Exploring the Impact of Personal Therapy and Factors that Affect Disclosure of Mental Health Difficulties in Applied Psychology Trainees

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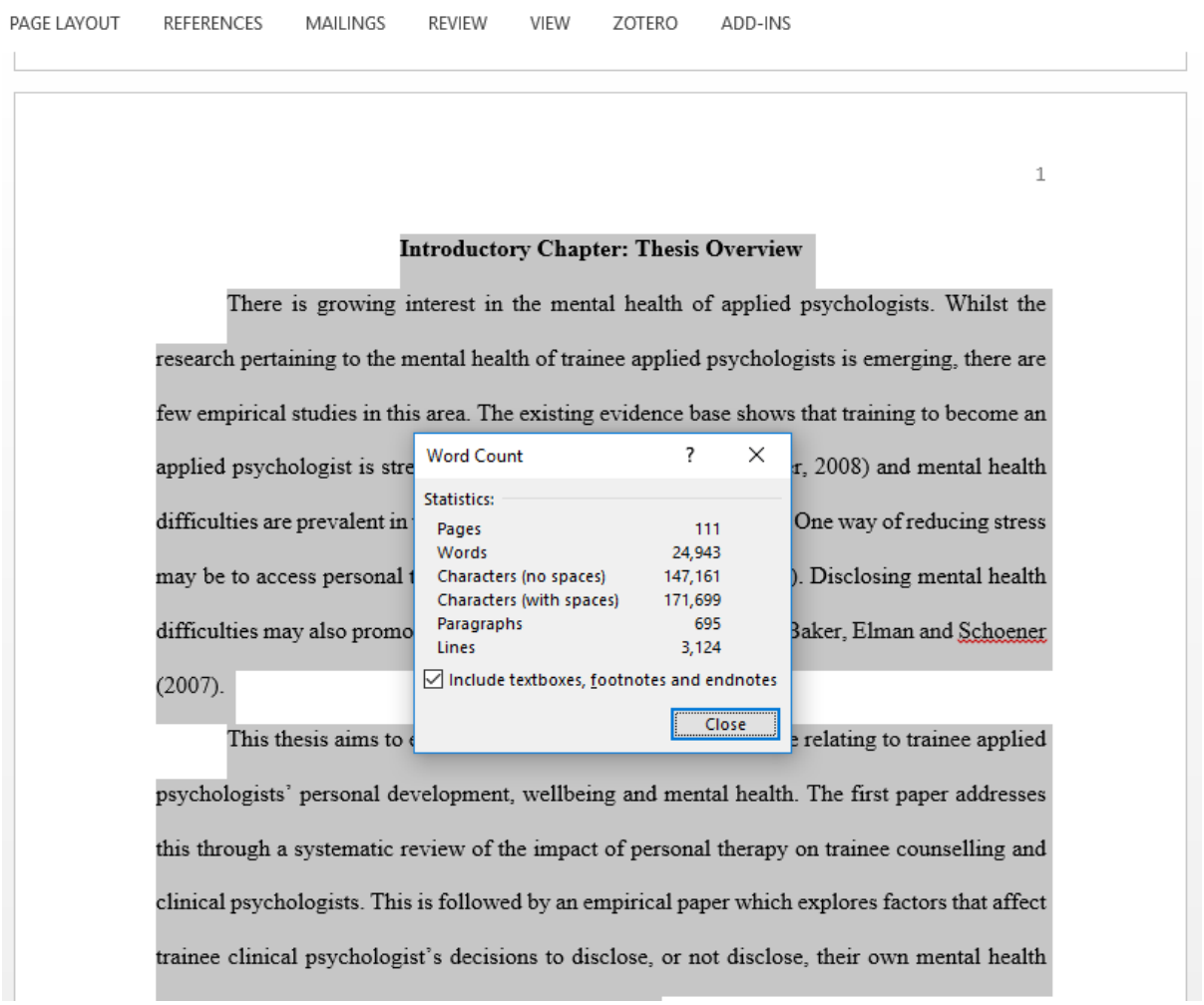

Introductory Chapter: Thesis Overview

There is growing interest in the mental health of applied psychologists. Whilst the research pertaining to the mental health of trainee applied psychologists is emerging, there are few empirical studies in this area. The existing evidence base shows that training to become an applied psychologist is stressful (Cushway, 1992; Kumary & Baker, 2008) and mental health difficulties are prevalent in trainees (Grice, Alcock & Scior, 2018a). One way of reducing stress may be to access personal therapy (Bike, Norcross & Schatz, 2009). Disclosing mental health difficulties may also promote self-care and reduce stigma (Barnett, Baker, Elman and Schoener (2007).

This thesis aims to explore and extend the research literature relating to trainee applied psychologists' personal development, wellbeing and mental health. The first paper addresses this through a systematic review of the impact of personal therapy on trainee counselling and clinical psychologists. This is followed by an empirical paper which explores factors that affect trainee clinical psychologists' decisions to disclose, or not disclose, their own mental health difficulties during their clinical psychology training.

The systematic literature review was prepared for the Training and Education in Professional Psychology. A meta-synthesis approach was used to synthesise qualitative research into the impact of personal therapy for trainee clinical and counselling psychologists. Seven papers were included in the review. A total of eight themes and ten subthemes were identified. These are described along with a summary of the findings in the context of clinical and counselling psychology training and current research. Recommendations for practice and future research are made.

The empirical paper was prepared for the Journal of Clinical Psychology. A grounded theory approach was used to understand what factors affect trainee clinical psychologists' decision to disclose, or not disclose, their own mental health difficulties during their clinical

psychology training. This research aimed to build on the results of recent studies which have found high levels of mental health difficulties and low levels of mental health disclosure in trainee clinical psychologists. Twelve recently qualified clinical psychologists were interviewed about their experiences of mental health difficulties and disclosure decisions during their clinical psychology training. A theoretical framework was developed, which describes trainees' decision making processes relating to mental health disclosure. Participants' reasons for disclosing are described as well as the factors that inhibited disclosure and factors that enabled disclosure. The paper provides a detailed description of the methodology, analysis and findings. The implications of the research in terms of clinical psychology training are discussed and a number of recommendations are made for practice and further research.

What is the Impact of Personal Therapy on Trainee Clinical and Counselling Psychologists?

A Systematic Review

Chapter 1: Systematic review

Prepared for submission to Training and Education in Professional Psychology.

Author guidelines are presented in Appendix A

Abstract

Aims: Personal therapy is advocated in a number of therapy approaches, however there is debate around whether personal therapy should be a mandatory requirement for training in clinical and counselling psychology. A number of studies have explored the impact of personal therapy on clinical and counselling psychologists. This review aimed to analyse and synthesise this research in order to answer the question 'What is the impact of personal therapy on trainee clinical psychologists and trainee counselling psychologists?'

Method: Using systematic review methodology, the following databases were searched: CINAHL, psychINFO, Scopus, Web of Science and Discover, to identify studies which explored the impact of personal therapy on trainee clinical and counselling psychologists. The included studies were assessed for quality and analysed used meta-synthesis methodology.

Results: Eight studies were included in the review, including four peer reviewed journal articles and four unpublished dissertations. The analysis identified a total of eight themes and ten subthemes.

Conclusions: The results show that personal therapy acts as a form of experiential learning for trainees. Personal therapy appears to have positive effects on trainees' professional development and personal lives. Trainees also report negative effects of personal therapy. When personal therapy is voluntary, trainees may fear how their attendance at personal therapy is perceived. When it is mandated, trainees may experience a lack of agency over their personal therapy. Training programmes need to consider ways to reduce the stress and fears associated with personal therapy, and increase trainees' agency over their personal therapy.

Key Words: training, clinical psychology, counselling psychology, personal therapy, meta-synthesis

Introduction

Personal therapy can be defined as "the psychological treatment of mental health professionals (and those in training) by means of various theoretical orientations and treatment formats" (Norcross, 2005, p. 841). The origins of the use of personal therapy during psychotherapy training can be traced back to the 1930's (Wigg, Cushway, & Neal, 2011). Yalom (2010) suggests that personal therapy is the most important part of psychotherapy training. Other authors argue that mandating personal therapy during psychotherapy training raises complex ethical issues (Ivey, 2014). Whether trainee therapists should have personal therapy continues to be debated (Malikiosi-Loizos, 2013).

In the UK, personal therapy is a mandatory requirement in counselling psychology training, although not in clinical psychology training (Division of Clinical Psychology [DCP] Executive Committee, n.d.). This difference in training requirements is historical and is attributed to counselling psychology focusing largely on individual psychotherapeutic work (DCP Executive Committee, n.d.). Outside of the UK, in countries such as America, Canada and South Africa, personal therapy is not required in order to register as a clinical psychologist, however some training programmes do encourage or mandate personal therapy (Graham, 2005; Ivey & Waldeck, 2014; McEwan & Duncan, 1993; Targatalia, 2013). No guidance could be found from regulatory bodies for counselling psychology in America, Canada and South Africa. This would suggest that personal therapy is not a mandatory requirement for trainee counselling psychologists in these countries.

