to find people that feel trusting and supportive, that you do feel like you can talk to, especially like peers. Or like tutors or someone, because I think sharing does help, but I feel like it’s gotta feel safe to share, and I don’t think it always is. (Sam)

Theme 6. Legacies of disclosure experiences

For many, the legacies of disclosure were related to how much, if, and how, they would disclose their distress in future. One participant highlighted that for negative experiences to not completely diminish future disclosure, at least one good experience is needed, especially when this consists of emotional support:

> That really good experience of disclosure can be so beneficial, and I think it’s really important in people’s training, but that yeah… having kind of bad experiences, or not even like, I wouldn’t say they were wholly negative, it was more just like indifference to it. (Andi)

For others, disclosure appeared to increase the likelihood of future disclosure by supporting personal development and learning: “It is a little bit of a confidence boost to just say something like that in training.” (Alex). For those with more negative experiences however, it was clear that the one positive experience of disclosure, perhaps, was not sufficient to mitigate against the overall negative impact their disclosure experiences had on them: “I just don't think it's worth it at this stage of training. Obviously, unless I was like “I cannot do training anymore, like this is not okay”, I probably wouldn't [disclose]”. (Jordan)

It is, however, important to recognise that for some disclosure may just not be considered needed or desired during training: “I wouldn't [disclose] also because I have a very strong support system outside of training and many other places I can go to disclose and get that support." (Jordan). Indeed, as highlighted earlier, this excludes times where disclosure may be required to prevent risk to service users, and to maintain ethical practice.

4. Extended Discussion

4.1. Discussion

It was evident that TCPs self-defined their distress using psychiatric diagnoses and categories, or using relational and trauma experience terms, and nearly a third described no diagnosis. This finding may be explained by the dominance of the medical model within the western culture, in which diagnostic labels are necessary for accessing services, and enabling support and benefits. Additionally, whilst there is increased recognition of diagnoses lacking validity (Johnstone & Boyle, 2018), and GPs being more reluctant to apply a diagnosis due to potential stigma, some individuals still find diagnoses helpful in understanding their distress (Archer et al., 2021). This was apparent within the current study, whereby some TCPs described that their diagnosis helped them to understand their distress, and nearly a third reported in the survey, that they had sought medication for the difficulties.

Many TCPs, however, described their distress in terms of relational and life trauma, in the context of COVID-19, and due to the demanding nature of clinical training. The language used to describe distress within the current study, may have enabled the inclusion of more diverse experiences and perspectives of distress. It is worth noting, that whilst this allowed for a wide range of experiences to be included, due to the diversity of distress experiences, there is likely greater heterogeneity within the findings, impacting the generalisation of the results.

It was also interesting to note within the quantitative findings, that just over half of TCPs, reported that their distress resulted in time off work. This may be interpreted in differing ways; one it is possible that TCPs are able to work despite their distress, or because TCPs may be reluctant to disclose distress at all. This may depend on the severity of distress, beliefs and worries about disclosure, and possible impact on training. Whilst employers are required to protect employees at work, from mental and physical health risks (Farmer & Stevenson, 2017; Health and Safety Executive, 2019), the disparity between how mental and physical health are viewed and responded to at work remains; whereby mental health stigma continues to exist (Mendel et al., 2015).

(Non)Disclosure experiences

The results highlighted that TCPs had specific motivations and purposes for disclosure, which is consistent with previous models of disclosure (Chaudoir & Fisher, 2010; Turner et al., 2021). However, the quantitative results show that for many TCPs disclosure occurred in the moment and was unplanned, which may mean that TCPs do not always have pre-contemplated goals or plans to disclose. Whilst the previous disclosure models explain that prior goals are associated with the disclosure, perhaps this does not explain the moment-to-moment goals and decisions, that TCPs may make, which may significantly depend on the context at the time, and the disclosure recipients' feedback, which may open up or close down disclosure opportunities. It is likely, that these in-the-moment disclosures are based on the relational trust at the time, which was evident in both the quantitative and qualitative findings. This suggests that even with specific goals, if the trust and relationship with the recipient is not experienced, then the disclosure may not occur. Considering this in attachment relationship terms, a driving force of attachment orientation, is that others are worthy of trust, and this may translate into greater likelihood of showing vulnerability (Ainsworth & Bowlby, 1991; Harms et al., 2016). However, the current study further found that relationships were not always static, and within the context of clinical psychology training, were complicated by inherent power differences at differing levels.

Beliefs and assumptions

TCPs' beliefs and assumptions about disclosure, particularly external stigma, self-stigma and shame, and power, were found to increase or decrease disclosure. Stigma (self and external) and shame are complex processes, which may be difficult to separate from power (Link & Phelan, 2014). In thinking about these ideas, it is important to recognise and understand within the context of clinical psychology training, not only where the power lies, but what observable behaviour may indicate its exertion (Foucault, 1980). Course staff member roles, enable them legitimate and expert power, however, may also enable coercive and reward power (Foucault, 1980). TCPs also hold power in relation to their roles within services and with clients. The findings suggested, that whilst all TCPs had some beliefs and assumptions related to stigma, and there was acknowledgement of power differentials, not all experienced negative operation of power. The worries may be related to the realisation of a power difference, and automatic assumptions of this being exerted in a negative way, due to self-stigma and widely held beliefs about mental health and distress (Gold et al., 2016; Rusch et al., 2018). However, the different manifestations of power, may be both enabling and constraining, as was discussed by some TCPs within their specific experiences of exclusion and stigmatisation. It is also possible that negative experiences are easier to recall, stay with a person, or those with negative experiences, may be more likely to talk about them and be drawn to taking part in research about disclosure. Whilst some examples of positive operation of power were highlighted, for example, within safe, supportive relationships and through practical support, it may be that there are other experiences of positive operation of power, that the study did not capture.

Responses from recipients

The DPM model (Chaudoir & Fisher, 2010) hypothesises that the reaction of the recipient, is classified as supportive or unsupportive, however, this explanation may be too broad and vague. The current study found that a supportive response may be one that enables practical support and adjustments to work, emotional understanding, validation of distress, and creation of safety. Therefore, the current study provides further nuance to what may consist of a ‘supportive’ response, highlighting the importance of relationships, trust, feeling heard, and compassion.

In considering the stigma power literature (Link & Phelan, 2014) and recipient responses to disclosure, it is possible that the practical responses from recipients are motivated by a desire to keep TCPs ‘in’ the normative society rules and expectations. It may be that the ‘Goldilocks zone’ is an example of when the distress fits within the norms of clinical psychology training, reflecting the hypothesis of keeping TCPs ‘in’. This was highlighted by some TCPs, whereby they received responses to “keep going” despite the distress. Many participants also discussed modifying their expression of distress, which from a stigma power perspective, may suggest was an internalised ‘in’ concern for TCPs (Link & Phelan, 2014). For example, needing to modify expression of distress to fit in to what may be perceived as ‘normal’ or ‘tolerable’. Whilst the ‘in’ concern for TCPs, may lead to suppression or modification of how distress may be expressed, it perhaps does not explain when distress may not be internalised, may be viewed as external to an individual and within the system. Additionally, an individual stigmatiser’s interests, need not be expressed or even acknowledged when his/her aims are effectively achieved at the macro level (Link & Phelan, 2014). Whilst an ultimate function of the HCPC (2019) standards of proficiency are to keep the public safe, it is possible that they inadvertently operate as macro level stigma power, embedded within policy, structures and practices, that may perpetuate stigma within systems.

4.2. Extended strengths and limitations

This is the first study to the researcher’s awareness that has employed quantitative and qualitative methodology; within the relatively limited field of psychological distress and disclosure, within the psychology professions. The two phased, mixed-methods design incorporated a large sample using a quantitative survey, and the subsequent in-depth interviews of a smaller sample, provided nuance and depth to the quantitative data, enabling the aims of the research to be met. Given that several workplace initiatives exist, that aim to support employers and employees in making workplace psychological distress disclosure decisions, this study adds to the literature to support these existing initiatives, and the prioritisation of provider mental health. The Sharing Lived Experiences Framework (SLEF): A framework for mental health practitioners when making disclosure decisions (Dunlop et al., 2022), was recently published which emphasises the areas of preparedness; confidence; competence; relevance; comfort; and supervision. However, this focusses more on disclosure within the therapeutic relationship, and does not include factors that may be specific concerns for TCPs when disclosing during training, as highlighted in this study. Despite workplace initiatives existing, research evidence to support initiatives has often fallen behind. Whilst not specifically drawing on one workplace initiative for attending to lived experiences of distress, the current study fills the research gap, by highlighting the specific beliefs and assumptions, experiences, and responses to disclosure, within the workplace, for TCPs.

One of the limitations of the study was that the quantitative data was descriptively analysed, and therefore relationships between aspects such as different types of disclosure recipients, and how decisions and experiences differed across these recipients, was not directly analysed. Whilst analysis of these differences was not a specific aim of the study, it may be that further exploration of the differences between recipients, the related prior assumptions and beliefs, and responses, may have enabled greater understanding and nuance to the results. Further quantitative data may be collected and analysed using correlational analysis to assess correlations between different disclosure recipients, strengths of these relationships, and how they relate to levels/likelihood of disclosure.

Additionally, as the study obtained limited demographics to maintain participant anonymity and confidentiality, the findings cannot be analysed in relation to specific courses and fed back individually to courses. It is acknowledged, that courses may already have guidelines and support systems in place for TCPs, that clarify the processes, possible actions and outcomes of disclosure, and what support is available. These are positive steps toward tackling workplace stigma, and creating a safe workplace environment, in which TCPs feel able to disclose. It may be that further research seeks to understand how local and national guidelines and support systems, are being used, and what impact they have on TCPs and recipients.

Whilst several steps were taken to reduce researcher bias, the primary researcher is a TCP, who has their own experiences of disclosing distress and witnessing other trainee cohort peers doing so. As such, the interpretations and conclusions drawn will inevitably have been impacted by the researcher’s own standpoints, experiences, and values, and seen through a TCP lens, as opposed to a course trainer lens. Several measures were used to limit these biases however, including the use of the reflective diary. The research supervisors, who are programme staff members and recipients of disclosure, provided alternate and course provider perspectives, to also limit researcher biases.

Given that the nature of the project itself consisted of asking TCPs to disclose their distress and experiences to the researcher, this inevitably may have been a barrier for some TCPs, who have not disclosed their distress, to take part in the research. This was highlighted within the limited number of TCPs who took part in the survey that had not disclosed and those who opted in for the second phase (interview). Furthermore, the lack of intersectional minority backgrounds within the study, may further suggest that there are barriers to disclosure for these individuals, and these voices were not represented within the study. In addition, whilst data was triangulated to a degree, by synthesising quantitative and qualitative methods, this lacked triangulation of data to include recipient experiences. This limitation is important to address and consider, given the different experiences, priorities, and perspectives, that recipients of disclosure may have.

Finally, the study captured TCP views at one point and was cross-sectional in nature. Further research that uses a longitudinal design and follows TCPs post-qualification and into their first roles as supervisors, to ascertain whether there are any differences in their views about how their disclosures were responded to, may be helpful. This may support greater understanding of how/ if their views change, and additionally, learn whether future disclosures post qualification are influenced. Additionally, following up TCPs post qualification may also help to learn if their experiences impact upon how they receive and respond to disclosures of distress, by TCPs they supervise.

4.3. Extended practice implications and recommendations

The study, being part of the limited literature on psychological distress and disclosure by TCPs during clinical psychology training, has several practice implications. Given the guidance from the BPS (2020), on supporting and valuing lived experiences of mental health difficulties during training, and the wider national priorities of attending to and promoting workplace health and well-being (OHID, 2022), the study provides an understanding of psychological distress experiences, disclosure choices, beliefs and assumptions, and responses to disclosure, within the UK clinical psychology doctoral training programmes. This study supports the BPS (2020) guidance and emphasises the importance of training institutions creating an environment of permission giving, in which TCPs feel able to disclose distress. The findings highlight that some good practices are already taking place, in that practical support is available to TCPs, however, perhaps greater emotional support is required alongside these practical responses. Based on the findings of the study, the following practice recommendations are suggested:

- Programme staff to further prioritise building of positive relationships with TCPs and prioritising emotional support to enable disclosure. Given that TCPs may not have had prior experience of disclosure, may be fearful of disclosing, and worry about judgement, programme staff may seek to explicitly name and acknowledge this within individual interactions, within the training curriculum, and within meetings/ supervision systems. This may support in creating an environment in which TCPs feel able to disclose and talk openly about distress (Farmer & Stevenson, 2017). Additionally, if TCPs feel able to talk about distress, it may enable them to disclose early, and receive the support that they may need. This has potential for not only improving individual outcomes (e.g., by reducing staff sickness and improving TCP well-being), this can prevent risks to service user care; all important priorities for employers and universities (BPS, 2020; HCPC, 2019).
- For training courses to provide TCPs with plentiful opportunity to disclose distress in formal ways (e.g., within supervision, curriculum, and meeting structures), and informal ways (e.g., by communicating an ethos of valuing lived experience of distress during training (BPS, 2020)).
- Enhancing structures and guidance that are in place for TCPs to navigate disclosure; for example, having clear guidance on the process of disclosure, where and what support is available, and empathic communication of possible actions and outcomes. It is important for programme staff to convey that disclosure is a positive thing and a “competency in action” (BPS, 2020).
- When receiving disclosures, it is important for programme staff to prioritise clarity of processes, possible actions, outcomes and support, confidentiality and consent, and its limits. It is recognised that confidentiality may need to be broken at times where there is genuine concern for the safety of the TCP or clients, however, these should be collaborative conversations as far as possible.
- For any support plans to be collaboratively developed with TCPs, based on their specific needs, and implemented early on. These should seek to prioritise emotional support, as well as practical support. Training providers are encouraged to refer to local policies and procedures when developing these plans with TCPs.

- Training providers may seek to draw upon existing practices (e.g., MIND employee well-being toolkit, ‘well-being check ins’, HOP-MHP (Scior, 2017) and All Our Health Resource (OHID, 2022)), to further enhance their support practices, and create an environment where TCPs feel able to disclose their distress.