Research suggests that personal therapy may have costs and benefits for trainee clinical and counselling psychologists (Eckhart, 2016; Everson, 2013; McEwan & Duncan, 1993; Moller, Timms, & Alilovic, 2009). There are a number of reasons to suggest trainees may benefit from personal therapy. For example, some therapeutic approaches place a premium on the use of countertransference and transference, requiring self-awareness (Smith & Garforth,

2012). In addition, trainee clinical and counselling psychologists may experience high levels of stress (Cushway, 1992; Kumary & Baker, 2008), personal therapy could eliminate stress, by providing emotional relief (Bike, Norcross, & Schatz, 2009). This systematic review aims to synthesise the international research evidence pertaining to the impact of personal therapy during clinical and counselling psychology training.

Training to be a Clinical or Counselling Psychologist

The core purpose of clinical psychology is "to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data" (Toogood, 2010, p. 2). The integration of theory, research and practice is key to fulfilling this function (Toogood, 2010). Becoming a clinical psychologist in the UK usually involves completing an undergraduate degree in psychology; relevant work experience; and a doctoral degree in clinical psychology (Cheshire & Pilgrim, 2004). Doctoral clinical psychology training involves supervised clinical practice, academic work and research; trainees are required to demonstrate competencies in these areas (Toogood, 2010). Most clinical psychology training places are funded by the NHS (Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2018).

Counselling psychology shares similarities with clinical psychology, focussing on the application of psychological and psychotherapeutic theory and research to clinical practice (British Psychological Society [BPS], 2017a). However, counselling psychology places relational practice at its centre by focusing on the co-construction of knowledge; the therapeutic relationship is considered the main vehicle for understanding and alleviating psychological difficulties (BPS, 2017a). In the UK, training to become a counselling psychologist involves completing a BPS accredited degree or conversion course, followed by completion of a doctoral degree in counselling psychology or the Qualification in Counselling Psychology (QCoP) (Kasket, 2017) The QCoP is the independent training route to qualification (BPS,

2018a). Counselling psychology training involves teaching, supervised practice, personal therapy, assessments and research (BPS, 2018a). In the UK, counselling psychology training is self-funded (Smook, 2017). Although a mandatory requirement, trainee counselling psychologists are required to pay for their personal therapy (BPS, n.d.), as well as funding other training related costs such as supervision and travel expenses (BPS, 2018a).

Training routes to becoming a clinical or counselling psychologist vary across different countries. In South Africa, training to become a clinical or counselling psychologist involves five years of full-time formal education in psychology, typically involving a Bachelor's degree, a post-graduate year and a Master's degree. In addition, trainees are required to complete a one year internship and pass an examination (Health Professions Council of South Africa, 2010). In the USA, training to become a licensed psychologist (including a clinical and counselling psychologist) usually involves meeting requirements related to examinations, education and supervised practice (Association of State and Provincial Psychology Boards, n.d.). Each state has specific requirements; in the state of California the licensure requirements include completion of an approved doctoral degree, two years of supervised professional experience, and passing two examinations (California Board of Psychology, 2016).

Historical Context to Clinical and Counselling Psychology Training

In Britain, postgraduate clinical psychology training initially developed at three sites; the Tavistock Clinic, London; the Institute of Psychiatry, London; and the Crichton Royal Hospital in Dumfries, Scotland, in the 1950's (Cheshire & Pilgrim, 2004). The Tavistock approach to training was largely based on psycho-analytic principles. In sharp contrast, the Institute of Psychiatry's approach trained people in applied abnormal psychology and the scientific method in a laboratory setting, rather than through clinical practice (Parry, 2015).

The scientist-practitioner model in UK clinical psychology developed at the Institute of Psychiatry (Parry, 2015). Pioneering this approach, Eysenck and Shapiro argued that clinical

psychology should concern itself solely with research and diagnosis, emphasising the single case and experimental method in pursuit of empirical knowledge (Corrie & Callahan, 2000). Eysenck later acknowledged the role of clinical psychologists in delivering treatment, although he dismissed psychoanalytic interventions. He argued that interventions should be based on theory and quantifiable experimental research, such as behaviour therapy (Routh, 2010). By the 1970's, clinical psychologists were increasingly delivering psychological therapy, although there remained continued support for the scientist-practitioner model (Kennedy & Llewelyn, 2001).

The dominance of the scientist-practitioner model in the UK was paralleled by similar developments in the United States. In 1949, a major conference on training, in Boulder, Colorado, convened by the American Psychological Association (APA) emphasised this model as the basis for training clinical psychologists in the United States. As a result, the scientist-practitioner model dominated the UK and North American clinical psychology training during the profession's early years and continues to influence training today (Cheshire & Pilgrim, 2004). Similarly, clinical psychology training in South Africa is led by the scientist-practitioner model (Pillay & Kritzinger, 2007).

Counselling psychology was developed as a discipline in the UK more recently (Strawbridge & Woolfe, 2010). It became officially recognised by the BPS, as a distinct profession with a unique identity and underpinning philosophy, in 1994 (Corrie & Callahan, 2000). Counselling psychology has subscribed to the scientist-practitioner model, in the UK and internationally (Nicholson & Madson, 2015; Orlans & Van Scoyoc, 2009; Strawbridge & Woolfe, 2010). The model now dominates counselling psychology training in the UK, USA, Australia and New Zealand (O' Gorman, 2001). However, there is disagreement about whether counselling psychology actually implements a scientist-practitioner approach (Gillon, Timulak, & Creaner, 2017). Some suggest that counselling psychology is better suited to a

reflective practitioner model (Donati, 2016). In practice, counselling psychologists emphasise the importance of the therapeutic relationship in the helping process (Strawbridge & Woolfe, 2010) and most counselling psychologists do not undertake empirical research on a regular basis (Gillon et al., 2017). Practising counselling psychology requires a high level of self-awareness and competence in applying the skills and knowledge of personal and interpersonal dynamics to the therapeutic context (BPS, 2001, as cited in Muellenbach, 2015).

Whilst clinical and counselling psychology training and practice remain strongly embedded in the scientist-practitioner model, the need for a reflective stance to practice has been increasingly recognised and adopted (Bury & Strauss, 2006; Cushway, 2009; Kennedy, Llewelyn, & Beinart, 2009; Lane & Corrie, 2006; Woolfe, 2012). Perhaps as a result, a reflective scientist-practitioner model has been adopted within clinical and counselling psychology training (BPS, 2017a; 2017b). The Health and Care Professions Council (HCPC) states that practitioner psychologists must "be able to use professional and research skills in work with service users based on a scientist-practitioner and reflective practitioner model" (HCPC, 2015, p.22). The reflective scientist-practitioner model synthesises the scientist-practitioner model and the reflective practitioner model, placing importance on empirical research and reflecting on, and subsequently adapting, practice (Llewelyn & Doorn, 2017).

Part of being a reflective scientist-practitioner involves personal and professional reflection and developing self-understanding (Llewelyn & Doorn, 2017). Self-reflection is a significant component of reflective practice (Lavender, 2003) and one way of facilitating this is through engaging in personal therapy (Wigg et al., 2011). Personal therapy for trainees may therefore provide a method of reflection that is consistent with the reflective scientist-practitioner model.

Theoretical Underpinnings to Personal Therapy during Psychotherapy Training

Traditionally, psychodynamic approaches insisted that trainee psychotherapists engage in personal therapy during their training (McLeod, 2013). Freud (1915, as cited in King, 2011) proposed that personal therapy was the deepest and most rigorous part of the clinical aspects of training in psychodynamic therapy. The aim of the psychoanalysis is to make the unconscious conscious; Freud believed that no analyst could help patients realise this goal if he/she could not do it for him/herself and thus he regarded personal analysis as essential (Freud, 1915, as cited in King, 2011). More contemporary psychodynamic approaches view personal analysis as encouraging self-knowledge in order to understand the meaning of countertransference reactions (Johnson & Kaslow, 2014).

Whilst the importance of personal therapy was first recognised within the psychodynamic tradition, it is also valued within other therapy models (Geller, Norcross, & Orlinsky, 2005). For example, personal cognitive analytic therapy (CAT) is required in training to become a CAT practitioner (Coumont, Parry, & Evans, 2001). The purpose of this is to develop trainees' self-understanding; to explore personal issues that arise during training; and to experience being a patient, to increase empathy, compassion and confidence in CAT (Coumont et al., 2001). Within a humanistic framework, personal therapy is highly valued as an important mechanism for richer learning, genuineness and authenticity, and empathy (Geller et al., 2005). Cognitive-behavioural therapy (CBT) training, does not stipulate personal therapy as a mandatory requirement, however over recent years a number of CBT training programmes have included personal therapy (Malikiosi-Loizos, 2013).

Personal Therapy in Clinical and Counselling Psychology Training

In the UK, personal therapy is a mandatory requirement during counselling psychology training (BPS, 2018a). This is aimed at enabling trainees to understand clients' perspectives on the experience of therapy; understand their own life experience and its impact on practice and

develop trainees' ability to reflect critically on the use of self in therapeutic processes (BPS, 2017a). Conversely, trainee clinical psychologists are not required to engage in personal therapy (DCP Executive Committee, n.d.), although, some training programmes encourage, and provide funding for, personal therapy (BPS, 2018b). The BPS explains that the difference in personal therapy requirement is due to counselling psychology focusing largely on individual psychotherapeutic work. It is deemed appropriate for counselling psychology trainees to have a space to reflect on therapeutic processes with clients, as this is a major focus of their training (DCP Executive Committee, n.d.).

Whilst personal therapy is not a requirement during clinical psychology training in the UK, all four clinical psychology programmes in the Republic of Ireland have recently mandated personal therapy (McMahon, 2018). Considering other countries, engagement in personal therapy during training is not a mandated by clinical psychology regulatory bodies in South Africa, Canada and the USA, although some training programmes mandate personal therapy for trainees (Graham, 2005; Ivey & Waldeck, 2014; McEwan & Duncan, 1993; Orlans & Van Scoyoc, 2009; Targatalia, 2013). No guidance about personal therapy could be found from regulatory bodies for counselling psychology in South Africa, Canada and the USA. This would suggest that personal therapy is not a mandatory requirement during counselling psychology training in these countries.

Rationale for Personal Therapy for Trainee Clinical and Counselling Psychologists

Trainee clinical and counselling psychologists experience comparable levels of stress and burnout (Weaver, 2000). In a study of psychological distress in 287 trainee clinical psychologists, Cushway (1992) found that 75% of participants reported being 'moderately' or 'very' stressed. In addition, 59% of participants met the criteria for 'caseness' of according to the General Health Questionnaire ([GHQ] Goldberg & Hillier, 1979). Similarly, trainee counselling psychologists have been found to experience high levels of stress and 59%

prevalence of ‘caseness’, according to the GHQ (Kumary & Baker, 2008). The GHQ measures minor psychiatric disorders across four subscales (somatic symptoms, anxiety and insomnia, severe depression and social dysfunction); a cut off score is provided, indicating ‘caseness’ (Goldberg & Hillier, 1979).

Stressors associated with completing clinical psychology training include: frequent change; high workload; lack of social support; client distress; personal stressors; course structure; poor supervision; distant placements; and relationships with NHS colleagues (Cushway, 1992; Galvin & Smith, 2017). Trainee counselling psychologists report high levels of stress related to placements, academic work and personal and professional development (Kumary & Baker, 2008).

In addition to high levels of stress associated with training, it has been well documented that mental health professionals, including psychologists, have often had difficult life experiences, such as loss, family difficulties and abuse (Barnett, Baker, Elman, & Schoner, 2007; Elliott & Guy, 1993; Sussman, 2007). These experiences place them at increased risk of experiencing distress (Farber, Manevich, Metzger, & Saypol, 2005).

Benefits and Risks Associated with Personal Therapy during Training

Research suggests that there are a number of benefits of personal therapy for trainee clinical and counselling psychologists. Such benefits include enhanced professional and therapeutic competence; gaining a practical understanding of therapy and exposure to a role model; increased empathy for clients and enhanced therapeutic relationships; personal growth; increased self-understanding and reflexivity (McEwan & Duncan, 1991; Moller et al., 2009). Personal therapy also appears to be a valuable source of support for trainees (Muellenbach, 2015; Parmar, 2016).

Ethical challenges are often cited as a risk of personal therapy for trainee clinical and counselling psychologists (Ivey, 2014; McEwan & Duncan, 1993). Ethical issues may concern

dual relationships, confidentiality, the negative effects when personal therapy is mandatory and the suitability of having personal therapy when the trainee is not actively experiencing mental health difficulties (Ivey, 2014; McEwan & Duncan, 1993).

The financial cost of attending therapy has consistently been reported as a concern (McEwan & Duncan, 1993; Moller et al., 2009; Parmar, 2016). Despite personal therapy being a mandatory requirement, counselling psychology trainees are required to self-fund their personal therapy (BPS, n.d.). Some clinical psychology training programmes provide a bursary or discount scheme for trainees accessing personal therapy, although most courses do not offer this (BPS, 2018b). Other negative impacts of personal therapy have been cited as the potential for such therapy to feel stressful; negative impacts on trainees' professional development; and therapy instilling a false sense of confidence as a therapist (McEwan & Duncan, 1993; Moller et al., 2009; Parmar, 2016).

Aims and Rationale

In light of the potential benefits and risks of personal therapy, and the disparity in mandating personal therapy across professions, training programmes and countries, this systematic review aims to answer the question 'What is the impact of personal therapy on trainee clinical psychologists and trainee counselling psychologists?'. For the purpose of this review the term 'impact' encompasses perceptions and experiences of personal therapy. The relevant literature pertaining to experiences of personal therapy during clinical psychology training and counselling psychology training will be synthesised and critically appraised.

Malpass (2017) recently conducted a review of trainees' experiences of personal therapy during clinical and counselling psychology training. Her review was limited to peer reviewed qualitative and quantitative research, which was undertaken with UK populations. Malpass (2017) did not describe the systematic review methodology used; providing only a description of the results. A quality assessment tool was not used. Instead, the 'evolving

guidelines' for publishing qualitative research (Elliott, Fischer, & Rennie, 1999) were used to assess the quality of the research. These guidelines were primarily designed for assessing qualitative research, although Malpass (2017) applied them to the quantitative studies in the review.

In contrast to Malpass's (2017) review, the current review will: consider a broader evidence base, using grey literature and global populations; use a formal review methodology and a quality appraisal tool, to expand the knowledge base pertaining to the impact of personal therapy on trainee clinical and counselling psychologists. A comparison of the Malpass (2017) systematic review and the current systematic review are provided in Appendix B, to highlight the differences between the reviews.

Method

A review protocol was developed and registered with the PROPSERO database for systematic reviews (CRD42018088943).

Search Strategy

Literature searches were conducted in March 2018. The following databases were searched: CINAHL, psychINFO, Scopus, Web of Science and Discover, using the search terms:

- "personal therapy" OR "personal-therapy" AND
- psycholog*

Additional searches were completed using google scholar; grey literature sources; and forwards and backwards referencing.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were developed in line with the review question. These are presented in Table 1.1.

Table 1.1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Studies recruiting trainee clinical psychologists/ trainee counselling psychologists. Trainee refers to being on a professional training programme in clinical or counselling psychology within the study country. Samples consisting of qualified clinical psychologists or qualified counselling psychologists will be included if the research primarily considers their experiences during training. Training refers to the professional training for clinical/ counselling psychology within the study country. Participants must have some experience of personal therapy during training. • Qualitative research studies or mixed methods research studies with a relevant qualitative component. • Studies that primarily explore the impact of personal therapy (including the perceptions and experiences of personal therapy) on trainee clinical psychologists/ trainee counselling psychologists.	• Studies which do not recruit trainee clinical psychologists or trainee counselling psychologists on the formal training route to becoming qualified (e.g. undergraduate psychology students, non-clinical or counselling trainee psychologists). Or, studies which recruit qualified clinical/ counselling psychologists, if the research is regarding their experiences post-qualification. • Studies utilising a purely quantitative methodology • Studies that do not utilise an empirical/scientific research methodology • Research papers that are not available in English. • Book chapters

A purely qualitative systematic review was utilised primarily based on the aims of the systematic review. The review aimed to explore the impact of personal therapy on trainee clinical and counselling psychologists. The exploratory nature of this review question is well suited to a qualitative review. In addition, combining quantitative and qualitative research can be problematic due to the different data collection methods, levels of analysis and very different

underlying epistemological assumptions (Gough, 2015). Finally, it was believed that eight papers was an adequate number for a DClin systematic review. Broadening the inclusion criteria to include quantitative papers was not deemed necessary.

Study Selection

Initial database searches yielded 1764 citations. One additional paper was identified through google scholar searches. Duplicate articles were removed and the abstracts of the remaining 1178 articles were screened for eligibility in line with the inclusion and exclusion criteria. A total of 1114 papers were excluded at this stage and 64 full text papers were reviewed. Of the 64 full text papers screened against the inclusion criteria, nine were considered eligible for the review (see Figure 1). This included five peer reviewed research papers and four theses/dissertations. Most papers were excluded because the sample did not meet the inclusion criteria or because the study employed a purely quantitative methodology.