Further research should seek to obtain views of people from minority intersectional backgrounds and consider, how multiple aspects of social difference may impact upon psychological distress and disclosure. Additionally, further research should seek to obtain views of people who do not disclose, and triangulate data further, by exploring perspectives of those receiving disclosures. For example, using a non-dyadic Framework method, in which members of the dyad are interviewed separately, may be one way to analyse future qualitative data (Collaco et al., 2021). This method allows for both sides of the dyad to be included; however, they need not be interviewed together. This may enable an in-depth understanding of the different priorities and experiences of each side of the dyad, further enhancing knowledge about how disclosures are received and responded to However, it must be considered that TCPs may be concerned about participating in dyadic research, which includes those involved in evaluating them during training, even if confidentiality is assured. Longitudinal studies, that follow up TCPs post qualification and into their supervisor roles, may be useful to understand any changes in perceptions of responses to disclosure, and future disclosure. Additionally, given that workplace initiatives may already exist, it seems that evaluation or audit of how these initiatives translate into practice is required. For example, if guidance around disclosure is already in place, how is this being used, and what is the impact of this would be helpful to understand. Additionally, given that the guidance from the BPS (2020) around supporting and valuing lived experiences of mental health difficulties within clinical psychology training is recent, further research may seek to consider how and if, this guidance is being used. Adherence to guidelines may be difficult to establish without accountability processes or guidelines being embedded within registration/ accreditation processes. It may be that incorporating the lived experience guidelines (BPS, 2020) into course registration and accreditation processes is required, to maintain accountability, and ensure that TCPs are well-supported.

5. Plan for dissemination of findings

The final written report, including the journal and extended paper was submitted to the Trent Doctorate of Clinical Psychology Course in June 2022. It is intended that the journal paper will be submitted to a peer-reviewed journal for publication, and the findings will be disseminated at relevant conferences; for example, the Group of Trainers in Clinical Psychology annual conference in 2022. It is planned that a summary of the findings will also be distributed to the participants who opted in to receive a summary after phase two, and on social media, via the project specific Twitter account. It is hoped that disseminating and promoting these findings, may help to influence other recipients of disclosure, and thus lead to more positive experiences for TCPs.

6. Extended Reflection

Critical reflection occurred throughout the project, and this is discussed in this section. Extracts from the reflective diary are also included to demonstrate the decision-making processes, enable transparency of researcher biases and assumptions.

Project conceptualisation

My own prior experiences of psychological distress made me drawn to the field. I initially pitched a vague idea to a supervisor about wanting to explore lived experienced professionals, however, initially I spoke more about service user involvement in service delivery and peer support worker roles. The ideas were surrounding how professionals who are also clients or have had experiences of distress themselves, may navigate work, what barriers they might face, how their skills might be utilised, and how colleagues may view or respond to these experiences that their colleagues have, if indeed they are aware of them. Through discussion in research supervision, and through some literature searching, I noticed that for people with experiences of distress, they may have a choice of whether to disclose these at work, and not all professionals may wish to disclose their difficulties. The literature search also indicated that disclosure of psychological distress and/or mental health difficulties at work, in the general population was often a complex decision for many individuals, and there may be several barriers associated with disclosure, including stigma. These factors made me curious about how the literature may differ or be similar for mental health professionals, including psychologists. On researching psychological distress and mental health difficulties among mental health professionals, compared to the general population, I found very little literature on disclosure itself. There was evidence to suggest that mental health professionals may also have experiences of a mental health difficulty or psychological distress, however, there was only small literature to consider disclosure decisions or experiences of these individuals. This made me wonder why there might have been this gap, what barriers mental health professionals might face, and whether it may be a taboo subject within the mental health provider professions; if so, why this was. Learning from the very few studies on disclosure by (trainee) clinical psychologists, that had experiences of distress, and their likelihood of disclosure, there appeared to be a mismatch. This further added to my curiosities around what might be going on for this population, and a desire to understand these experiences further.

The decision to focus on the TCP population occurred through feedback from submission of my research proposal to the Trent Doctorate course, and through critical discussions within supervision. Whilst it was acknowledged that psychological professionals may also include, therapists, counsellors, counselling, and forensic psychologists, who may also have similar concerns surrounding disclosure, it was decided that including such a range of professionals may result in the sample being too heterogeneous, limiting the application of findings, and the conclusions that may be drawn. Additionally, these professions all have different training routes, processes, and procedures, including some (counselling psychology doctorate and psychotherapy courses) that state that personal therapy is a compulsory part of training. Whilst personal therapy does not equal lived experience of distress, it implies a level of disclosure of personal and private information and emotions. Therefore, the experiences of disclosure at work, across these professions, may differ.

Focussing on TCPs as opposed to qualified professionals was also decided through discussion with the research team, and acknowledgment of the gaps in the literature. TCPs with lived experiences of distress have multiple roles. They are employed, salaried, NHS professionals, and students who, as well as undertaking clinical work, are learning and developing their skills. In this respect, distress disclosure may be even more complex. It was considered, that narrowing the population to TCPs would allow for more specific application of findings, and conclusions to be drawn, within the context of clinical psychology training courses.

The decision for the study design occurred following feedback from the research presentation panel, delivered to course staff members and cohort peers. Originally, given the limited literature on disclosure and distress on clinical psychology trainees, and the literature often using survey methodology, I initially considered that a qualitative methodology was indicated; for example, a Grounded Theory (Glaser & Strauss, 1967) approach may have been useful in developing a specific theory, related to TCPs within the context of training. However, following feedback, it was agreed that given the existing prior theories related to stigma and disclosure, which were relevant to the project, the study could draw on these existing theories. As such, a mixed-methods approach, which may allow for a wide-range of data to be derived using existing theories, and a small sample where the nuance and depth can be obtained, was considered an appropriate approach.

Data Collection

Following ethical approval, it was highlighted that if recruitment is taking place through social media, a specific Twitter handle needs to be created to avoid directly recruiting people I know and to reduce bias. I had initial concerns about this which I reflected on in my dairy:

> *"I understand the reasoning behind needing a separate Twitter handle, and not recruiting via my own social media accounts, however I am concerned about the reach of the project and gaining enough participants. I am not massively savvy on social media, so I'm not sure how to even go about creating a new handle and recruiting this way. I have seen a couple of research specific handles on my Twitter before, perhaps I can look at those and see what they have done. I am feeling anxious about how this will go…"*
> (1st February 2021)

Despite my concerns and anxieties, which I felt derived from being relatively new to this way of recruiting (via social media), and whether or not I would gain enough participants, I was surprised by the response to the study:

> *"I have posted my study on Twitter, and my god! I am blown away by the interest so far… I have already received over 50 retweets. I did not expect this! Hopefully this response translates into people taking part in the project if they can or sharing it more widely. I have received 30 responses so far... which is better than I expected in 2 days!"* (7th February 2021).

Recruitment for phase one of the study continued via social media (Twitter and Facebook) and emails (through course admins), and I did not have any particular difficulties in this. The study was retweeted over 100 times and I was receiving ongoing responses steadily over the 6-week period the survey was open. I noticed that response rates increased when the study was re-tweeted, and at the time I sent follow the up email to courses. I noticed feeling relieved, and I was excited to hear about people's experiences. I wondered whether the interest in the project was due to the need for research in this area, and just like myself perhaps others also valued learning about lived experiences of distress and disclosure experiences among TCPs. Perhaps, recruitment was also easier than anticipated due to my own role as a trainee, and the population being more likely to have experiences of recruiting themselves and understanding what it may be like. The population may have related to this, and so perhaps the study received greater attention than what I had originally anticipated.

Following the survey closing, I had discussions with research supervisors about the number of participants who had opted in for phase two. Again, I felt overwhelmed by having over 60 people opt in for interview. I recognised the incredibly privileged position this was to be in, given that for some recruitment may pose significant challenges. I shared with my supervisors however, that I felt pleased about the response rates, and felt pride for this, given the work I had also put in. This pride was reinforced by my supervisors who shared how great it was that I had received so many responses and interest.

Prior to my first interview I felt incredibly anxious about taking a different stance as a researcher, rather than a therapist. Following the first interview, I wrote in my diary:

> *"I am so glad to have done to first interview and I think it went okay! I noticed myself being pulled into wanting to offer interpretations, reflections, and hypotheses around what I had heard, just as I would when seeing clients in the therapy room. I know as a researcher my role in the interviews is different. I remember during teaching on doing qualitative interviews, the lecturer mentioned, that 'if you find yourself interpreting… just stop there!' I think I will write this down on a post it note as a reminder throughout all the interviews. As it goes against what we have been taught to do over the last year and half, I think I need this reminder in front of me! I know I can also transcribe the first interview and send it to my supervisors for comments. This might help me to consider what I might need to change, what I did well, and this will inform the future interviews, and help me to feel more confident in how I am conducting the interviews."* (1st April 2021).

Following discussion of the first interview transcript and my questioning style, I felt validated by the questions I was asking, and I also incorporated supervisor feedback by asking participants for specific examples about what they were discussing, to really illustrate what they were saying. I recognised that holding the position of a TCP myself, I may have been more drawn to wanting to respond to the participant, by validating or offering reflections. Perhaps this was because I felt I could understand and relate to the context of training that all participants spoke about. This was important for me to be aware of and respond to, as this could have impacted upon the ways in which I was asking questions, or the areas where I was probing more or less, which may have swayed them.

Data Analysis

Whilst I had already descriptively analysed some of the quantitative data prior to interviews, as the themes informed the interview questions, following completion of the interviews, I noticed myself feeling extremely tired and in need of a break prior to beginning additional analysis. Following supervision, I felt reassured to learn that thesis progress does slow down at different points, due to the other demands of the course. Slowing down with thesis therefore felt okay to do.

As I began to analyse the quantitative data and qualitative data further, I experienced increased anxiety with the sheer volume of data I had. I fluttered between acknowledging what a privileged position this was to be in, whilst also feeling “where do I start”, and overwhelmed by the amount of data. Through seeking support via personal tutorials and research supervisions, I began to consider how to break the tasks down, so it did not feel like such a huge task. I planned my study days and followed a step-by-step approach, focussing on quantitative data analysis on one day, specifically the tables and graphs, and then the qualitative thematic analysis of the free-text boxes. I then moved onto the transcriptions and coding of the interviews, and focussed on one task at a time, which hugely helped me to manage the data and workload.

During the analysis of the interviews and as I was coding, I had doubts about the inductive and deductive process, which I reflected on in my reflective diary:

> *“I am unsure how to inductively code the interviews first, when I have already had sight of some the themes that have emerged from the survey. Surely, I can’t truly inductively code without prior preconceptions or knowledge?! I also already have knowledge of the prior literature and theories given the literature review I have completed when planning the project. I need to seek further supervision in relation to this”* (1st October 2021).

Following discussion in supervision and sharing one interview that I had inductively coded, my supervisor fed back that I had coded the interview well. There were occasions where I had ‘sanitised’ what the participant was saying however, therefore my supervisor fed back that inductive coding would stick as closely as possible to the participant words. This was extremely helpful for me in coding the subsequent interviews. It was also acknowledged, that whilst I cannot truly remove all prior knowledge and biases when initial coding, being clear about the knowledge I already have in the write up of the project, and sticking as closely as possible to participant words, is useful and supports reducing biases. Acknowledging and reflecting on these aspects themselves, were acts that aimed to reduce bias.

Themes were derived and refined over several research supervisions. Through this process, I was able to critically consider the interpretations of the results, the initial thematic map, and consider where there were too many similarities and overlaps between themes. Reflecting on the process of analysis of the interview I wrote in my diary:

> *"I recognise that I am coming from a trainee perspective, and the project also looks only at the trainee experience. However, I am mindful that the experiences of the disclosure recipients may be different. Perhaps course staff members view the situation differently? Perhaps the practical support is also viewed as emotional support and of a priority to them for specific reasons that I may not be aware of, given that I am not a course staff member or trainer. My research supervisors are course staff members however, and can provide an alternate critical view, therefore using research supervision feels extremely important. I have had my head in analysis for a while now as well and perhaps I need to come away from the project to then have fresher eyes on it!"* (18th February 2022).

I also noticed at times feeling disappointed by the need to simmer down the data so much, as I felt I was not doing justice to everything the participants had shared. Through supervision, I realised however that the primary task is to convey the main themes that answer the research questions, and it was normal to lose many codes.

Closing thoughts

The process of completing this work, right from the generation and refinement of initial ideas, seeking ethical approval, data collection, analysis, and writing of the report, has developed my skills and confidence in my abilities as a researcher. Particularly, in how quantitative and qualitative methodologies may complement each other. Additionally, through the process of reflexivity, I have become aware of my own biases, and how to respond to and manage these. I endeavour to take this learning forward and continue to apply these skills in future research projects, and through supporting the research of those I supervise.

Finally, through completing this project, and through my own experiences of distress and disclosure, I have learned about how I would want to respond to disclosures of distress I receive in the future. By prioritising emotional support, as well as practical support, I hope to be able to create safe and supportive environments in which TCPs feel able to disclose. Additionally, I endeavour to advocate for the support TCPs need to prosper, within an intensive three-year, doctoral training programme.