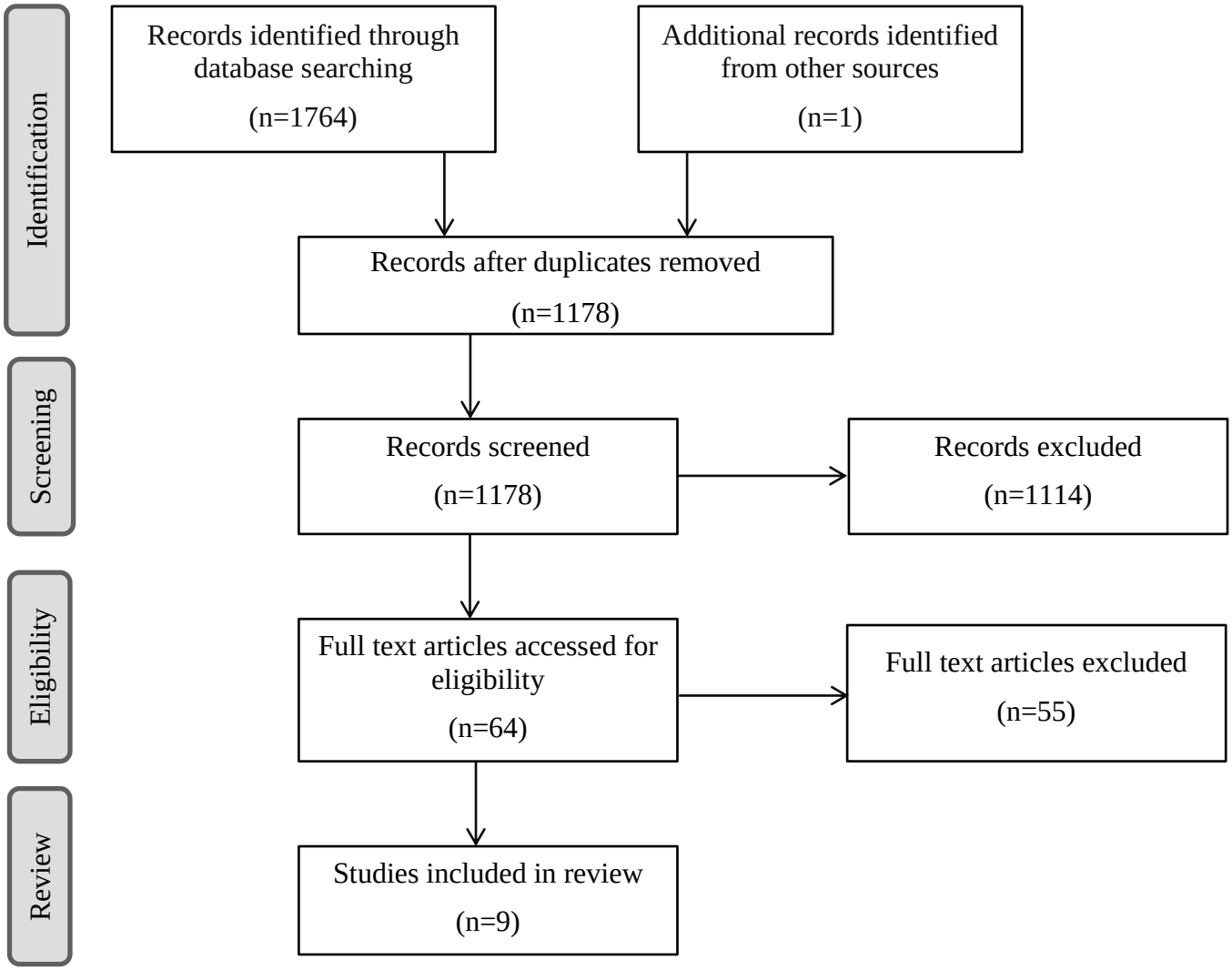

Figure 1. Prisma Diagram (Liberati et al., 2009). This figure illustrates a flow chart of the study selection process.

As part of quality standard procedures, an independent reviewer blindly assessed 10% of the articles at the title and abstract stage, and the full text review stage, against the inclusion and exclusion criteria. Any discrepancies were discussed and full agreement on all of the papers was reached. In addition, all of the papers that were deemed to meet the inclusion criteria were reviewed for eligibility by the primary research supervisor.

Quality Assessment

The quality of the included studies was assessed using the Critical Appraisal Skills Programme qualitative study checklist (CASP, 2018). The CASP contains 10 questions, which consider the validity of the results, the findings of the study and the impact of the research (CASP, 2018). The CASP is commonly used to assess the quality of healthcare studies using a qualitative design (Noyes et al., 2018). It facilitates rapid evaluation of all types of qualitative data (Butler, Hall, & Copnell, 2016).

The reviewer followed the CASP guidance; each of the studies was reviewed against the CASP assessment criteria and assigned a rating of 'yes', 'no' or 'can't tell'. Quality assessment was conducted in order to consider how the quality of the studies may impact on the review findings.

During the quality assessment process, the review authors concluded that the results of one paper (Gillman, 2002) were ambiguous and confusing. There were inaccuracies between what was presented in a results table and in a narrative of the findings; clear descriptions of the themes generated during data analysis were not provided. As the results of Gillman's (2002) study were too confusing to interpret, the review team decided that inclusion of the study would compromise the quality of the review and the paper was, therefore, rejected at the quality assessment stage.

Data Extraction and Synthesis

A meta-synthesis approach was used to synthesise and analyse the data. Meta-synthesis seeks to understand and explain phenomena (Walsh & Downe, 2004) by accumulating findings of individual qualitative studies at a more abstract level, through a process of translation and synthesis (Zimmer, 2006). The data extraction and synthesis took place over a number of stages, as outlined by Cubis, Ownsworth, Pinkiham and Chamber (2017); Nolte, Downing, Temane and Hastings-Tolsma (2017); and Walsh and Downe (2004). First, the descriptive

characteristics of each study were extracted, this included details of methodology, personal therapy, participant characteristics and analysis. The findings of the study were then read and re-read and the key findings were extracted. Only information from the papers' results sections was extracted in order to stay close to the original data and ensure findings remained grounded in the original experiences of participants (Noyes et al., 2018). The studies' results were carefully compared and contrasted to identify similarities and differences. The findings were then translated and synthesised into core themes and subthemes. These were summarised in a table, and described with illustrative quotes.

Results

Study Characteristics

Eight research papers were included in the review. The descriptive characteristics of the included studies are presented in Table 1.2. Four papers were peer reviewed journal articles (Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Wilson, Weatherhead, & Davies, 2015) and four were unpublished dissertations (Avis, 2010; Graham, 2005; Nikolopoulou, 2016; Malpass, 2017). The database searches identified that Ivey and Waldeck's (2014) study was available as an unpublished dissertation (Waldeck, 2011). Some slight differences between the published and unpublished versions of the study were noted. Waldeck's (2011) original study aimed to explore, describe and interpret trainee clinical psychologists' subjective experience of personal psychotherapy during training. Ivey & Waldeck (2014) used the same dataset but focused on "exploring themes, tensions and complexities missing or under-developed in the literature" by discussing relevant themes and subthemes (Ivey & Waldeck, 2014, p.89). For the purpose of the current review, the study was treated as one study, however findings were extracted from both of the research papers as there were some slight differences.

All of the studies employed a qualitative methodology. Seven of the studies utilised individual interviews and Grimmer & Tribe (2001) used a combination of individual and group interviews. A range of data analysis methods were used; one study used narrative analysis (Wilson et al., 2015), one study used thematic analysis (Ivey & Waldeck, 2014), one study used thematic analysis and grounded theory (Graham, 2005), two studies used grounded theory (Grimmer & Tribe, 2001; Malpass, 2017) and three studies used interpretative phenomenological analysis ([IPA], Avis, 2010; Kumari, 2011; Nikolopoulou, 2016).

Three studies recruited trainee clinical psychologists (Graham, 2005; Ivey & Waldeck, 2014; Malpass, 2017) and one study recruited qualified clinical psychologists (Wilson et al., 2015). Two studies recruited only trainee counselling psychologists (Kumari, 2011; Nikolopoulou, 2016), and one study recruited both qualified and trainee counselling psychologists (Grimmer & Tribe, 2001). Avis (2010) recruited trainee and qualified counselling psychologists, however only the data pertaining to trainee counselling psychologists were applicable to the current review. Therefore, only this sub-section of data was used for the review.

Personal therapy was mandatory during training in five of the studies (Avis, 2010; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Nikolopoulou, 2016) and voluntary in three studies (Graham, 2005; Malpass, 2017; Wilson et al., 2015). Participants across all studies had undertaken varying amount of personal therapy. Whilst the therapeutic orientation of participants' personal therapy varied, the majority of participants across all of the studies engaged in psychodynamic or psychoanalytic psychotherapy. Avis (2010) did not report on the therapeutic orientation of participants.

Six studies were UK based (Avis, 2010; Grimmer & Tribe, 2001; Kumari, 2011; Nikolopoulou, 2016; Malpass, 2017; Wilson et al., 2015). One study was based in South Africa (Ivey & Waldeck, 2014) and one study was based in California, USA (Graham, 2005).

Table 1.2

Descriptive Characteristics of Included Studies

Study	Paper Type	Aims	Method	Participants	Training Programme	Personal Therapy Amount	Mandatory / Voluntary Therapy	Personal Therapy Orientation	Geographical Context	Data Analysis
Avis (2010)	Unpublished doctoral dissertation	To explore how trainee counselling psychologists experience their personal therapy	Individual interviews	Four trainee counselling psychologists	Doctorate in Counselling Psychology	At least six sessions	Mandatory	Not stated	London, England	IPA
Graham (2005)	Unpublished doctoral dissertation	To explore the impact of the student therapist's personal therapy insofar as it relates to his or her clinical development and clinical practice with his or her patients	Individual interviews	Five trainee clinical psychologists (4 females, 1 male)	Doctoral-level clinical psychology training programmes	At least 6 months	Voluntary	Psychodynamic (2), psychodynamic & control mastery (1), integrative- mainly psychodynamic (1), Gestalt/process (1)	California	Thematic analysis & grounded theory
Grimmer & Tribe (2001)	Peer reviewed journal article	To investigate recently qualified and trainee clinical psychologists' opinions about the impact of mandatory personal therapy on their professional development	Group and individual interviews	Seven trainee counselling psychologists (5 females, 2 males), Seven counselling psychologists (7 females)	MSc in Counselling Psychology	Qualified psychologists: at least 40 hours of personal therapy during MSc	Mandatory	Qualified psychologists: psychodynamic (3), person-centred (3), transactional analysis (2), eclectic (1), Jungian (1), psycho-synthesis (1), approach not known (1). Trainees: not known	London, England	Grounded theory
Ivey & Waldeck (2014)/ Waldeck (2011)	Peer reviewed journal article/ unpublished masters dissertation	To explore trainee clinical psychologists' perceptions and experiences of mandatory personal therapy and its' impact on their professional development and personal lives	Individual interviews	Nine trainee clinical psychologists (7 females, 2 males).	Masters in Clinical Psychology	At least 1 year of weekly personal therapy during postgraduate training	Mandatory	Psychodynamic (8), Rogerian (1)	South Africa	Thematic analysis

Kumari (2011)	Peer reviewed journal article	To explore trainee counselling psychologists' experiences of personal therapy and its impact on their personal and professional development	Individual interviews	Eight trainee counselling psychologists (7 females 1 male)	Doctorate in Counselling Psychology	At least 40 hours	Mandatory	Not stated	Teeside, England	IPA
Malpass (2017)	Unpublished doctoral dissertation	To develop an understanding of the mechanisms through which trainee clinical psychologists experience personal therapy and how it relates to development within training	Individual interviews	12 trainee clinical psychologists (11 females, 1 male)	Doctorate in Clinical Psychology	Personal therapy during Doctorate in Clinical Psychology	Voluntary	Psychodynamic (4), psychoanalytic (5) psychotherapy (1), integrative (1), cognitive analytic therapy (1)	United Kingdom	Constructivist grounded theory
Nikolopoulou (2016)	Unpublished doctoral dissertation	To explore the lived experience of trainee counselling psychologists as clients of psychological therapy, within the specific context of their professional training	Individual interviews	Seven trainee counselling psychologists (5 females 2 males)	Doctorate in Counselling Psychology	Completion of mandatory personal therapy throughout doctoral training so far	Mandatory	Psychodynamic (3), psychoanalytic (1), integrative (3)	London & South East England	IPA
Wilson, Weatherhead & Davies (2015)	Peer reviewed journal article	To explore the experiences of trainee clinical psychologists who utilised therapy whilst training, and its role in their personal and professional development	Individual interviews	10 clinical psychologists (10 females).	Not stated	Personal therapy during Doctorate in Clinical Psychology	Voluntary	Integrative (3), cognitive analytic therapy (1), psychodynamic/psychoanalytic (6)	United Kingdom	Narrative analysis

Quality assessment

All of the studies included in this review met the majority of the CASP criteria (Appendix C). All of the studies had clear, similar overarching research aims and suitable research methodologies. Six studies aimed to explore participants' experiences of personal therapy and seven studies aimed to explore how personal therapy impacted on/ related to participants' professional development and practice, and/or their personal lives. All studies employed a suitable design. Three studies (Avis, 2010; Ivey & Waldeck, 2014; Kumari, 2011) lacked information about the recruitment of participants (for example, why participants were most appropriate for the study, how many people expressed an interest that were not included in the final sample). Data collection methods were deemed appropriate in all of the studies; all studies used interviews and many justified the rationale for this and provided details of the interview questions. Kumari (2011) did not consider the relationship between the researcher and research participants. This is particularly pertinent given that the researcher was studying on the same programme as the participants, potentially influencing the research process. Grimmer and Tribe (2001) did not consider any ethical issues within their research report. Whilst Kumari (2011) utilised an IPA approach, limited information was presented about how this was implemented. Within the paper, the authors did not discuss whether any contradictory information was discovered within the results.

As part of the quality assessment, all of the studies were judged by the reviewer as adding value to the research literature.

Findings

A total of eight themes and ten subthemes were identified from the meta-synthesis (Table 1.3). The distribution and frequency of these themes across each of the studies is presented in Table 1.4.

Table 1.3

Meta-Synthesis: Themes and Subthemes

Theme	Subthemes
Fears associated with personal therapy	
Navigating mandatory personal therapy	Distinguishing training and therapy Lacking agency The evolving experience of mandatory personal therapy
The relationship between personal therapy and supervision	
Therapy as support through training	
Personal therapy as experiential learning	Modelling Knowing how it feels to be the client
Professional development	Increased understanding of theory Increased awareness of process issues
Personal impact of personal therapy	Increased self-understanding
Challenging aspects of personal therapy	Emotional demands of personal therapy Financial costs of personal therapy

Table 1.4

Frequency of Themes and Subthemes

Theme/ Subtheme	Avis (2010)	Graham (2005)	Grimmer & Tribe (2001)	Ivey & Waldeck (2014)	Kumari (2011)	Malpass (2017)	Nikolopoulou (2016)	Waldeck (2011)	Wilson, Weatherhead & Davies (2015)
Fears associated with personal therapy	X		X			X	X		X
Navigating mandatory personal therapy	X			X	X		X	X	
Distinguishing training and personal therapy							X	X	
Lacking agency	X			X	X		X	X	
The evolving experience of mandatory personal therapy	X			X	X		X	X	
The relationship between personal therapy and supervision		X	X	X			X	X	
Therapy as support through training		X	X	X	X			X	X
Personal therapy as experiential learning	X	X	X	X	X	X	X	X	X
Modelling	X	X	X	X	X	X	X	X	
Knowing how it feels to be the client	X	X	X	X	X	X		X	X
Professional development				X	X	X	X	X	X
Increased understanding of theory		X		X	X		X	X	
Increased awareness of process issues		X	X	X	X		X	X	X
Personal impact of personal therapy	X	X	X	X	X	X	X	X	X
Increased self-understanding		X	X	X	X	X	X	X	
Challenging aspects of personal therapy	X		X	X	X	X	X	X	X
Emotional demands of personal therapy			X	X	X			X	X
Financial cost of personal therapy	X			X	X			X	X

Each of the themes and associated subthemes are described below, along with illustrative quotes.

Theme: Fears associated with personal therapy. Two studies identified fears of judgement at the outset of personal therapy (Malpass, 2017; Wilson et al., 2015). Both explored voluntary personal therapy. Fears of judgement from the course, peers and therapists, and a sense of shame within the profession around experiencing emotional difficulties were identified. Malpass (2017) described participants' beliefs around the profession as being "emotion phobic" (p.68). The lack of acknowledgement of trainees' potential to experience emotional struggles and the way teaching was "set up", contributed to these beliefs (Malpass, 2017, p68). Similarly, Nikolopoulou (2016) described how one participant reflected on the value of the mandatory requirement to attend therapy, as a means to legitimise his choice to be in therapy, managing potential feelings of shame and fears of social stigma associated with being a client.

Grimmer & Tribe (2001) found that disclosure in mandatory personal therapy could initially be hindered by fears of being deemed unsuitable to practice therapy. Nikolopoulou (2016) also identified fears of being pathologised or scrutinised, based on information presented in personal therapy. Avis (2010) identified different fears. Participants reported anxiety around ensuring that personal therapy was not superficial; that it was worthwhile for the trainee and the therapist. A pressure to perform as a 'good client' and a 'good trainee' was also described by Avis's participants.

Theme: Navigating mandatory personal therapy. This theme and associated subthemes applied only to studies of mandatory personal therapy.

Subtheme: Distinguishing training and therapy. This subtheme applied to two studies (Nikolopoulou, 2016; Waldeck, 2011). Some participants described seeing therapy as an extension of training (Nikolopoulou, 2016) or having difficulty separating therapy from their

training programme (Waldeck, 2011). The relationship between the training programme and personal therapy appears to create anxiety about being monitored and assessed during training (Nikolopoulou, 2016; Waldeck, 2011), “It took me a while in the therapy itself to try and separate my personal therapy from the course, it did feel like another element of assessment” (Waldeck, 2011, p. 60-61).

Subtheme: Lacking agency. Four studies described participants’ lack of agency over their personal therapy, for example over the function and amount of therapy they were required to undertake and the type of therapist they were required to see (Avis; 2010; Ivey & Waldeck, 2014; Kumari, 2011; Nikolopoulou, 2016). For example “No, other than as I say, why forty hours? … why not twenty or maybe fifty, why is it forty? … I think it should be spread out over a longer period of time" (Kumari, 2011, p.223).

Subtheme: The evolving experience of mandatory personal therapy. Four of five studies into mandatory personal therapy found that the experience changed over time (Avis, 2010; Ivey & Waldeck, 2014; Kumari, 2011; Nikolopoulou, 2016); with therapy being increasingly valued. Avis (2010) and Nikolopoulou (2016) found a greater authenticity and more genuine engagement in personal therapy over time. Kumari (2011) found a shift in some participants’ attitudes towards personal therapy; initially feeling frustrated or reluctant and then believing it to be a necessary part of training. This is illustrated by a participant quote, “Now I would feel that every therapist should have to have therapy...Which is not something I would have said a couple of years ago” (Kumari, 2011, p. 224).

Theme: The relationship between personal therapy and supervision. The relationship between personal therapy and supervision was discussed in a number of studies. Some participants identified therapy as complementary to supervision; providing additional supervisor-like support (Graham, 2005; Grimmer & Tribe, 2001; Nikolopoulou, 2016).

> As I said my first couple supervisors, I didn't hate, but I didn't love, they were just kind of there. And to have somebody that I sort of had chosen, and actually trusted her opinion of therapy a little bit more.... to bounce clinical kind of stuff off of... I kind of liked that. (Graham, 2005, p. 123).