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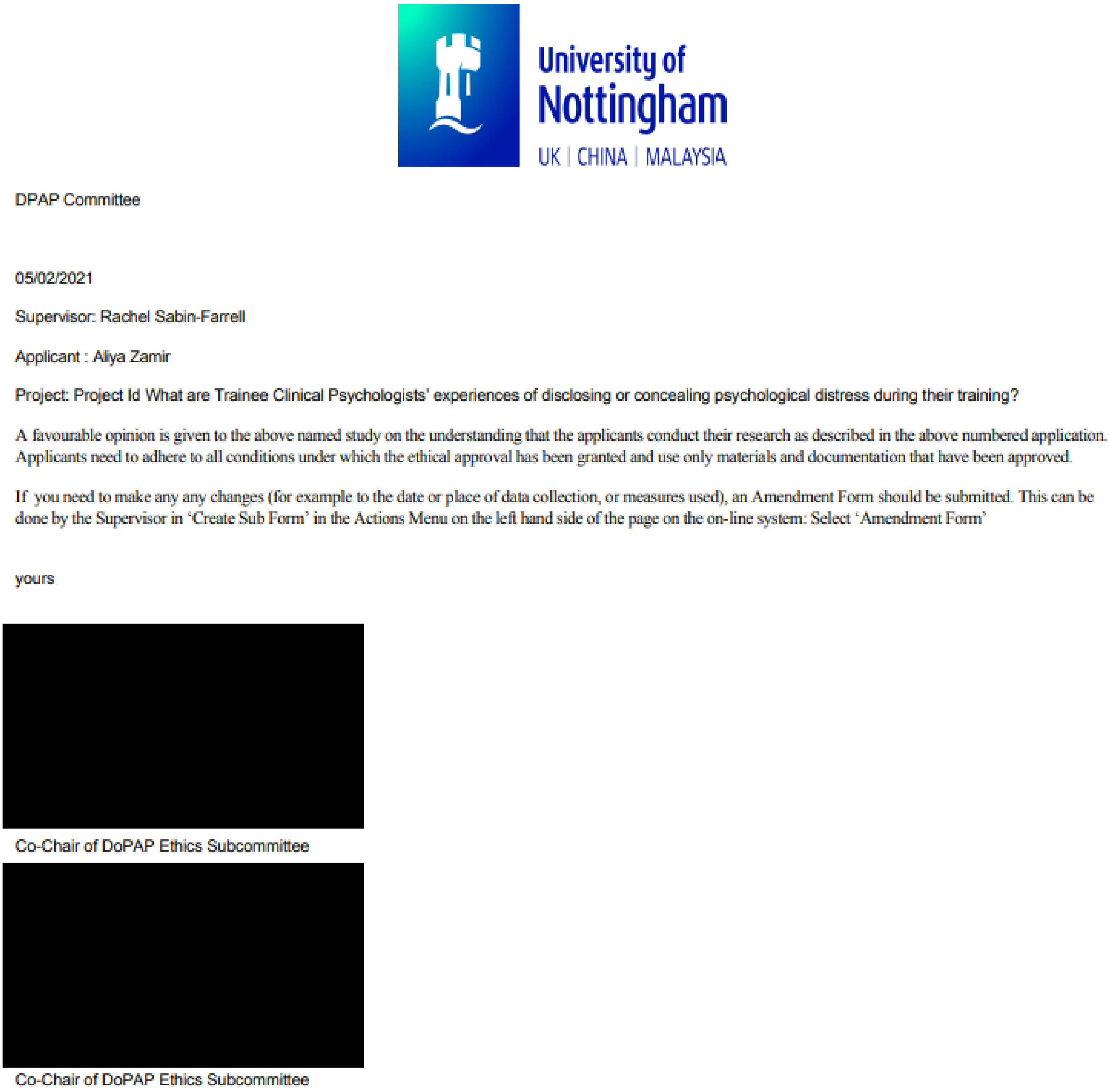
Appendices

Appendix A: Ethical Approval



University of Nottingham
UK | CHINA | MALAYSIA

DPAP Committee

05/02/2021

Supervisor: Rachel Sabin-Farrell

Applicant : Aliya Zamir

Project: Project Id What are Trainee Clinical Psychologists' experiences of disclosing or concealing psychological distress during their training?

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

yours

[redacted]

Co-Chair of DoPAP Ethics Subcommittee

[redacted]

Co-Chair of DoPAP Ethics Subcommittee

Note: the names and signatures of the reviewers have been redacted to ensure anonymity.

Appendix B: Participant Information Sheet

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

Division of Psychiatry & Applied Psychology

Project Title: What are Trainee Clinical Psychologists' experiences of disclosing or concealing psychological distress during their training?

Researcher/Student: Aliya Zamir, aliya.zamir@notttingham.ac.uk

Supervisors/Chief investigators: Dr Rachel Sabin-Farrell, Rachel.sabin-farrell@nottingham.ac.uk and Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Ethical approval for study granted by University of Nottingham Ethics Committee – 1662

We would like to invite you to take part in a research study about disclosure and concealment of psychological distress during clinical psychology training. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. Ask us, by contacting the researchers via email, if there is anything that is not clear or if you have any questions.

What is the purpose of this study?

The purpose of the study is to explore Trainee Clinical Psychologists' experiences of disclosure or concealment of psychological distress during their clinical training. This study also aims to explore if trainees have any beliefs or thoughts that influence their choices about disclosure. In addition, this study aims to investigate what responses trainees get from people they disclose to (e.g., cohort peers, placement supervisor, academic/ course tutor, line manager, mentor). For this study, the term 'psychological distress' includes overwhelming emotional states that disrupt everyday functioning, believing, seeing, or hearing things that others may view as out of the ordinary (Cromby et al., 2013). This also includes mental health difficulties and experiences that may sometimes be called 'mental disorder' or 'mental illness', which may or may not have received a psychiatric diagnosis. You do not need to have disclosed your psychological distress during training to take part in the study.

The aims will be investigated using an online survey with a mixture of multiple choice and free text answer boxes. Types of questions asked in the survey include: "Was the psychological distress a pre-existing difficulty (e.g., before you started clinical training) or did it arise during training?" and "What was the purpose of this disclosure?" Following the survey, a smaller selection of the sample will be asked to take part in video or telephone interviews. Interview questions that may be asked include: "How did disclosing impact you and your training experience?" and "Is there anything you would say to others who might be in a similar position and thinking about disclosing psychological distress during training?"

We cannot promise the study will help you but the information we get from this study will help us to explore the beliefs, assumptions and predictions that may underlie disclosure decisions. This study can also highlight what support trainees have or have not got during training and any changes that may be required during training.

Why have I been invited?

You will have heard about the study through social media, through another participant who has shown an interest in taking part or via your Doctorate of Clinical Psychology (DClinPsy) course. You are being invited to take part because you are a current Trainee Clinical Psychologist on a British Psychological Society (BPS) accredited doctoral clinical psychology course or a recently qualified (within last two years) Clinical Psychologist. We are inviting several other participants like you to take part.

Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part, completion and submission of the online survey will be taken as your consent to take part in the study. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights. You do not have to take part even if you have heard about this study from someone you know, because you belong to a social media group where the advert was posted, or just because you heard about it via the DClinPsy course you are studying on.

What will I be asked to do?

There are two phases to the research study. Everybody who consents to take part (by completing the online survey) will take part in phase one. We will then ask a smaller number (10-12) of those participants to take part in phase two.

Phase one – online survey

You will be asked to answer a series of questions in one online survey. This will include demographic questions and questions related to your disclosure experiences. The questionnaire should take approximately 15 to 45 minutes to complete depending on your experiences. At the end of the questionnaire, you will be asked if you wish to ‘opt in’ for the second phase of the research study. If you choose to opt in, you will be asked to include a contact email address. Your email address will be stored separately to your survey responses. Not all participants who opt in will be contacted for phase two of the study. We will seek participants with a range of disclosure experiences based on their survey responses.

Phase two - interviews

If you have consented to taking part in phase two and your survey scores represent the sample being sought, you will be contacted to take part in phase two. If we contact you to take part in phase two, this will involve us setting up a time to go through some more detailed questions about your experiences of disclosure or concealment of distress during training. The specific interview questions will be guided by the responses in the survey. The interview will last approximately 60-90 minutes and will be conducted over the telephone or via video conferencing. It is up to you which interview format you choose. The interview will be audio-recorded and will take place during March and April 2021.

Expenses and payments

Participants will not be paid to participate in the study. Travel expenses will be offered for any visits incurred because of participation.

Will my taking part in the study be kept confidential?
A transcription service will be used to transcribe part of the interviews conducted in phase two. The other half of the interviews will be transcribed by the primary researcher. In both cases we will follow ethical and legal practice and all information about you will be handled in confidence. If you ‘opt in’ to take part in the interview, your email address will be stored separately to your survey data via a separate survey link.

If you join the study, we will use information collected from you during the research. This information will be kept strictly confidential, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Your contact information will be kept by the University of Nottingham for 12 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham’s, the Government’s and our funders’ policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any harm, we may feel it necessary to share this with the appropriate persons. We may need to ask you for further personal details. Should this be the case and we will discuss courses of action with you wherever possible as well as signposting you to support.

Are there any possible disadvantages or risks in taking part?
As the study topic explores disclosure and concealment of psychological distress, depending on whether your experience of this has been positive or negative you may experience some discomfort when talking about this. If you are currently feeling distressed or feel as though you would be distressed by the questions in the survey or interview, please do not take part.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study will help us to explore the beliefs, assumptions and predictions that may underlie disclosure decisions. This study can also highlight what support trainees have or have not got during training and any changes that may be required during training.

What will happen if I do not want to carry on with the study?
Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, we will no longer collect any information about you or from you. Once you have completed and submitted the survey you have two weeks to withdraw your data. You will be asked to create and make a note of a unique code at the beginning of the survey. You will be asked for this code so that we can identify you if you do choose to withdraw. If you wish to withdraw your data following the interview you can do so within 2 weeks of completion. After this point data will be analysed. To safeguard your rights, we will use the minimum personally identifiable information possible.

What will happen to the results of the research study?
The results of the research study will be written up for the submission of a thesis for the Trent Doctorate in Clinical Psychology by Winter 2022. The study will also be presented at relevant conferences, and we intend to submit the findings for publication in a suitable peer-reviewed journal. You will not be identified in any report or publication. A summary of the results will be emailed to participants who request this. We will seek permission to hold your contact details for purposes of sending the findings to you.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk. We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Who is organising and funding the research?
This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?
All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The Division of Psychiatry and Applied Psychology Research Ethics

Committee and the University of Nottingham.

Further help and support

The following organisations may be able to provide help and advice should you need this.

Samaritans - Confidential support for people experiencing feelings of distress or despair. www.samaritans.org.uk Phone: 116 123 (free 24-hour helpline)

Mind - Promotes helpful information about dealing with distress/mental health within the workplace www.mind.org.uk/workplace Phone: 0300 123 3393 (Mon-Fri, 9am-6pm)

Mindful Employer® is an NHS initiative designed to help employers access information and local support for staff who experience difficulties with stress, depression, anxiety and other mental health problems: https://www.mindfulemployer.net

SANE runs a mental health helpline from 4:30pm to 10:30pm daily which offers specialist emotional support and information. To access this, call: 0300 304 7000 https://www.sane.org.uk/what_we_do/support/helpline

Student Minds - Students minds are a student mental health charity that offer peer support programmes and workshop through different universities. https://www.studentminds.org.uk/

In2gr8mentalhealth - Centre which aims to support lived experiences of distress in mental health professionals. They provide peer support, training, and advocacy services. https://www.In2gr8mentalhealth.com

Honest, Open, Proud - Online resource workbooks to support disclosure decisions https://comingoutproudprogram.org/index.php/manual-and-resources

It may be useful to find out whether your employer offers any staff support schemes for employees experiencing psychological distress e.g., workplace counselling or services provided via Occupational Health. If you feel you do not have the appropriate support in place, then we advise that you contact your GP.

Further information and contact details

Aliya Zamir: aliya.zamir@nottingham.ac.uk
Dr Rachel Sabin-Farrell, rachel.sabin-farrell@nottingham.ac.uk
Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Appendix C: Consent Form

School of Medicine
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Participant Consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: What are Trainee Clinical Psychologists' experiences of disclosing or concealing psychological distress during their training?

Researcher: Aliya Zamir, aliya.zamir@notttingham.ac.uk

Supervisors: Dr Rachel Sabin-Farrell, Rachel.sabin-farrell@nottingham.ac.uk and Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Ethical approval for study granted by University of Nottingham Ethics Committee – 1662

Please tick box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that I have two weeks to withdraw my data after completing the survey and after the taking part in the interview, after which point my data cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that due to the online nature of the study there is a small risk of my data being hacked. ☐
5. If I opt in and am contacted to take part in phase two (interview) I understand that the interview will be audio-recorded and that anonymous direct quotes from the interview or survey may be used in the study reports. ☐

6. I understand that if I take part in phase two (interview) my interview data might be transcribed by a transcription service however all my data will be held in strictest confidence. ☐

7. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

8. I confirm that I am a current Trainee Clinical Psychologist or a recently qualified (within last two years) Clinical Psychologist that studies/ studied on a UK based Clinical Psychology Doctoral (DClinPsy) course. ☐

9. I confirm that I self-identify as having experienced significant psychological distress (with or without diagnosis) which impacted upon my functioning, before and/or during clinical training. ☐

10. By clicking the button below, I indicate that I understand what the study involves, and I agree to begin the phase one questionnaire. If I do not want to participate, I can close this window/press the exit button. ☐

Appendix D: Participant Debrief

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT DEBRIEF

Division of Psychiatry & Applied Psychology

Project Title: What are Trainee Clinical Psychologists' experiences of disclosing or concealing psychological distress during their training?

Researcher/Student: Aliya Zamir, aliya.zamir@notttingham.ac.uk

Supervisors: Dr Rachel Sabin-Farrell, Rachel.sabin-farrell@nottingham.ac.uk and Dr Anna Tickle, anna.tickle@nottingham.ac.uk

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We would like to thank you for taking part in our research study. This research will provide crucial information and broaden our understanding of self-disclosure and concealment of psychological distress among trainee clinical psychologists during their training. The findings from the study may help other psychologists in a similar situation in their decision-making processes and inform current practices relating to disclosure of psychological distress within training courses for clinical psychology.

Questions and withdrawing

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher or their supervisors at any time on aliya.zamir@nottingham.ac.uk. If you wish to withdraw your data please also contact the researcher or supervisor on aliya.zamir@nottingham.ac.uk or rachel.sabin-farrell@nottingham.ac.uk with your unique code. Please note you will only be able to withdraw up until 2 weeks after completion of the survey and/or the interview (if you take part in this).

Further help and support

If you have any ethical concerns regarding the current research, your treatment as a participant or your involvement in the study please feel free to contact DPAPEthics@exmail.nottingham.ac.uk.