Sense of safety appears to be an important element of personal therapy. Grimmer and Tribe (2001) found that personal therapy was seen as place to make confidential disclosures that would not rebound on participants' professional development. Participants described feeling more able to discuss their personal reactions to their clinical work on a deeper, more personal level, with their personal therapists:

> I try to present what are the most emotional issues for me that's going on in my clinical cases with my therapist - stuff that I'm afraid to talk about with my supervisor, because I'm not sure about our relationship or don't feel I can trust her as much as a trust my therapist. (Graham, 2005, p.121).

Although personal therapy was viewed as complementary to supervision in some studies, two studies highlighted the importance of distinguishing personal therapy from supervision (Graham, 2005; Ivey and Waldeck, 2014). Ivey and Waldeck (2014) found that participants were grateful for discussion being re-orientated towards them, when supervisory issues arose during therapy, "He was quite clearly just my therapist. Stuff I took about what I was experiencing with my patients, what I was doing with patients in therapy, he related it directly back to me" (Ivey & Waldeck, 2014, p. 95).

Theme: Therapy as support through training. Five studies identified that personal therapy helped participants cope with the stress and demands associated with training (Graham,

2005; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Wilson et al., 2015). For example:

> It was a very, very tough year. I think it throws most people into some kind of spin and I think that the therapy is also just basically a very supportive place, a place where you could go with that. (Ivey & Waldeck, 2014, p. 93).

Graham (2005) found that personal therapy was seen as providing vital support for coping with the different stressors experienced during training. Participants believed they would have lost touch with their identity as a therapist or dropped out of their training programme without personal therapy.

Theme: Personal therapy as experiential learning

Subtheme: Modelling. All but one of the studies (Wilson et al., 2015) identified a theme of 'modelling'; participants replicated aspects of their therapy that they found helpful. Participants internalised and replicated a variety of factors modelled by their therapists, including boundaries, mannerisms, communication style, relational style, professional conduct, therapy conditions and therapy techniques. For example, "I kind of heard his words through my words, it's okay just let it out, don't hold it in, it's okay, it's about us accessing our emotions and so yeah I definitely heard him through me there" (Malpass, 2017, p.78).

In addition to replicating helpful aspects of their therapist, participants avoided replicating practice that they experienced as unhelpful (Graham, 2005; Nikolopoulou, 2016).

Subtheme: knowing how it feels to be the client. All but one of the studies found that personal therapy provided an opportunity to experience being a client in therapy (Avis, 2010; Graham, 2005; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Malpass, 2017; Wilson et al., 2015). This experience, in turn, increased understanding of clients' feelings and

perspectives. Being a client in therapy appeared to generate more sensitivity and appreciation for the position of clients. This is illustrated in the following participant quote: “What it really gives you is true empathy to have sat in their place, to take on what it's like to be them” (Avis, 2010, p. 68). Graham (2005) found that many participants reported that they could not have understood how it felt to be a client, without having experienced personal therapy.

Theme: Professional development. All but one (Avis, 2010) of the reviewed studies reported that personal therapy impacted on participants’ professional development, which in turn impacted on their clinical practice. This theme differed from ‘experiential learning’ in that it encompasses *what* participants learn, whereas ‘experiential learning’ describes *how* participants learn. The professional impact of personal therapy was separated into two subthemes:

Subtheme: Increased understanding of theory/technique. Gaining first-hand experience of particular therapies and techniques informed participants’ learning of theory/ therapy technique in four studies (Graham, 2005; Ivey & Waldeck, 2014; Kumari, 2011; Nikolopoulou, 2016). Personal therapy was found to enliven and solidify theory (Nikolopoulou, 2016). The following participant quote illustrates this subtheme: “I’ve taken some things that I’ve learnt about the therapist, her way of working... I’ve used with a client...Of the Gestalt way of working, sometimes I’ve taken something and worked with a client in that way” (Kumari, 2011, p.219).

Subtheme: Increased awareness of process issues. In six studies, personal therapy was reported to increase participants’ awareness of process issues (Graham, 2005; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Nikolopoulou, 2016; Wilson et al., 2015). This included the dynamics of therapy (e.g. countertransference), the therapy frame (e.g. boundaries, timing issues) and the importance of the therapeutic relationship. Personal therapy appeared to foster a greater insight into trainees’ contribution to interpersonal dynamics in the

therapeutic relationship with clients; they appeared to become more aware of countertransference and better able to separate what belongs to them and what belongs to the client, in the therapy space. This can be seen in the following participant quote: “I think it was all about becoming more acutely aware of yourself and of your issues and how your stuff can impact on your relationship with the client and how the client can impact on you as a professional” (Grimmer & Tribe, 2001, p.294).

Theme: Personal impact of personal therapy. All of the reviewed studies describe some kind of personal impact of therapy on participants, such as personal development and growth, self-insight, and working through personal issues. Kumari (2011) explained how personal therapy had a number of positive personal benefits for participants, including building strength and courage in order to face difficult personal issues and generating a deeper understanding of themselves (Kumari, 2011, p.221). Avis (2010) found that personal therapy was used to explore long standing personal problems, course related experiences and difficulties that arise as part of delivering therapy to clients. Ivey & Waldeck (2014) found that personal therapy specifically impacted on participants’ relationships with friends, family and partners. Whilst interpersonal changes were reported positively retrospectively, at the time they were not always experienced positively; putting pressure on relationships (Ivey & Waldeck, 2014).

Subtheme: Increased self-understanding. Increased self-understanding was described as an effect of personal therapy in six studies (Graham, 2005; Ivey & Waldeck, 2014; Kumari, 2011; Malpass, 2017; Nikolopoulou, 2016). Personal therapy appeared to foster trainees’ understanding of their own behaviour and vulnerabilities, and how they relate to others, for example:

> Sometimes you have things [happen] as you grow up and, you know, they pass, but you never really work through them, or really have space to explore them all that much. Having had the space to do that has helped me to know my issues, to know myself more and to grow as a person. (Ivey & Waldeck, 2014, p.93).

Increased self-understanding appeared to have a professional impact. Specifically, understanding the self in relationships with supervisors (Graham, 2017), peers (Malpass, 2017), and clients (Graham, 2005; Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011).

Theme: Challenging aspects of personal therapy. Whilst all of the reviewed studies identified a number of benefits of personal therapy, all but two of the studies (Graham, 2005; Nikolopoulou, 2016) identified challenging aspects of personal therapy. These were grouped into two subthemes.

Subtheme: Emotional demands of personal therapy. Four studies descried how personal therapy elicited difficult emotions and a sense of vulnerability (Grimmer & Tribe, 2001; Ivey & Waldeck, 2014; Kumari, 2011; Wilson et al., 2015). For some, personal therapy was identified as an additional source of stress and pressure, whilst trying to manage the demands of training. One of Waldeck's (2011) participants described: "feeling overwhelmed with a lot of stuff happening at [once]…because I do think that therapy is challenging under the best circumstances" (Waldeck, 2011, p. 56). Words used to describe experiences of therapy included "scary", "exiting" (Wilson et al., 2015, p. 39), "overwhelmed" "stressful" "challenging" and "demanding" (Ivey & Waldeck, 2014, p.95). Two studies identified the negative impact that therapy can have on clinical work (Ivey & Waldeck, 2014; Kumari, 2011). For example, Kumari (2011) identified that by becoming preoccupied with issues that arose in therapy, some participants were unable to give clients their full attention.

***Subtheme: Financial costs of personal therapy*.** The financial cost of personal therapy was identified in four of the studies (Avis, 2010; Ivey & Waldeck, 2014; Kumari, 2011; Wilson et al., 2015). This creates additional stress and pressure for trainees, as demonstrated in the following participant quote:

> the money, it was a huge thing, I mean it's an expensive course, I'm not saying I don't agree with personal therapy but I think the timing with the money, you know I could have put that thousand pounds or whatever it ended up costing, towards my course, which would have made me have, not have to go out and work so many hours to earn the money to pay the course, which would have taken a lot of pressure off me. (Kumari, 2011, p. 222).

Discussion

This review aimed to synthesise and critically appraise the research literature pertaining to the impact of personal therapy on trainee clinical and trainee counselling psychologists. Eight studies were included in the review. The results suggest that personal therapy fosters learning processes in trainees. It brings personal and professional benefits, such as support through training and professional development, as well as emotional and financial costs. Trainees may experience fears around engaging in personal therapy, particularly at the outset of therapy.

A number of issues surrounding the mandatory nature of personal therapy were described in the reviewed studies, such as difficulty separating personal therapy from training and a lack of agency over personal therapy. Regardless of any initial negative feeling towards mandatory personal therapy, the reviewed studies suggest that trainees learn to value personal therapy and participation in personal therapy becomes more authentic over time.

Trainee clinical psychologists and trainee counselling psychologists have been found to experience high levels of stress during training (Cushway, 1992; Kumary & Baker, 2008). Trainees experience stressors related to academic work and placements, among other stressors (Cushway, 1992; Galvin & Smith, 2017; Kumary & Baker, 2008). One study has noted that a lack of support for trainee clinical psychologists contributes to increased stress (Cushway, 1992). External support is an important protective factor for trainee clinical psychologists (Galvin & Smith, 2017). Talking to a partner, colleagues or accessing a support group appears to mediate stress (Hannigan, Edwards & Burnard, 2004). The current review shows that personal therapy can be a source of support for trainee clinical and counselling psychologists; helping them to navigate the stressors and demands of training.