If you have been affected by any of the issues raised by taking part in this study the following organisations may be able to provide help and advice:

Samaritans
Confidential support for people experiencing feelings of distress or despair.
www.samaritans.org.uk
Phone: 116 123 (free 24-hour helpline)

Mind
Promotes helpful information about dealing with distress/mental health within the workplace
www.mind.org.uk/workplace
Phone: 0300 123 3393 (Mon-Fri, 9am-6pm)

Mindful Employer® is an NHS initiative designed to help employers access information and local support for staff who experience difficulties with stress, depression, anxiety and other mental health problems: https://www.mindfulemployer.net

SANE runs a mental health helpline from 4:30pm to 10:30pm daily which offers specialist emotional support and information. To access this, call: 0300 304 7000 https://www.sane.org.uk/what_we_do/support/helpline

Student Minds
Students minds is a student mental health charity that offer peer support programmes and workshop through different universities. https://www.studentminds.org.uk/

In2gr8mentalhealth
Centre which aims to support lived experiences of distress in mental health professionals. They provide peer support, training, and advocacy services. https://www.In2gr8mentalhealth.com

Honest, Open, Proud
Online resource workbooks to support disclosure decisions https://comingoutproudprogram.org/index.php/manual-and-resources

It may be useful to find out whether your employer offers any staff support schemes for employees experiencing psychological distress e.g. workplace counselling or services provided via Occupational Health.

If you feel you do not have the appropriate support in place then we advise that you contact your GP.

Further information and contact details
Aliya Zamir: aliya.zamir@nottingham.ac.uk
Dr Rachel Sabin-Farrell, rachel.sabin-farrell@nottingham.ac.uk
Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Appendix E: Qualtrics Survey

Survey introduction

This survey relates to trainee clinical psychologists’ experiences of disclosing or concealing psychological distress during their clinical training.

You may experience some discomfort when answering the questions depending on whether you disclosed or concealed your experiences and whether your experiences were positive or negative. Please look after your own well-being and if you wish to stop the survey at any time, you may close your browser and exit the survey.

Unsubmitted responses will be stored for 7 days before being deleted. If you wish to return to complete the survey within 7 days, you can do so and pick up where you left off. If you decide to restart the survey after 7 days, you will need to follow the survey link again and complete the questions from the beginning.

We thank you for contributing to this research.

Questionnaire

Firstly, create a unique code so that your responses can be identified should you wish to withdraw from the survey later. Please use the first three letters of your surname, the two numbers of your birth date and the last two digits from your mobile phone number. For example, if your surname was 'Taylor', you were born on the 15th of the month and the last two digits of your phone number was 73, your code would be: TAY1573. Please write this code here and make a note of it. You will be asked for this code if you request to withdraw your data after completion of the survey.

Enter your unique code:

1) **Are you a Trainee Clinical Psychologist or a recently qualified Clinical Psychologist?**

   Trainee - 1st year, 2nd year, 3rd year, prefer not to say
   Qualified – 1 year qualified, 2 years qualified, prefer not to say

2) **What is your age?**

   20 – 30, 31-40, 41-50, 51-60, over 60, prefer not to say

3) **What is your gender?**

Male, female, other, prefer not to say

4) **What is your ethnicity?**
    - White – English/Welsh/Scottish/Northern Irish/British, Irish, Other white background _______
    - Mixed/multiple ethnic groups – white and black Caribbean, white and black African, white and Asian, any other mixed ethnic background _________
    - Asian / Asian British – Indian, Pakistani, Bangladeshi, Chinese, other ______
    - Black/African/Caribbean/Black British – African, Caribbean, any other _____
    - Other ethnic group ________
    - Prefer not to say

Experience(s) of psychological distress

This section asks about your experience(s) of psychological distress. For this study, the term ‘psychological distress’ includes overwhelming emotional states that disrupt everyday functioning, believing, seeing, or hearing things that others may view as out of the ordinary (Cromby et al., 2013). This also includes mental health difficulties and experiences that may sometimes be called ‘mental disorder’ or ‘mental illness’, which may or may not have received a psychiatric diagnosis.

Please describe the nature of the psychological distress that you have experienced. This includes psychological distress that may have been experienced prior to training (e.g., throughout your life) and that which may have arose because of/ during training. You may have experiences of psychological distress both prior to and during training, which may be related to the same difficulties or different difficulties. Please include these experiences. Please use the box below to provide details of your experience(s).

5) **Nature of difficulties (e.g., what were you experiencing and how did it impact you)**

6) **Did you receive a diagnosis for any of these experiences?**
Yes, no.

7) **Please state which diagnosis/diagnoses you received. If you received more than one diagnosis, please tick all options that apply to you.**
I did not receive a diagnosis

Anxiety, depression, psychosis, schizophrenia, specific phobia, obsessive compulsive disorder, personality disorder (state which e.g. borderline/emotionally unstable, anti-social)_______, bipolar disorder, post-traumatic stress disorder, eating disorder. Other____________________

8) Was the psychological distress a pre-existing difficulty (e.g., before you started clinical training) or did it arise during training?
My distress was pre-existing
My distress arose during training
My distress was both pre-existing and arose during training

9) Did you seek professional help for any of your experiences of psychological distress?
Yes, no.
If no selected, they skip to question 12.

10) What form of help did you seek? (tick all that apply)
Medication through my General Practitioner
Talking therapies (e.g., cognitive behavioural therapy, psychodynamic psychotherapy etc.) through my General Practitioner
Medication, privately
Talking therapies (e.g., cognitive behavioural therapy, psychodynamic psychotherapy etc.), privately
Other__________

11) When did you seek professional help?
Before training
During training
Both before and during training

12) Did your psychological distress result in any time off work at any time?
(work includes roles before training, as well as training).
Yes, no.

If yes, they are shown question 13, otherwise they go to question 14.

13) How long were you off work? (e.g., you may have had one period off work, or several periods at different times, please use free text box to describe this further):
None, 1-2 days, 1 week, 2 weeks, 1 month, 2 -3 months, 4-6 months, over 6 months, other:

Disclosure experience(s)

This section asks you about your disclosure experiences. By ‘disclosure’ we mean sharing with or telling someone about the distress that you have experienced. Disclosures may be made verbally (e.g., through the use of language, written (e.g. via email or letter) or spoken) or non-verbally (e.g. through body language or gestures). In this case we are asking about your experience of verbally sharing or communicating your distress with someone.

14) **During training, have you/ did you disclose your experience(s) of psychological distress to any of the following people? (tick all that apply)**
Cohort peers
Placement supervisor
Academic/ course tutor
Line manager
Mentor
I did not disclose my experiences
If ‘did not disclose’ is chosen, the questionnaire skips to ‘conceal’ survey questions.

The following questions are related to the disclosure(s) you made. You might have had more than one experience of disclosure during training. If this is the case, please think about the experience that you were most satisfied with and the one that you were least satisfied with. Please complete the questions for each experience separately. If you have had one experience of disclosing, please complete the following questions for that disclosure.

15) **Were you selective in who you disclosed to?** (by selective, we mean you chose to tell some people, over others, for specific purposes)
Yes, no

16) **Who did you disclose to? (select one option)**
Cohort peers
Placement supervisor
Academic/ course tutor
Line manager
Mentor

17) **How much/ little of your experiences of psychological distress did you disclose?**
Fully, partially, selectively.

18) **Was the disclosure planned or unplanned?**
Planned

Unplanned (occurred in the moment)
I had no choice in the disclosure (e.g., due to significant distress at the time of disclosure).

19) What was the purpose of this disclosure? (tick all that apply)

To gain/ seek support
To seek professional help (e.g., in the form of medication or therapy)
To be a role model for others
To normalise experiences of distress
To be honest and open about your mental health
Other_________________

20) Did you have any beliefs, thoughts, or emotions about disclosing to this person? (tick all that apply)

I would be judged negatively
Disclosure would have a negative impact on my relationship with the person
Disclosure would help me to integrate my personal and professional identities
I would be judged as incompetent
I was unsure if I could trust the person
I would feel better by disclosing
Disclosure would have a negative impact on my self-esteem
I trusted the person therefore I assumed I would have a positive experience of disclosing
Experiencing distress is a weakness
Disclosure would help me to build strength and resilience in my personal and professional life
I would be discriminated against
I would feel less burdened by my difficulties
I would be stigmatised
I would be perceived as weak
Disclosing would help me manage my distress
I feared disclosing would impact negatively on my training experience
I feared I would be 'kicked off' the course
I was ashamed
I was embarrassed
Lived experience of distress is an asset to the work and disclosure would be beneficial during my training and clinical work
I would feel inferior to others on my cohort/ other psychologists
My previous experience of disclosing was negative so I feared negative experiences.
I would be perceived as 'unfit'
I was anxious / fearful
Disclosure would have a negative impact on my mental health and well-being

I was worried about the outcome
I would be viewed as a client and therefore less powerful
My previous experience of disclosing was positive so I assumed this experience would also be positive
Support would not be available or provided
I thought disclosing would give me a sense of relief
I would receive the care and support I needed
Disclosure at work would help me with my confidence with considering disclosure within client work.
Other:____

21)What was the outcome of the disclosure? (tick all that apply)

I received the help that I needed
I was supported by the person I disclosed to
I did not receive the help that I needed
I was not supported
Disclosure adversely affected my training
Disclosure helped me to manage my distress
My clinical work was limited by supervisors
I was referred to occupational health
My line manager was informed
My mental health worsened
I was relieved
I felt understood
I felt safe
I did not feel safe
I developed confidence for future disclosure
I was able to connect with others in similar situations
I was able to integrate my personal and professional identities
Disclosure aided self-reflection
I experienced increased anxiety
Other ________________________________

22) How did the person who you disclosed to respond? (tick all that apply)

They:
Listened
Did not listen
Were sensitive towards me
Were non-judgemental
Were judgemental
Did not pressurise me to share more than I wanted
Were helpful
Provided containment
They pressurised me to share more than I wanted

Were unhelpful
They were clear about confidentiality and/or information sharing
Provided safety
They normalised my experiences
They were clear about any actions they were going to take
They were unclear about confidentiality and/or information sharing
Provided useful resources for support
Did not provide clarity about next steps/actions
Provided support
Other: ___________________

23) Could they have done anything differently?
Yes, no, unsure
What could they have done differently? ___________________

24) Were your beliefs or thoughts confirmed/ disconfirmed (e.g., any of those reported in question 19)? (5-point Likert scale)
My beliefs were confirmed
My beliefs were partly confirmed
My beliefs were neither confirmed nor disconfirmed
My beliefs were partly disconfirmed
My beliefs were disconfirmed

Please specify what beliefs were confirmed: ______________
Please specify what beliefs were disconfirmed: _______________

25) If you were in the same situation again would you still choose to disclose to this person?
Yes, no, unsure
Please state reasons___________________

26) Do you have any regrets about disclosing to this person?
Yes, no, unsure
Please state reasons______________________

27) How would you rate the overall experience of disclosing to this person? (sliding scale)
0=very negative to 10= very positive
Please describe your answer:

28) **Is there anything that could have made the experience better?**
Yes, no, unsure
If yes, what could have made the experience better? ___________________

Second disclosure experience (if applicable)

29) **Who did you disclose to? (select one option)**
Cohort peers
Placement supervisor
Academic/ course tutor
Line manager
Mentor
Not applicable (if this option is chosen the survey skips to question 30)

Otherwise questions 14 to 28 are repeated.

30) **Were there other people (apart from the ones who you disclosed to) that you wanted to tell, but chose not to?**
Yes, no.
If yes, please state who____

If they choose yes, this directed them to the 'conceal' questions. Otherwise they were directed to question 31.

31) **Do you wish to take part in phase two (interview) part of the study?**

- I would like to take part in the next part (interview) of the study. ***(if this option is chosen then the participant was taken to a Qualtrics link separate to the survey link, to ask for their email address to be entered. Once they had entered their email address they were shown the debrief sheet as below.)***

- I would like to end here ***(if this option is chosen then the participant was taken directly to the debrief sheet as below.***)

Conceal questions:

15) Were there any beliefs, thoughts, or emotions that stopped you from disclosing to someone? (tick all that apply)

No, I chose not to disclose because I saw no purpose in disclosing
Disclosure would be too exposing
Concealing would protect me from potential damage to my self-esteem/ worth

I feared further emotional strain and stress
Disclosure would have a negative impact on my training
I would be judged as incompetent
I would be stigmatised
I would be discriminated against
I feared that I would be perceived as ‘unfit’
I feared I would lose opportunities on placement
I feared I would be ‘kicked off’ the course
I was ashamed
I was embarrassed
Concealment was easier
I was not ready to disclose
I was anxious/ fearful
I feared that disclosure would raise ‘fitness to practice’ concerns
It would have a negative impact on mental health and well-being
I would be perceived as a client and thus less powerful
I would feel inferior to others on my cohort/ other psychologists
Experiencing distress is a weakness
I would be perceived as ‘weak’ or ‘inferior’
I did not feel safe to disclose
The culture on the course prevented me
My previous negative experiences prevented me
Other: ___________________________

16) What would have needed to have happened to have enabled you to have disclosed to someone? (tick all that apply)

Nothing, I saw no purpose in disclosing
Open conversations about mental distress during training
Normalising of distress during training
Specific guidance surrounding process and potential outcomes of disclosure
Clarity around support available
Clear guidance on confidentiality and limits in relation to own mental health difficulties
Guidance on the processes and outcomes of disclosure
Support from staff in considering decisions surrounding disclosure
Opportunity to speak to others in a similar situation
Quality supervision
Building good relationships with trusted psychologists
Resources to support decision surrounding disclosure (e.g., peer support, online resources)
Other:____________________________________

17) Do you regret not having disclosed to someone?

Yes, no, unsure

Why?____

18) If you were in the same situation again would you still choose not to disclose?

Yes, no, unsure

Why?____

19) Do you wish to take part in phase two (interview) part of the study?

- I would like to take part in the next part (interview) of the study. ***(if this option is chosen then the participant was taken to a Qualtrics link separate to the survey link, to ask for their email address to be entered. Once they had entered their email address they were shown the debrief sheet as below.)***

- I would like to end here ***(if this option is chosen then the participant was taken directly to the debrief sheet as below.***)

Participant debrief –

We would like to thank you for taking part in our research study. This research will provide crucial information and broaden our understanding of self-disclosure and concealment of psychological distress among trainee clinical psychologists during their training. The findings from the study may help other psychologists in a similar situation in their decision-making processes and inform current practices relating to disclosure of psychological distress within training courses for clinical psychology.

Questions and withdrawing

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher or their supervisors at any time on aliya.zamir@nottingham.ac.uk. If you wish to withdraw your data, please also contact the researcher or supervisor on aliya.zamir@nottingham.ac.uk or rachel.sabin-farrell@nottingham.ac.uk with your unique code. Please note you will only be able to withdraw up until 2 weeks after completion of the survey and/or the interview (if you took part in this).

Further help and support

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specialist emotional support and information. To access this, call: 0300 304 7000

https://www.sane.org.uk/what_we_do/support/helpline

Student Minds

Students minds is a student mental health charity that offer peer support programmes and workshop through different universities. https://www.studentminds.org.uk/

In2gr8mentalhealth

Centre which aims to support lived experiences of distress in mental health professionals. They provide peer support, training, and advocacy services. https://www.In2gr8mentalhealth.com

Honest, Open, Proud

Online resource workbooks to support disclosure decisions https://comingoutproudprogram.org/index.php/manual-and-resources

It may be useful to find out whether your employer offers any staff support schemes for employees experiencing psychological distress e.g., workplace counselling or services provided via Occupational Health.

If you feel you do not have the appropriate support in place, then we advise that you contact your GP.

Further information and contact details

Aliya Zamir: aliya.zamir@nottingham.ac.uk

Dr Rachel Sabin-Farrell, rachel.sabin-farrell@nottingham.ac.uk

Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Appendix F: Interview schedule

Disclosed/ partially disclosed:

1) Can you tell me about your experience(s) of psychological distress during and/or before starting training?
(prompts: how do you understand this experience? What was the impact on you (personally and professionally) and/or others? What help (if any) did you seek? Why this form of help over others?)

2) Can you tell me about the disclosure of distress you made during training?
(prompts: who did you tell? Why this person? How did you tell? When did you tell? How much/little did you tell? At what point in training? Why at this point? How did you go about telling? (e.g. what did you do?) What was the outcome of telling? How did the person respond? What happened after you told? Did you tell more than one person?)

3) What was the purpose of your disclosure(s)?
(prompts: why did you tell? what did you hope you gain?)

4) What did you expect or think would happen after you told this person?
(prompts: why did you think this?)

5) Did you have any prior beliefs or assumptions about disclosing?
(prompts: about self, others or outcomes)

6) What happened after you disclosed?
(prompts: were your expectations met? How?)

7) How did disclosing impact you and your training experience?
(prompts: did disclosing impact others?)

8) Is there anything that you or others could have done differently?
(prompts: any regrets? Wishes?)

9) If you were in the same situation again, would you still choose to disclose?
(prompts: Why? Why not?).

10) Were there other people (apart from the ones who you disclosed to) that you wanted to tell, but chose not to?
(prompts: Why did you choose not to tell these people?)
11) Is there anything you would say to others who might be in a similar position and thinking about disclosing psychological distress during training?
(prompts: any do’s or don’ts?)

Concealed:

1) Can you tell me about your experience(s) of psychological distress during and/or before starting training?
   (prompts: how do you understand this experience? What was the impact on you (personally and professionally) and/or others? What help (if any) did you seek? Why this form of help over others?)

1) What stopped you from disclosing your experience of distress during training?
   (prompts: why/ how did this stop you?)

2) What did you expect or think would happen if you disclosed your experiences?
   (Prompts: why did you think this?)

3) Did you have any prior beliefs or assumptions about disclosing?
   (prompts: about, self, others or outcomes)

4) What would have needed to have happened to enable you to disclose to someone if you wanted to?
   (prompts: what would others have needed to do? What would you have needed to do? Anything that could have been in place? Support required?)

5) How did your decision / choice impact upon your training experience?
   (prompts: any regrets? wishes?)

6) If you were in the same situation again would you still choose not to tell anyone about your distress?
   (prompts: why? why not?)

7) Is there anything you would say to others who might be in a similar position and thinking about disclosing psychological distress during training?
   (prompts: any do’s or don’ts?)

Appendix G: Recruitment email to Clinical Psychology Courses

Attached study recruitment poster

Dear all,

Recent guidance from the Division of Clinical Psychology (DCP), (British Psychological Society, 2020) outlines the importance of supporting and valuing lived experiences of mental health difficulties in clinical psychology training. However, there is very little research investigating the experiences of disclosure of psychological and/or mental health difficulties during training. I am writing to ask for your help with a study that aims to close the gap in this area of research.

As part of my DClinPsy thesis project I am investigating Trainee Clinical Psychologists' experiences of disclosure during training, what responses they got from those they disclosed to, and what beliefs or assumptions influenced their disclosure choices. This is an important area of research as it can highlight what support trainees have or have not got during training and any changes that may be required during training. I am kindly requesting your support in circulating the attached poster and the survey link to all year groups within your DClinPsy programme. The study has received ethical approval from the University of Nottingham's Research Ethics Committee.

If you would like more information or to take part please click on this link:
https://unioflincoln.eu.qualtrics.com/jfe/form/SV_6fD6KMXtlF3YCTr

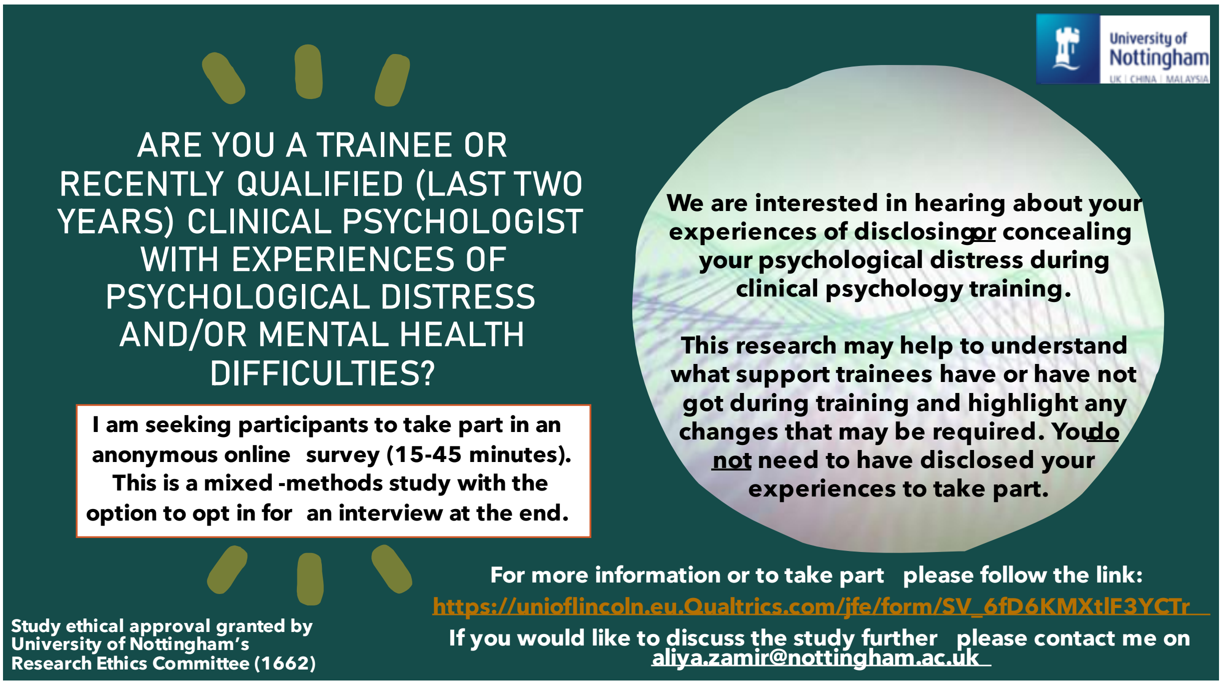
This is a two-phase study and data for phase one is being collected via an anonymous survey. At the end of the survey trainees will be asked if they would like to partake in phase two of the study which will involve an interview. Participation is voluntary and trainees are not obliged to take part just because they are on the DClinPsy course. We kindly ask that trainees are not uniquely picked for participation.

The results of the research study will be written up for the submission of a thesis for the Trent Doctorate in Clinical Psychology by Winter 2022. The study will also be presented at relevant conferences and we intend to submit the findings for publication in a suitable peer-reviewed journal. Whilst we acknowledge that training programmes would welcome findings specific to their course, we are not asking trainees to share where they study to protect their anonymity.

I thank you in advance for your support. Should your course be unable to distribute the survey to trainees, e.g. due to institutional data protection rules, I would be very grateful if you are able to let me know. I'd also be extremely grateful if you, or the person who forwards this invitation to your trainees, could send me a quick line confirming that it has been circulated. We would be happy to discuss any queries you may have.

Kind regards

Appendix H: Recruitment Poster



University of Nottingham
UK | CHINA | MALAYSIA

ARE YOU A TRAINEE OR RECENTLY QUALIFIED (LAST TWO YEARS) CLINICAL PSYCHOLOGIST WITH EXPERIENCES OF PSYCHOLOGICAL DISTRESS AND/OR MENTAL HEALTH DIFFICULTIES?

I am seeking participants to take part in an anonymous online survey (15-45 minutes). This is a mixed -methods study with the option to opt in for an interview at the end.

We are interested in hearing about your experiences of disclosing or concealing your psychological distress during clinical psychology training.

This research may help to understand what support trainees have or have not got during training and highlight any changes that may be required. You do not need to have disclosed your experiences to take part.

For more information or to take part please follow the link:
https://unioflincoln.eu.Qualtrics.com/jfe/form/SV_6fD6KMXtlF3YCTr
If you would like to discuss the study further please contact me on
aliya.zamir@nottingham.ac.uk

Study ethical approval granted by University of Nottingham's Research Ethics Committee (1662)

Appendix I: Anonymous Extracts of Transcription, Initial and Deductive Coding

I: Were there any expectations that were met that you might have had or?	
P: I think with the practical side of things they acknowledged okay, we realise that you might need to take time off and we can discuss that if that happens. So that was sort of met, the practical side of things. but the rest of it, not really. That was just it. That was the only thing. I guess I gave them quite a direct request	Expectations met [CT]: practical support Expectations met [CT]: acknowledged if I needed time off
with that and they'd given quite a direct answer, but anything that was	Direct question of practical support: answered
ambiguous… may in retrospect if I'd gone in with things that I wanted from	Disclosure: Anything ambiguous not answered
them it might have been different, but I	Difference: if gone in with what I wanted
guess I didn't articulate those things with them because I didn't think I would need to, I have never done anything like that	Beliefs: didn't think I needed to articulate exactly what I needed
before so there wasn't really a framework	No prior framework about disclosure
to go with. I guess I trusted them to help me navigate and scaffold that a little bit.	Beliefs: trusted them to navigate/scaffold me

I: I just want to go back to a little bit about those kind of beliefs and assumptions about disclosing to them. I was wondering if there were any other beliefs or fears or assumptions that you had about yourself when you made that disclosure to them?	
P: I guess in terms of beliefs about myself, I think the kind of psychologist I want to be, the kind of things that I value is that, it's hard to articulate but as a	
psychologist, I want to seem like a human being, as well sort of a	Beliefs: I wanted to seem like a human being as well as a professional
professional. I want to be authentic. I	Beliefs: I want to be authentic
guess my hopes of training were that I would sort of be able to build those things	Hopes for training: build sense of identity
and be able to build that sense of identity where I was able to be sort an authentic practitioner who has experienced distress	Hopes: be an authentic practitioner who has experienced distress
and part of that would be disclosing and talking about these things and I think I	Part of being authentic: talking about distress
guess I hoped that that first disclosure	Expected first disclosure to be hardest then easier

would be the hardest one and then everything will be easier after that.	
That was also another assumption that I had that wasn't really met.	Assumption: first disclosure would be hardest
I think actually it did just get harder in different ways,	Disclosure got harder
because I guess my beliefs hopes about what might happen weren’t met so the next time we spoke about it was just harder.	Beliefs / expectations not met so disclosure was harder
I: Yeah, you mentioned about the kind of authentic practitioner and I guess I'm just wondering what do you mean or what does that mean for you?	
P: I guess it it means that I don't think that we can disentangle and divide who we are as professionals and who were are as a person. its not… it’s like a theatrical trick that you can't actually achieve. We are people and we are	We can’t detangle person and professional selves
professionals. and I think for me being an	We are people and we are professionals
authentic practitioner is I guess being able to conjoin those things… in a way in	Being an authentic practitioner: conjoining personal and professional

which you can bring the whole of yourself to your work. and that's about disclosing everything, but I guess it's about being	Bringing whole of self to work
able to show awareness of all parts of you.	Showing awareness of all parts of you
Yeah, I think for me being that authentic practitioner is about being able to integrate the personal and professional	
rather than trying to separate them off, because I don't believe that's realistic. and I don't think that's authentic either.	Separating personal and professional not realistic or authentic
so if you have got experiences of distress they are going to be part of you. and it would be inauthentic of me to conceal and hide those throughout my whole professional journey.	Distress experiences are part of you Inauthentic to conceal parts of me during whole professional journey