Within the current review, personal benefits of personal therapy were identified, particularly for generating a greater self-understanding. This increased self-understanding was described as having positive implications for trainees' clinical work and professional development. The importance of therapists' self-awareness and self-knowledge is recognised by many established therapy approaches (McLeod, 2013). Being self-aware is an important component of being an effective therapist (Jennings & Skovholt, 1999; Ryle & Kerr, 2002). For example, within psychodynamic approaches, self-awareness is seen as important for distinguishing countertransference reactions that are triggered by the clients' transference and those that are related to unresolved personal conflicts (McLeod, 2013). This helps prevent burnout and eliminate defences that may present when faced with clients' painful emotions, in order to remain with them in their distress (McLeod, 2013).

The current review highlighted that personal therapy is a form of experiential learning. Trainees apply their experiences in therapy, to their work as therapists with clients; increasing their understanding of theory and the processes involved in therapy. Previous research has demonstrated the importance of experiential learning for the training of clinical psychologists

(Nel et al., 2012). Clinical psychologists who feel more confident in their therapeutic work have engaged in longer periods of personal therapy, indicating the value of personal therapy in increasing therapeutic confidence (McMahon & Hevey, 2017).

Clinical psychology training places emphasis on learning through academic, research and clinical experience (BPS, 2017b). In contrast, counselling psychology training integrates academic study, research and clinical placements, alongside personal therapy to facilitate learning (2017a). The findings of the current review highlight the value of this experiential learning, which cannot be substituted by other methods of learning.

By participating in therapy, trainees experience how it is to be a client in therapy. The participants in the reviewed studies reported that this increased their awareness of clients' perspectives and fostered a greater sense of empathy towards their clients. Empathy is an important factor for client outcomes; research has demonstrated that the common factors in therapy, such as empathy, warmth and therapeutic alliance, correlate more highly with outcomes than specific therapy techniques (Lambert & Barley, 2001). These qualitative findings are in marked contrast to quantitative reviews of research into personal therapy for therapists. Macran and Shapiro (1998), and Macaskill (1988) concluded that there does not appear to be any substantial evidence to show that therapists' engagement in personal therapy leads to increased therapeutic effectiveness or beneficial client outcomes (Macran & Shapiro, 1998; Macaskill, 1988). The authors concluded that personal therapy could instil a false sense of confidence in trainees (Macran & Shapiro, 1998; Macaskill, 1988). These reviews are, however, dated.

The relationship between personal therapy and supervision was also identified in the reviewed studies. Some participants saw personal therapy as an extension of supervision, providing valuable supervisor-like support. The sense of safety that personal therapy fostered appeared to be particularly important for this. This finding is consistent with previous research

which demonstrates that having a safe and trustworthy relationship with supervisors is a primary concern of trainee clinical and counselling psychologists, within the context of their supervision (McMahon & Errity, 2014). Some psychologists prefer external supervision to internal (McMahon & Errity, 2014). Safety, trust and openness are important for being able to disclose and learn from errors (Beinart, 2014). This may suggest that personal therapy is a valuable forum for having 'safe' discussions.

Within the current review, two themes around the negative impacts of personal therapy were identified. Firstly, personal therapy can be an additional source of stress for trainees, at an already stressful and demanding period of training. Numerous other studies have shown that therapy is perceived as stressful or unsettling by trainee psychologists (McEwan & Duncan, 1993; Moller et al., 2009). Moller et al. (2009) reported that therapy had the potential to trigger a period of feeling unsettled or emotional; this was likened to 'opening a can of worms'.

Secondly, the negative impact of the financial cost of personal therapy on trainees is an important theme. In the UK, counselling psychology training is self-funded (Smook, 2017) and trainees are required to pay for their personal therapy (BPS, 2018b). Most clinical psychology training places are funded by the NHS (CHPCCP, 2018) and some training programmes provide a bursary or discount scheme for trainees accessing personal therapy. Despite the disparity in funding, both trainee clinical psychologist and trainee counselling psychologist participants in the reviewed studies reported the financial cost of therapy as a burden.

Some participants described fears of how their attendance at personal therapy would be perceived, and a sense of shame within the profession for experiencing emotional difficulties. This is consistent with other research that has demonstrated that fear and self-stigma inhibits the disclosure of trainee clinical psychologists' mental health problems (Grice, Alcock & Scior, 2018). Walsh and Cormack (1994) found that clinical psychologists' feared being stigmatised for accessing support. They cited concerns about how they would be viewed by the profession

or their NHS organisation, as well as concerns about being viewed as a client (Walsh & Cormack, 1994). Fears around how personal therapy would be perceived were only reported in studies of trainee clinical psychologists, perhaps because within counselling psychology training personal therapy is mandatory and trainees therefore need not explain their attendance.

It is important to note that Graham (2005) reports that the majority of participants in his study gave examples of negative experiences in personal therapy but that it did not interfere with their clinical work or clinical development. Malpass (2017) also reported that many participants described the process of personal therapy as painful at times. One participant described 'very painful' experiences within their personal therapy. Malpass's study aimed to explore trainee clinical psychologists' experiences and development in personal therapy. Painful aspects of therapy were not considered to be central to participants' experiences or development. Therefore, they were not considered key to the theoretical model, and not reported within the results. It seems that participants in both Graham's (2005) and Malpass's (2017) study had some negative experiences of personal therapy. However, as these were not central to the original research questions, they were not included in the results. The quality assessment indicated that both Graham (2005) and Malpass (2017) described their reflexive position in order to remain mindful of the impact of this on the research process. Thus, it is hoped that their positions within clinical and counselling psychology training did not bias the interpretation and reporting of data.

Within the current review, those who attended mandated personal therapy described a lack of agency. Some participants did not fully understand the purpose of therapy or the rationale for the amount of personal therapy required. The right for clients to freely choose whether to receive psychological services and to make this choice on the basis of the best information available is recognised globally by professional and regulatory bodies for psychology (APA, 2017; Australian Psychological Society, 2007; BPS, 2018c; Psychological

Society of South Africa, 2007). The current review shows that, as clients of therapy, trainee clinical and counselling psychologists are not always given the best available information about mandatory personal therapy. This raises ethical concerns.

Ivey (2014) provides a detailed discussion and debate on the ethics of mandatory personal therapy for mental health professionals in training. He states that it is the unethical implementation of mandatory personal therapy that is a cause for concern, rather than mandatory personal therapy being inherently unethical. Ivey (2014) states the importance of balancing the trainees' rights as psychotherapy clients and students with their ethical obligations as psychotherapists. He suggests that trainee therapists have a moral obligation to develop the self in order maximise client gain, establish effective therapeutic relationships, and prevent the inadvertent harm that may result from the enactment of their own difficulties and unresolved personal conflicts in therapy (Ivey, 2014).

The current review found that, other than the theme 'navigating mandatory personal therapy' and associated subthemes, there were no obvious differences between different groups in the findings. There were no distinguishable themes between: those who accessed mandatory personal therapy and voluntary personal therapy; clinical psychology trainees and counselling psychology trainees; and participants across different countries. This would suggest that trainees benefit from personal therapy regardless of whether it is mandatory or voluntary, where they are studying, or whether they are training in counselling psychology or clinical psychology.

Strengths and Limitations

One of the main strengths of the review is the quality of the included studies. The quality assessment process demonstrated that all of the studies added value to the research

literature on the impact of personal therapy during clinical and counselling psychology training. Whilst, areas for improvements in studies were highlighted, all of studies met the majority of the criteria in the quality assessment; increasing the rigor of the systematic review findings (CASP, 2018).

The ethics of mandating personal therapy for trainees is contentious and has long been debated. This is the first review to summarise international research concerning the main impacts of personal therapy for trainee clinical and counselling psychologists. It elucidates the main benefits and costs of personal therapy for trainees; providing greater insight into this area. The review has implications for practice and future research, which are detailed below. It is hoped that this review will promote further critical reflection, research and discussion regarding the requirement for personal therapy during clinical and counselling psychology training.

The main limitation of the review is the sample size; eight papers were included in the final review. Eliminating studies of participants who had not yet experienced personal therapy; that did not distinguish personal therapy during training to that undertaken after qualifying; and that did not distinguish trainee clinical/counselling psychologists from other populations, limited the number of studies included in the review. However, narrowing the focus in this way ensured that the results reflected the impact of personal therapy during clinical and counselling psychology training. In addition, whilst the review utilised a range of search strategies, an additional strategy of contacting experts in the field could have been implemented.

Whilst the limitations of the review are acknowledged, this systematic review provides an understanding of how personal therapy impacts on trainee clinical and counselling psychologists; common themes in the research literature are highlighted. This review acts as a valuable starting point for further research, discussion and critical review about personal therapy during clinical and counselling psychology training.

Recommendations for Training and Practice

The findings of this review suggest that trainee counselling and trainee clinical psychologists value personal therapy. Some participants who attended personal therapy voluntarily, questioned why it was not a mandatory training requirement. Given the clear benefits of personal therapy on the learning and professional development of trainees, ways of eliminating the negative impacts of personal therapy need to be considered.