Relevant transcript extract	Initial code	Deductive coding framework
So what I learned from that experience, if we're talking about kind of core beliefs and all of that, is people can't handle my distress, they don't know how to help me. People won't be able to help me if I can't help myself. So that's possibly why I was feeling under confident about my ability to explain and also about other people's ability to hold my distress and help me, because in my first experience, I don't think anyone really could.	Beliefs: others can't handle my distress Beliefs: others don't know how to help me Beliefs: people won't help me if I can't help myself	2
It's very complicated relationship with your supervisor and she knows that on my last placement before I went on long term sick leave, I was really stressed out and I was struggling and I kind of don't want to give her any indication that, that was going to jeopardise this placement because at the end of the day I need her	Non-disclosure [PS]: don't want to jeopardise placement	4

to pass me on it and I know that I'm not under performing on this placement, so yeah I don't want to jeopardise that by talking too much about past experiences and getting her too worried. So there is an assumption there that, it will be taken really seriously in this context and that it could be detrimental to me to disclose.	Non-disclosure [PS]: want her to pass me Non-disclosure [PS]: don't want to jeopardise talking too much about past experiences Non-disclosure [PS]: coping okay now so don't want her to worry Belief [PS]: It would be taken really seriously and be detrimental	
So I think that comes from a core place of my own being, but also I'm just anxious because there is still shame in those experiences. I think I still, despite having worked through a lot of them are still hold shame about the experience of being in an abusive relationship. I still hold shame about experiencing dissociation cause I think that's a bit more down the severe end of the spectrum of when you talk about distress. Although I told her little bit about	Belief: shame in those experiences [distress] Hold shame about being in an abusive relationship Shame about dissociation and it being on severe end	**3, 2**

the dissociation, but it didn't go into massive amounts of detail, so I think a mixture of internalised shame, worries about how other people would see me. Those were the main two reasons I think.	Disclosure [cohp]: didn’t tell massive details due to shame Beliefs: internalised shame Beliefs: worry about how other people see me	
My experiences of disclosure with course staff and supervisors on training has made me very anxious about doing that again. So if I were to ever feel distressed, whether it be related to my bereavement, or probably something else in the future now or for whatever reason. I can [probably] say unless it got to a point where I genuinely thought this is really impacting on me and I can't quite cope with this. I don't think I would disclose.	Disclosure impact: with staff and PS made me very anxious to disclose again Disclosure impact: unless it got to point where I couldn’t cope I wouldn’t disclose to staff	**1**
[It] Depends on the supervisor. To course staff, probably not now, I just don't think it's worth it at this stage of training. Obviously, unless I was like “I cannot do training anymore like this is not okay”, I probably wouldn't.	Disclosure impact: wouldn’t disclose to staff on course	

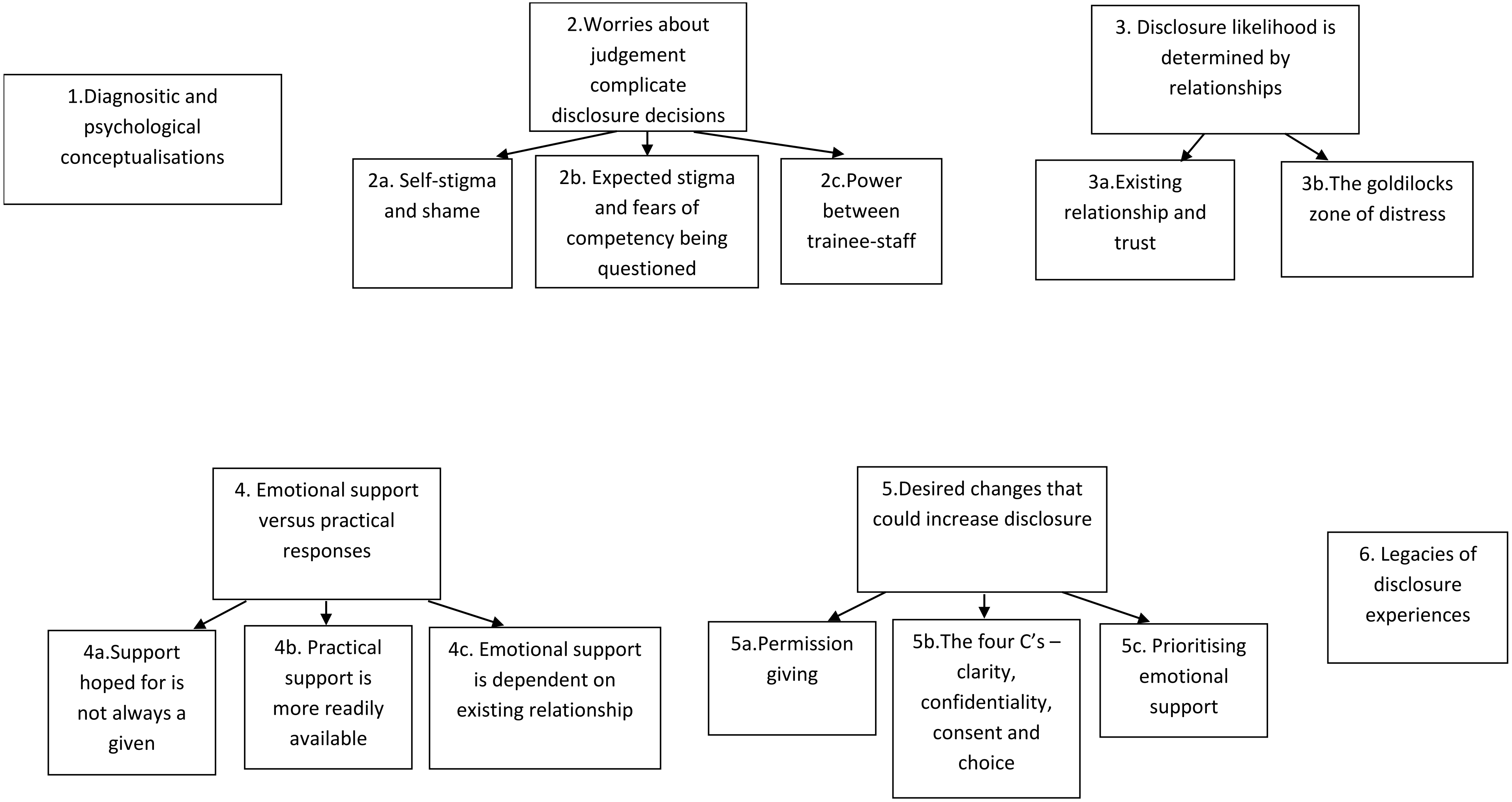
But I wouldn't, also because I have a very strong support system outside of training and many other places I can go to disclose and get that support. With supervisors it depends, I have the most fantastic supervisor at the moment.	Disclosure impact: would only disclose to certain PS's Disclosure impact: only disclose if really couldn't cope I would disclose outside of training for support	
Because there's still, there's still the thing within me that says you're a trainee clinical psychologist, your three years away from qualifying and here you are still having moments of anxiety. and that somehow, that's not acceptable...But I know it is. As I said I know that we're all humans and we all have things going on. We're all going to experience these emotions. But I guess there's still some kind of stigma for me that your a mental health professional and you're not supposed to be the one that's also struggling. erm yeah, that's what I mean by that.	Strong support system outside of training Somehow having moment of anxiety not acceptable I know it is okay but back of mind not somehow acceptable	**2, 3**

I guess in terms of beliefs about myself, I think the kind of psychologist I want to be, the kind of things that I value is that, it's hard to articulate but as a psychologist, I want to seem like a human being, as well sort of a professional. I want to be authentic.	Stigma: mental health professional not supposed to struggle	**5**
I guess my hopes of training were that I would sort of be able to build those things and be able to build that sense of identity where I was able to be sort an authentic practitioner who has experienced distress and part of that would be disclosing and talking about these things and I think I guess I hoped that that first disclosure would be the hardest one and then everything will be easier after that.	Beliefs: I wanted to seem like a human being as well as a professional Beliefs: I want to be authentic Hopes for training: build sense of identity Hopes: be an authentic practitioner who has experienced distress Part of being authentic: talking about distress Expected first disclosure to be hardest then easier	**5**
I would say you know I mean a positive way, really. I think I was able to reflect on it and learn from it, and I think you know the course is demanding and challenging and it shapes you as a person and part of that process is personally and professionally is	Positive impact of disclosure	

to develop reflective skills and to reflect on your own experiences so it's kind of giving the opportunity to do that.	Course demanding and challenging and shapes you as a person Disclosure impact: able to reflect and learn Disclosure impact: opportunity to reflect on own experiences	**4, 3**
This is a person with great, power, rank and seniority over me, and she can pass or fail this placement… and maybe there's a fear in me somewhere that it would not have been helpful. For my progress on the placement to disclose. No that I logically think any psychologist would react like that. but there's the worried voice and worried part of me, I guess that still thought that, that was a barrier to me actually saying anything.	Non-disclosure [PS]: person with great power, rank and seniority over me Non-disclosure [PS]: PS can pass or fail this placement Non-disclosure [PS]: fear it would not be helpful for progress on placement Logically don't think PS would respond negatively Non-disclosure [PS]: worried part of me that PS would respond	

Appendix J: Initial Thematic Map

Appendix K: Final Thematic Map



Appendix L: Mixed Methods Quality Appraisal

Completed by Lead Researcher

Mixed methods quality appraisal	Response	Comments
Screening questions		
1. Are there clear research questions?	Yes	The research aims and questions are clearly highlighted in the journal and extended paper.
2. Do the collected data allow to address the research questions?	Yes	The paper clearly highlights the reasons for why a mixed-methods strategy is required for wide range of data to be collected, followed by a smaller sample to be followed up for interviews.
Quality Criteria (Mixed methods study)		
1. Is there an adequate rationale for using a mixed methods design to address the research question?	Yes	The rationale for using a mixed-methods strategy is clearly explained, including evidence of gap in research and qualitative findings being limited within the field.
2. Are the different components of the study effectively integrated to answer the research question?	Yes	Phase one and two data are integrated together appropriately; it is highlighted how the survey findings supported tailoring of interview questions, and how the qualitative results in both phases were integrated together. The discussion integrates findings by reporting on both survey and interview data together.
3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes	The discussion section adequately interprets the data from both the quantitative and qualitative findings, through discussion of the triangulation methods and where research needs to be directed.
4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes	No divergences or inconsistencies are apparent
5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes	Quality criteria of both traditions are adequately followed by use of appropriate sampling strategies, using direct quotes, and choosing the most appropriate measures derived from previous relevant literature within the field.

Appendix M: Mixed Methods Quality Appraisal

Completed by Independent Person

Mixed methods quality appraisal	**Response**	**Comments**
Screening questions		
1. Are there clear research questions?	Yes	Clear research questions (alongside a clear rationale) are outlined in the introduction.
2. Do the collected data allow to address the research questions?	Yes	The writer clearly outlines who data was collected from, how data was collected, and how this was analysed. All of which are appropriately in line with the research questions and clear rationales are woven throughout the method section.
Quality Criteria (Mixed methods study)		
3. Is there an adequate rationale for using a mixed methods design to address the research question?	Yes	The writer offers a compelling rationale for using a mixed methods design. Given the limited previous research in the area, the writer suggests that use of such a mixed methods design allows for exploring 'widespread data' followed by more 'in-depth exploration.'
4. Are the different components of the study effectively integrated to answer the research question?	Yes	The writer outlines their rationale for presenting the quantitative and qualitative results separately – this aids understanding on the part of the reader. They ensure, however, that these results are appropriately integrated in the discussion section, answering their research questions.
5. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes	Interpretation of the quantitative results include clearly outlining the context available surrounding the results. For instance, the writer clearly outlines for the reader the differences found between time one and time two disclosures, offering additional context-setting information where appropriate. The writer offers a reflexive and interpretive analysis of the qualitative data, they go above simply describing quotes, instead again placing all findings within the context they are set (particularly important given the research aims).
6. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes	The writer does not outline any significant divergences or inconsistencies between the quantitative and qualitative data. In fact, the writer clearly outlines the areas of comparison between the two methods. The writer does however ensure to outline divergences throughout the results and discussion section (often within the qualitative methodology and aspects where participants are offering contradictory or misaligned information regarding a theme or subtheme).
7. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes	The writer is transparent and clear regarding how both aspects of the mixed methods approach was conducted, this allows the reader to understand clearly how data was gathered, analysed, and reported. The writer openly discusses both strengths and limitations of their approach which offers a balanced view of the project and increases the credibility of the writer in assessing the quality of their own work.

POSTER

“Isn’t it mad that we’re all psychologists and we can't talk about our feelings?”

UNIVERSITY OF LINCOLN

Aliya Zamir, Rachel Sabin-Farrell and Anna Tickle
Trent Doctorate in Clinical Psychology

University of Nottingham
UK | CHINA | MALAYSIA

Introduction

Disclosure of psychological distress and/or mental health difficulties in the workplace is a complex decision. Disclosure may enable suitable adjustments and access to support, however may also risk stigma, discrimination and exclusion. (1)

Trainee clinical psychologists, are just as likely, if not more to experience psychological distress (2), however to date, little research has explored trainee mental health and their disclosure experiences during clinical psychology training.

Aims

To explore:

1) trainee experiences of (non)disclosure of psychological distress during training,
2) what beliefs, assumptions or predictions decisions about disclosure are based on,
3) what response trainees got if they disclosed.

Methods

Phase one: 165 current (or recently qualified) trainees took part in an online survey.

Phase two: 13 were interviewed.

Analysis: Descriptive statistics and reflexive thematic analysis was used.

Results

Trainees who had disclosed distress largely took part. **Six main themes** were constructed, of which four had subthemes.

1. Diagnostic and psychological conceptualisations
2. Worries about judgement complicate disclosure decisions
3. Disclosure likelihood is determined by relationships
4. Emotional support versus practical responses
5. Desired changes that could increase disclosure
6. Legacies of disclosure experiences

Discussion

There is a need for training programmes to prioritise emotional support, increase permission giving and enhance guidance in place to support trainees who may wish to disclose.

Limitations

There were a lack of participants who did not disclose their experiences and those from underrepresented groups

Future research

Exploration of disclosure from a recipient perspective and those from underrepresented groups is required.

References: (1) Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., ... & Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC psychiatry, 12*(1), 1-14. (2) Grice, T., Alcock, K., & Scior, K. (2018). Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical psychology & psychotherapy, 25*(5), 721-729.

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SMALL SCALE RESEARCH PROJECT

A qualitative evaluation of workplace stress within a Child and Adolescent Mental Health Service during the 2020/21 coronavirus pandemic

Workplace stress during a global pandemic

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Abstract

Objective: To explore workplace-stress within a Child and Adolescent Mental Health Service during the coronavirus pandemic (COVID-19), staff perceptions of the causes and impact of stress, and any perceived changes to these after UK lockdown ending.

Methods: Using a longitudinal qualitative design, two Reflective Practice Groups (RPGs) were facilitated using Palmer et al's. (2004) stress model by the internal psychologist in July and September 2020. Fifteen multi-disciplinary staff members attended RPG one and 10 attended RPG two. Data was analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006).

Results: RPG 1 revealed four main themes during COVID-19: ‘increased demands-reduced access to resources’, ‘work-home life merge’, ‘carry on culture’ and ‘shame and guilt’. Post-lockdown, RPG 2 revealed three themes: ‘increased choice and freedom’, ‘team connection and support’ and ‘improvements in stress, physical and mental health’.

Conclusion: Workplace-stress increased following the UK lockdown and adversely impacted on staff mental health. However, post-lockdown, stress reduced which positively impacted on staff physical and mental health. Further longitudinal data to understand the longer-term impact of COVID-19 and workplace-stress, an increase in staff access to resources and promotion of staff choice in ways of working and workplace-stress interventions is needed, to mitigate against ongoing workplace-stress.

Keywords: Workplace stress, coronavirus pandemic, child and adolescent mental health service, qualitative, psychological impact

Introduction

Work-related stress has been defined as a negative (unpleasant) emotional experience, which occurs when individuals perceive themselves to be subject to excessive demands/pressures, in which they cannot cope (Health and Safety Executive [HSE], 2020). Whilst pressure at work can support goal achievement, excessive pressure/demands can result in stress and negatively impact employee physical and mental health, and subsequent burnout (HSE, 2019; Zaghini et al., 2020). Work-related stress, and related anxiety and depression is reported to be increasing; HSE (2020) found that 51% of all work-related illnesses and 55% of all working days lost due to work-related ill-health were related to workplace-stress, anxiety and depression. This data may have been affected by the emergence of the global coronavirus (COVID-19) pandemic in March 2020; however, HSE (2020) analysis showed that COVID-19 did not appear to have been the main driver of changes seen in 2019/20 data. This suggests that work-related stress is a pre-existing issue, exacerbated by COVID-19 (Krystal, 2020; Yıldırım et al., 2020).

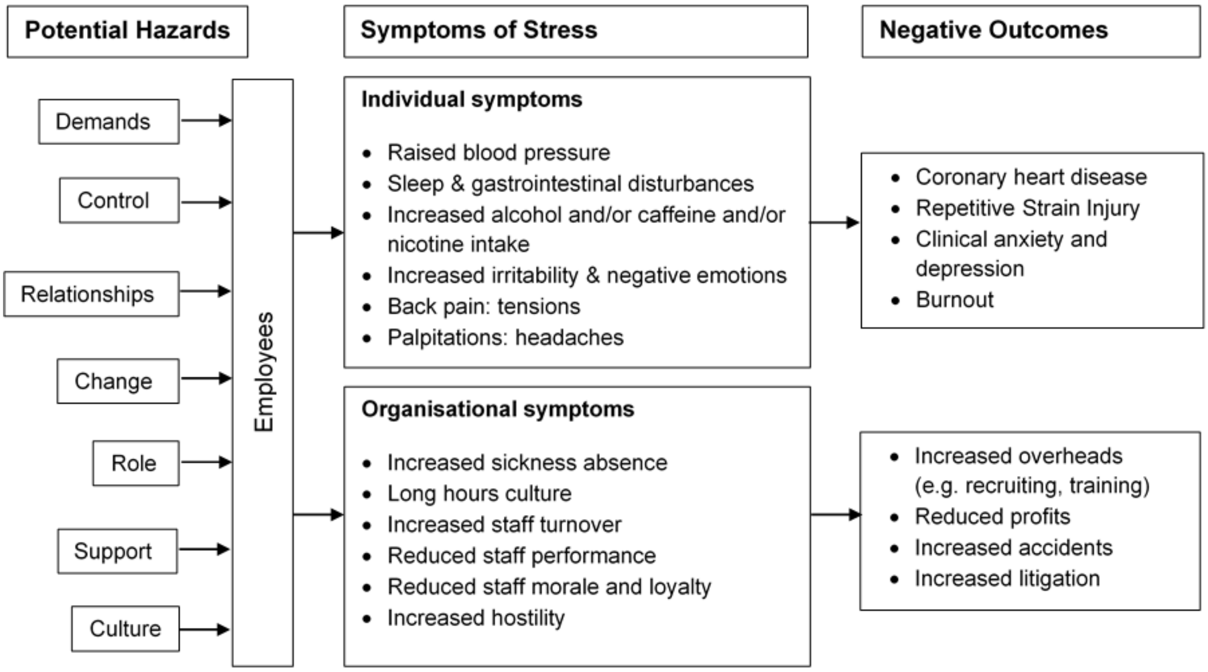
Within the National Health Service (NHS) 2020 staff survey, data showed that 44% of respondents reported illness caused by work-stress, representing an increase from 40% in 2019 and 37% in 2016 (O'Dowd, 2021). Child and Adolescent Mental Health Service (CAMHS) staff may be at increased risk of workplace-stress, due to greater exposure to trauma narratives (Hunt, 2020), consistently high service demands and recurrent issues with staffing levels (Care Quality Commission, 2017). Children and families accessing CAMHS may also have special educational needs and disabilities, making them more vulnerable to experiencing poor mental health and greater pressure during COVID-19 (Asbury et al., 2021), increasing service demand. Workplace-stress has a considerable economic impact through sickness from work and a significant impact on individuals and organisations (Edwards & Burnard, 2003). Individually, prolonged work-stress can increase mental health problems including anxiety and depression and lead to poor physical health (Cousins et al., 2004; Rosengren et al., 2004). Organisationally, workplace-stress is related to greater staff turnover and poorer patient outcomes (Blake et al., 2013; McFadden et al., 2015; West & Dawson, 2012), and can reduce work productivity and commitment (Ekienabor, 2016).

Under the Health and Safety at Work, etc. Act (1974), employers in the UK have a legal duty to ensure, as far is reasonably practical, the health and safety of their employees at work. The HSE (2019) have developed stress-management standards based on six core areas; demands (e.g., workload/unrealistic deadlines), control (e.g., lack of autonomy), support (peer and managerial), relationships (e.g., avoiding conflict), role (e.g., avoiding conflicting roles) and change (e.g., managing change appropriately). The HSE (2019) outline that poor management of these areas within the workplace are associated with poor health, lower productivity and increased sickness absence. To underpin the standards, Palmer et al. (2004) developed a model (Figure 3) of stress, with the inclusion of workplace culture, to explain how the main stress-related hazards relate to organisational/individual symptoms and outcomes of stress. This model however, only outlined the contributing factors to workplace-stress and outcomes and did not include any mechanisms of how stress may develop.

Lazarus and Folkman's (1984) transactional theory of stress and coping was therefore drawn upon within the current evaluation; individuals are suggested to repeatedly appraise stimuli within the environment and this process generates emotions. When stimuli are appraised/perceived as harmful, threatening, or challenging (i.e., stressors), the resultant distress produces emotion-focussed (EF) or problem-focussed (PF) coping strategies to help overcome the stressors. Coping strategies are suggested to produce outcomes which are reappraised as either favourable, unfavourable, or unresolved. Favourable outcomes are suggested to produce positive emotions whereas unfavourable or unresolved outcomes produce distress (Lazarus & Folkman, 1984). This theory goes beyond Palmer et al.'s (2004) model and highlights the importance of appraisals and environment-individual interactions. However, EF and PF coping taxonomies are not conceptually clear (Skinner et al., 2003); strategies such as ‘support seeking’ or ‘making a plan’ may contribute to both problem-solving and managing emotions (Folkman & Moskowitz, 2004).

Figure 3

Palmer et al.'s (2004) model of workplace-stress



Current context

The current CAMHS team was established as a Children and Young People's-Increasing Access to Psychological Therapies service in April 2016. The team is composed of mental health nurses, social workers, psychologists, psychiatrists, peer support workers and an assistant practitioner. Following the UK going into 'lockdown' on the 23rd of March 2020 due to COVID-19, as well as many other community mental health services the current CAMHS team experienced significant changes to service provision and ways of working. With the stay-at-home message, staff members were required to work remotely; usual care was being provided digitally with variable resources. Whilst digital care provision has shown efficacy for mental health difficulties such as anxiety and depression (Berryhill et al., 2019), in CAMHS, this has not been the norm prior to the pandemic; only 4.5% of 154 CAMHS clinicians reported using videoconferencing technology for care provision in one study (Cliffe et al., 2020), consistent with the current services' structure. Further to digital working, some staff in the current service also faced increased demands related to childcare due to school closures, shielding and financial pressures.

Study rationale

The current project was prioritised by the service managers as staff members were reporting in team meetings rising stress levels and inability to take on additional client cases, due to the pandemic. The service waiting list was also increasing due to greater demand and staff sickness. Given this, and the importance of attending to workplace-stress (HSE, 2019) the internal psychology team facilitated the project. It was first considered important to explore workplace-stress within the team, and staff perceptions of the causes and impact of this, given what is perceived as harmful/threatening may be influenced by individual appraisals of events (Lazarus & Folkman, 1984). After lockdown restrictions were gradually eased (see Table 14), staff were reporting reduced stress in team meetings. To understand changes to work-related stress, causes and impact data was gathered on a further occasion using a longitudinal method (Thomson & Holland, 2003).

Reflective Practice Groups (RPGs) aim to facilitate supportive and non-judgemental spaces for reflection, and processing of staff-patient, team and organisational changes and dynamics (Adlam, 2019; The British Psychological Society, 2017). Within the current evaluation, RPGs were used to gather qualitative data with the rationale being two-fold; it was considered that RPGs would allow team reflection on organisational changes related to COVID-19 and workplace-stress, meeting the aims of the project, and in turn also facilitate team connection and support (Riordan, 2008; Thorndycraft & McCabe, 2008; Walsh et al., 2002). Palmer et al.'s (2004) model underpinned the RPG questions and Lazarus and Folkman's (1984) theory informed the research questions and aims. Originally, the service had planned to use quantitative outcome measures to contextualise the qualitative findings; however, there were methodological issues within the data collection procedures. The survey was sent to the entire team and identifiers were not used; therefore, it was not possible to track/link individual survey responses at the two points of data collection (July and September 2020). Given this, reliable change could not be measured, and the quantitative measures were therefore excluded from this report. Recommendations of how the service may improve this in future evaluations are provided in the discussion.

This evaluation was intended to inform the development of an effective organisational stress-management response. The project aims were to explore:

1) Workplace-stress within the CAMHS team during COVID-19
2) Staff perceptions of the causes of workplace-stress
3) Staff perceptions of the impact of workplace-stress
4) Any changes to workplace-stress, and perceived causes and impact following the UK national lockdown ending

Method

Approval for the current evaluation was gained through the governance and approval processes of the organisation involved. Ethical guidelines were maintained including gaining informed consent, the study being voluntary, and confidentiality and anonymity being maintained.

Design

The study utilised a qualitative longitudinal design (Holland, 2007). Data was collected via two RPGs: July and September 2020. Table 14 outlines the constraining measures in place at the time of data collection.

Table 14

Timeline of 2020 coronavirus restrictions and data collection procedures

23rd March	• Full UK lockdown – CAMHS staff working-from-home
April – May	• Increase in CAMHS waiting lists • Staff report increased stress in team meetings • Increase in staff sickness • Staff report inability to pick up new cases due to stress • Managers recognise importance of attending to stress in team and psychology team lead on project
10th May	• Announcement of conditional plan for lifting lockdown
June	• Psychology team review evidence and literature surrounding workplace-stress • Possibility of RPGs discussed in team meetings
23rd June	• Announcement of plans for relaxation of restrictions; two-metre social distancing • CAMHS staff continue to work-from-home
14th July	• Staff invited to attend RPG
28th July	• RPG 1 took place
14th August	• Lockdown restrictions eased (reopening of indoor theatre venues)
31st August	• Staff report a decrease in stress during team meetings • RPG 2 discussed in team meetings to understand any changes in stress
1st September	• Staff invited to attend RPG 2 • Desk-booking system in place in team office and staff able to work from office if required
9th September	• RPG 2 takes place • Schools re-open and limited lockdown restrictions in place

Reflective Practice Groups

RPGs are facilitated in a variety of settings with varying structures; however creation of an open, safe space is a key element of these (Heneghan et al., 2014; Kurtz, 2020). Therefore, whilst the format of the RPGs studied by the current evaluation was guided by Palmer et al.'s (2004) model (e.g., staff were asked about areas related to ‘potential hazards’ as identified in Figure 3), the structure of the RPGs was flexible and open-ended, responding to what staff brought. The team had no prior experience of RPGs, and these were introduced to the team by the internal psychologist as an opportunity to reflect on workplace-stress in the context of COVID-19, and to understand their perceptions of the causes and impact of workplace-stress. Staff were informed that they would be asked about relevant areas (such as demands, control, support) related to workplace-stress and that this would inform the development of an effective organisational stress-management response. No session guide was provided. It was clarified that findings would be fed back to management so ways to manage stress could be considered; staff were in favour of this.

The internal psychologist facilitated both RPGs via Microsoft Teams (MsT). The first two-and-a-half-hour-long RPG took place in July 2020 and was recorded over MsT. The RPG 2 structure and questions were similar in nature with the inclusion of a further question related to perceived changes in stress and causes and impact. This RPG lasted one hour.

Epistemology

A critical realist epistemological position was adopted, which accepts the existence of an observable reality yet proposes that reality is constructed through individual meanings, experiences, standpoints and social contexts (Creswell & Plano Clark, 2011). The author acknowledged that there was no ‘one truth’ related to workplace-stress and as such multiple ‘truths’ and perspectives were considered during data analysis and the report write-up.

Reflexivity

The author (a Trainee Clinical Psychologist) has experience of working within NHS community teams during COVID-19 and a specific interest in workplace-stress. The author therefore recognised possible biases toward looking for positive findings. To manage biases, the author used research supervision to check and challenge her interpretations of findings and kept a reflective diary throughout.

Procedure

All staff members (excluding managers) were invited to attend RPG 1 via email by the internal psychologist in July 2020 (see Table 14). Managers were excluded because they themselves had suggested that their non-attendance might help staff to feel more comfortable to talk about workplace-stress, and this was clarified in the invitation email. It was made clear that RPG attendance was voluntary and no individual demographic information was being recorded or would be written up in the final report. Staff were asked to email the internal psychologist to confirm RPG attendance. RPG 2 was facilitated in September 2020 using an identical procedure.

Participants

The same cohort (team) were invited to attend both RPGs. Fifteen out of the 21 staff members invited, attended the first RPG. Out of the ones who did not attend, three were on leave, one person was off sick, and for one person the RPG fell on their non-working day. Ten out of the 18 (three had left the service) staff members invited, attended the second RPG. Two were on leave and the rest did not respond.

Data Analysis

A Reflexive Thematic Analysis (TA) (a theoretically-flexible approach to identifying patterns across data) using Braun and Clarke's (2006) six steps (see Table 15) was used to analyse the data. The internal psychologist hand transcribed RPG 1, and the first author transcribed RPG 2. Initial codes were generated inductively on Microsoft Word by the first author using a semantic focus (e.g., explicitly stated ideas, concepts, meanings, and experiences). The data was coded again deductively, by comparing codes against two relevant theories; Lazarus and Folkman (1984) and Palmer et al. (2004). Developing patterns and themes were discussed within research supervision, by checking interpretations, debating themes and contradictory explanations, until themes were further refined, developed, and labelled. This approach was suitable as it allowed for theoretically-informed interpretation of meaning (Braun & Clarke, 2019) within the context of COVID-19. This procedure was repeated for RPG 2.

Table 15

Braun and Clarke's (2006) six steps for Thematic Analysis

Phase	**Description of procedure**
1.Becoming familiar with the data	Transcription and reading the data several times
2.Generating initial codes	Noting initial ideas on the data and reducing large chunks of data into manageable segments
3.Searching for patterns and themes	Looking for patterns within the data and coding them into themes
4.Reviewing themes	Going over themes to ensure they fit with initial codes
5.Defining and naming themes	Deciding on names that best describe each theme
6.Producing the report	Writing up the analysis illustrated by extracts from the data

Analysis of RPG 1 and 2 was conducted separately, rather than across the sample, as there were differences in the number of RPG attendees; this allowed for exploration of any changes from RPG 1 to RPG 2 (Holland, 2007; Saldaña, 2003). The results from the RPGs are therefore presented separately.

Results

July RPG

Four themes were constructed from RPG 1:

Increased demands, reduced access to resources

Almost all staff members reflected on greater and uncertain workplace-demands, within the context of COVID-19 and changes to service provision, including increased admin tasks, uncertainty about therapy rooms, office desks and changing nature of service provision and how this increased workplace-stress:

> Before it was always tricky to find rooms but now we have to juggle coordinating rotas which sounds like a small thing, but it takes up a load of additional emails that you probably don't have time to write. Then on top of that we will now have to book desks which is another stress… (Gerard)

Half of the staff members recognised that the demands within CAMHS were already high and usually these are manageable. Naomi shared "…stress isn't just about what are the demands because they will always be there but the demand that is peeing me off this week, if that is gone next week there will be another one to take its place."

Almost all staff recognised that the resources, particularly team relationships, support, face-to-face contact, non-work related chats, connection and debrief that helped them to previously manage workplace-demands, were now not accessible to them due to the pandemic and this had an adverse impact on stress. Ben shared: "When you have team's meetings at the minute it is nice to see everyone but it is all talking about work stuff, we don't have that space to talk about other things that are not work-related."

Staff members also reflected on the importance of these resources and how they help them to keep coming back to work, despite the nature of the service being highly demanding:

> That made me reflect on what keeps me going outside of this pandemic… that Friday afternoon that last hour and you have that laugh and giggle with people,

> debrief and de-stress before you go home for the weekend and it is just absolutely vital, it is what keeps you coming back in on Monday. (Sam)

Overall, there was a consensus amongst all staff that there was an imbalance between workplace-demands and accessibility of resources, and this was a contributing factor to workplace-stress during COVID-19.

Work-home life merge

Almost all staff members reflected on the impact of change, specifically homeworking because of the pandemic and the lack of separation of home and work-life. Some staff members reflected that home-life *was* now work-life and doing clinical work this way was inappropriate and increased levels of stress:

> It is totally inappropriate for me to do this work at home… there is stuff going on in the house the kids have come back. I have not got the room. I am now in my bedroom to have this conversation. (Robert)

This lack of separation also appeared to impact upon staff motivation, enthusiasm for work, and overall enjoyment in their roles. One staff member shared:

> I have nothing to get out of bed for, I can just pick my laptop up or trot downstairs in my joggers and work and I hate that because I am so unmotivated. Work used to make me really excited and now it doesn’t. (Melissa)

Carry on culture

Majority of staff felt that the NHS culture resulted in them feeling that they needed to carry on despite the additional stressors they were facing. Staff commented on the idea of NHS staff being ‘heroes’ as widely reported within the media and related to a sense of increased pressure and that they needed to be ‘cruising’ all of the time:

> I feel a pressure from the whole thing to work as hard as I can because we are the NHS. We are the NHS heroes aren’t we? We are meant to be cruising at 90 miles an hour all of the time. (Naomi)

Furthermore, when discussing the NHS culture, several staff members reported a sense that even if they were struggling, they would not share their levels of stress, in fear of their competence and resilience being questioned. The perceived consequences of sharing their stress levels with others appeared to outweigh the perceived benefits. These feelings and beliefs appeared to be a barrier to disclosing how they were really feeling:

> Within the culture there is an expectation of resilience so if someone says to me how are you doing, my answer is always going to be fine. Actually, if I'm a bit stressed I would never tell anyone I'm stressed and I can't cope with this because that brings in to question my competence… (Kerry)

Shame and Guilt

Majority of staff members reflected on how COVID-19 changes were taking a toll on them and their personal and professional lives. Particularly some staff shared feelings of shame and guilt:

> Not only do I feel like I am not giving a good enough service, I feel I am not being a good mother or partner. It is not just my work role, it is every single role in my life I am not doing good enough in. (Kay)

Some staff members commented on feeling shame and guilt for even admitting feeling stressed. This further highlights the fear of sharing vulnerability to others which perhaps is exacerbated by the NHS culture as identified by the previous theme:

> Every day I feel huge amounts of guilt about it [stress]…. even admitting all of that feels wrong and I know it is not. I know we are a good team and we back each other up but it is hard to tell people that those kind of things. (Robert)

Overall, there was agreement amongst staff that following the first national lockdown, their stress increased, and this had a negative impact upon their personal and professional lives.

September RPG

Three themes were revealed from RPG 2:

Increased choice and freedom

Almost all staff members reported that being able to go into the office where they had a separation of work and home-life gave them more freedom and flexibility which was previously missing, and this had a positive impact on stress:

> I think a little bit better for me [stress]. Just being in the office a bit more now and also having a bit more flexibility now with the kids being back at school… it feels as though there's more choice. (Ellie)

Half of the staff members acknowledged that being in the office was now different with desk booking systems and social distancing measures in place and this increased demands. However, they recognised that this gave a greater sense of normality, which positively impacted upon stress. As Sam shared: "I think it makes a difference being able to come in, obviously not for everyone but for me, I love being in it brings back a degree of normality even though things are different".

Team connection and support

All staff members reported that team connection and support was helpful to manage stress and demands and having greater opportunity to connect as a team would be helpful. In addition, after the July RPG, some staff members reported that they had felt less alone in their stress and difficulties. One person shared that having the space to talk with the team in the RPG allowed them to feel validated and this in turn had a positive impact on their mental health: "Hearing that other people were feeling the same as me in the reflective session also made me feel less alone and more validated." (Jenny).

Furthermore, almost all staff reported that physically being in the office meant greater opportunity to talk to the team and this was less burdensome than trying to talk with team members online:

> …it's just the physical practicality of me just being able to pop into one office and then another to have a two-minute conversation to say 'not sure if you're

> aware of this this and this…' done. Whereas it's the time that that can take when you're working from home and also it's not the same is it… (Kay)

Improvements in stress, physical and mental health

Majority of staff reported that post-lockdown, workplace-stress had reduced, and this had a positive impact on their physical and mental health. Some staff described that being in the office meant appropriate desks and chairs as opposed to the facilities available at home. This highlighted the multiple practical benefits of office-working:

> My back's been better and I think that's been just sitting in better working environments… at a decent desk more with a decent chair and my backache has reduced massively, and I think pain can make you feel more stressed. (Gerard)

One staff member commented that the increased balance in home-working and face-to-face contact with clients and staff appeared to contribute to improved stress: "it's making working from home a little bit more manageable…" (Helen)

Overall, the results highlight improvements in workplace-stress and subsequent physical and mental health from July to September, despite staff reporting demands remaining high. After lockdown ended it appeared that staff had greater access to resources that they appraised as helpful and this had a positive impact on staff stress, physical and mental health.

Discussion

This small-scale research project contributes to the nascent evidence-base exploring workplace-stress within (mental) health services during the novel COVID-19 pandemic and found - consistent with previous literature (Bentham et al., 2021; Joshi & Sharma, 2020) - an increase in workplace-stress following the first UK national lockdown, and this had a negative impact on staff mental health. The results suggest that whilst staff perceived workplace-stress hazards within Palmer et al.'s (2004) model impacted on workplace-stress, it was not the hazards within themselves that resulted in stress, but the inaccessibility of the resources (e.g., team connection and support) that they perceived as helpful in coping with stress-hazards.

This suggests that whilst HSE (2019) stress standards are important to assess and monitor within workplaces to mitigate against individual/organisational symptoms and outcomes, these are not sufficient in responding to workplace-stress during COVID-19 and nuanced stress-management responses that increase access to resources are required.

Linking the findings to Lazarus and Folkman's (1984) theory, staff prior to lockdown appeared to adopt both EF and PF coping strategies (e.g., seeking support, office chats), which likely had a favourable outcome and produced positive emotions, thereby helping to manage workplace-stress. However, during the pandemic, previously deployed coping strategies were now less likely to be deployed; for example, staff members were less likely to reach out to team members due to shame or guilt. It is possible that the coping strategies that staff employed (e.g., seeking support in online team meetings) had unfavourable/unresolved outcomes due to meetings being online and being seen as an added demand or burden. This therefore may have limited generation of positive emotions, thereby increasing workplace-stress.

A further contributing factor to workplace-stress was staff perceptions of the culture of the NHS, which meant that they did not feel comfortable sharing stress, or its impact, with others. Staff reported feeling shame and guilt for even admitting stress to others, which highlights that stigma toward mental health professionals experiencing stress and mental health difficulties may exist; this is consistent with previous literature investigating distress among mental health professionals (Elliott & Marta, 2020; Zerubavel & Wright, 2012). It may be that staff were reluctant to share their stress due to self-stigma (public stereotypes that are internalised) (Corrigan & Rao, 2012)) or the possibility of structural stigma (societal/cultural norms or institutional practices that limit opportunities for stigmatised populations) (Hatzenbuehler & Link, 2014); however further investigations of these factors, as well as how stress and mental health is conceptualised within NHS services is needed.

Findings in relation to the final aim are consistent with previous research whereby staff perceived improvements in stress, physical and mental health post-lockdown (Pieh et al., 2021), specifically due to greater choice and freedom and team connection and support. However, it was not possible to determine whether workplace-stress and perceived causes and impact would differ or persist going forward in the current team, as further qualitative data was not obtained. Given that lockdown restrictions in the UK were again implemented on the 5th of November 2020 and research suggests that mental health consequences after the pandemic may continue for some time (Galea et al., 2020), further data could have enhanced the understanding of the lasting impact of COVID-19 and related workplace-stress.

Strengths and limitations

This evaluation has provided an insight into workplace-stress within the CAMHS team, staff perceptions of the causes and impact of this, and any changes in these after the first UK COVID-19 lockdown ended. There was a drop-out in membership between RPG 1 and 2 and therefore the themes identified in the evaluation do not reflect the entire team. One reason for the drop out may be that staff stress was less of an issue for some in September 2020 following restrictions easing, and so there was less of a reason to take part in RPG 2. Or it may be possible that stress for some increased and so RPG 2 was avoided; therefore, some conflicting views may not have been captured. Future evaluations may seek to consider ways in which participation may be maximised to capture a larger sample to mitigate against these limitations.

To improve the methodological issues in quantitative data collection procedures, in future evaluations staff members may be given individual unique numbers when completing quantitative measures; allowing individual responses to be tracked and statistical analysis of change to be conducted.

Recommendations

Based on the findings it is recommended that the current service:

1) Gather further longitudinal data on workplace-stress, causes, and impact to understand the lasting impact of COVID-19 and workplace-stress. This may be conducted using further RPGs; if using quantitative questionnaires adding unique identifiers to these will be helpful to track meaningful change.
2) Gather data (e.g., via RPGs) on what stress-interventions staff would find helpful to manage stress and implement these. Whilst individual stress-management interventions may have positive results (Holman et al., 2018;

Public Health England, 2016), research suggests that stress interventions targeting the organisation/system have the potential to maintain their positive effects over longer periods of time compared to those aimed at individuals or small groups (Awa et al., 2010). Therefore, as well as managing the workplace-hazards as identified by the HSE (2019), an organisational stress-management intervention should seek to increase staff access to resources (e.g., team connection/support) and promote staff choice in relation to ways of working/stress interventions.

3) Evaluate any workplace-stress interventions that are implemented to assess their effectiveness and amend these in line with COVID-19 context/restrictions.
4) Further evaluation on how stress and mental health is conceptualised within the NHS and the CAMHS team, how this may contribute to workplace-stress and how harmful cultural norms may be shifted is warranted.

Conclusion

The findings from this evaluation outline an increase in staff stress following the national lockdown with a consequent negative impact on mental health. However, post-lockdown staff perceived workplace-stress was more manageable, specifically due to greater freedom and choice and team connection and support. Whilst it was not the workplace-stress hazards as outlined by the HSE (2019) in themselves that increased stress, it was the reduced access to the resources that staff perceived as helpful, the NHS culture, and work-home life merge that exacerbated workplace-stress in the context of COVID-19. Further research should seek to collect further longitudinal data on workplace-stress, causes and impact, obtain further data on staff views of what stress-interventions would be helpful, implementing both individual and organisational stress interventions, and evaluating/amending these in line with COVID-19 restrictions. Finally, further evaluation of how stress and mental health is conceptualised within the CAMHS team and more broadly, is of importance.

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