To reduce the stressful impact of personal therapy on trainee counselling and trainee clinical psychologists, it is recommended that there is some flexibility regarding when therapy is undertaken. Trainees experience different levels of stress at different times in their training (Cushway, 1995). In Kumari's (2011) study, participants reported that personal therapy was helpful, as long as it was provided at the right time in the person's life and they felt ready for therapy. Participants also talked about how going to therapy without specific problems can be stressful (Kumari, 2011). Perhaps there is an optimum time to undergo personal therapy, when trainees feel it is the right time for them, for example, by considering their training demands and their mental health.

In order to eliminate the financial costs of personal therapy a bursary/discount scheme for trainees accessing personal therapy could be considered. This may help eliminate some of the negative effects of personal therapy, whilst continuing to generate such positive impacts on trainees' professional development.

In the studies reviewed, when therapy was mandatory some participants had difficulty distinguishing personal therapy from their training and this seemed to create anxiety about being monitored and assessed in therapy. It is important for training programmes to make explicit the relationship between personal therapy and the training programme; how this relates (or does not relate) to assessment, how confidentiality is managed and what communication exists between the therapist and the training institution.

The findings of this review highlight that trainee clinical psychologists, who attend personal therapy voluntarily, fear how their engagement with personal therapy may be perceived by others. In order for trainees to feel more comfortable in accessing personal therapy, more open discussions need to be held within the profession about personal experiences of mental health difficulties and accessing personal therapy. At present, some clinical psychology training courses explicitly encourage personal therapy, whilst others do not (BPS, 2018b). Removing the sense of shame around experiences of mental health difficulties and accessing personal therapy should allow trainees to access personal therapy. In this way, trainees can reap the benefits of personal therapy without fearing the judgement of their colleagues, the course team or the profession more generally.

Future Research

Although this review offers some insight into the costs of attending personal therapy, more research is needed into negative aspects of personal therapy. This is consistent with recommendations made by Graham (2005) and Malpass (2017). Future research studies, which specifically focus on negative experiences in personal therapy, are warranted. Such studies should help gain a more in depth understanding of how personal therapy can negatively impact trainee clinical and counselling psychologists. From this, further consideration can be given to ways of reducing the negative impact of personal therapy for trainees.

Given the extent of the evidence in support of the self-reported benefits of personal therapy for trainees' professional development, more up-to-date research is needed to understand how personal therapy affects trainees' clinical work, from the perspective of others. This may involve assessing the relationship between personal therapy and client outcomes, or trainees' performance, as rated by their supervisors.

Considering the fears expressed by trainee clinical psychologists around accessing personal therapy, more research is needed into clinical psychology training programmes' attitudes towards trainees accessing personal therapy.

Summary and Conclusions

This review considered the impact of personal therapy for trainee clinical and counselling psychologists, by assessing and synthesising the research undertaken this area. The results show that personal therapy acts as a form of experiential learning; having a positive impact on trainees' professional development. Personal therapy also has positive effects on trainees' personal lives, and increases their self-understanding. Whilst there are clear benefits to personal therapy, the emotional demands and financial costs of personal therapy can place additional stress and pressure on trainees. When personal therapy is voluntary, trainees may fear how their attendance at personal therapy is perceived. When personal therapy is mandated, trainees experience a lack of agency over their personal therapy. Training programmes need to consider ways to reduce the stress and pressure caused by personal therapy, reduce fears around attending personal therapy, and increase trainees' sense of agency over their personal therapy.

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What Factors Affect Trainee Clinical Psychologists' Decision to Disclose, or Not Disclose, Their Own Mental Health Difficulties during Clinical Training?

Chapter 2: Empirical Paper

Prepared for submission to The Journal of Clinical Psychology. Author guidelines are presented in Appendix D

Abstract

Objective: This study aimed to understand what factors affect trainee clinical psychologists' decision to disclose, or not disclose, their own mental health difficulties during clinical psychology training.

Method: Twelve recently quailed clinical psychologists were interviewed about their experiences of mental health difficulties, and their mental health disclosure decision making, during training. A constructivist grounded theory methodology was used.

Results: A theoretical framework, containing ten categories, was developed. The theoretical framework shows that trainee mental health disclosure decision making is a dynamic process that relies on multiple factors, including whether the trainee has a reason to disclose; the anticipated response; situational factors; and the amount of fear and shame associated with personal experiences of mental health difficulties and disclosure.

Conclusions: The findings emphasise the importance of fostering an open and supportive environment in clinical psychology training; eliminating shame and fear; and ensuring trainees receive a validating and normalising response to disclosure.

Key Words: Metal health difficulties, disclosure, clinical psychology training.

Introduction

One in four people experience mental health difficulties[1] in England in any one year, yet people with mental health difficulties continue to experience stigma and discrimination (The Mental Health Taskforce, 2016). UK initiatives, such as 'Heads Together' (n.d.) and 'Time to Change' (2008), aim to raise awareness of mental health difficulties and to tackle mental health stigma within society. As part of tackling stigma, personal openness about mental health problems is promoted (Ruddle & Dilks, 2015).

Mental health professionals are not exempt from experiencing mental health difficulties and stigma (Neish, 2012; Reynolds, 2017). 'The NHS Health and Well-being Review' (Boorman, 2009) found that mental health difficulties were a major contributor to NHS staff sickness absence. Despite this, staff mental health is not always responded to effectively (Boorman, 2009). NHS organisations that prioritise staff health and wellbeing perform better, have greater patient satisfaction and staff retention, and lower rates of sickness absence (Boorman, 2009). UK government initiatives have therefore prioritised promotion of health and wellbeing in the NHS workplace (Department of Health, 2011).

The mental health of psychologists has received particular attention over recent years; discussions about psychologists' mental health are alive in blogs, social media, traditional media and discussion articles (e.g. Blackshaw, Rahim, & Rosebert, 2017; Cooke & Watts, 2016; Gilchrist et al., 2017; Holttum, 2016; Kemp, 2018). Recent empirical evidence demonstrates that mental health difficulties are prevalent in trainee and qualified clinical psychologists (Grice, Alcock, & Scior, 2018a; Tay, Alcock, & Scior, 2018). The current research aims to add to this emerging evidence base by understanding the factors implicated in

[1] When developing this study, a sample of trainee clinical psychologist were surveyed about their preferences around language. 'Mental health difficulties' was the preferred term and so this was used. The use of language in relation to disclosure was also carefully considered. The term 'disclosure' was chosen, as this is consistent with previous research in this area (e.g. Aina, 2015; Grice et al., 2018a; Tay et al., 2018).

trainee clinical psychologists' decision to disclose, or not disclose, their own mental health difficulties.

Policy Context

The British Psychological Society (BPS) recognises the importance of encouraging diversity and fostering equality and inclusivity within the profession of clinical psychology (BPS, 2015). The BPS, Division of Clinical Psychology (DCP) Inclusivity Strategy has been developed to increase access to the profession and to encourage a more diverse network of clinical psychologists (BPS, 2015).

Over recent years, the New Savoy Conference Workplace Wellbeing Survey has consistently demonstrated high levels of stress and feelings of depression in psychology professionals (BPS, 2017). As a result, the 'Charter for Psychological Staff Wellbeing and Resilience' was developed. Through the charter, various mental health charities, mental health trusts, professional bodies and third sector providers have committed to support a collaborative effort to improve the wellbeing and resilience of psychological staff who deliver key services (Hacker Hughes et al., 2016).

The 'Honest Open Proud for Mental Health Professionals' project (HOP-MHP, Mills & Scior, 2017) is being undertaken in response to the Charter for Psychological Staff Wellbeing and Resilience. The HOP-MHP is a guided self-help intervention for mental health professionals with experience of mental health difficulties. It aims to support decision making around disclosure of mental health difficulties in a way that is personally meaningful, safe, and empowering (Mills & Scior, 2017).

Doctorate in Clinical Psychology (DClin) programmes should provide applicants and trainees with multiple opportunities to disclose a disability, including mental health difficulties (Harper, Rowlands, & Youngson, 2006). However, there is a lack of detailed guidance on how to support trainees with mental health difficulties (Harper et al., 2006). In contrast, within the

medical profession, the General Medical Council (GMC) provides a national framework for supporting medical students with mental health difficulties (GMC, 2015).

Mental Health Difficulties in Applied Psychologists

Whilst there has historically been a lack of research into the mental health of psychology professionals, major developments in this area of research have emerged in recent years (BPS, 2018; Grice et al., 2018a; Tay et al., 2018). The New Savoy Partnership's annual survey of psychological therapists has found a sustained increase in stress and depression in this workforce, with levels of depression increasing from 40% in 2014, to 46% in 2015 and 48% in 2016 (BPS, 2017). Although, it should be noted that 'depression' was measured by participants' self-reported responses to the question: 'How much of the time in the past week have you felt depressed?' (BPS, 2015).

Empirical research into the prevalence of mental health difficulties in clinical psychologists in the UK is addressed in two published studies (Cushway & Tyler, 1994; Tay, et al., 2018). In an early survey of stress and mental health difficulties, Cushway and Tyler (1994) found that 75% of clinical psychologists reported being 'moderately' or 'very' stressed. In addition, 29.4% of participants met the criteria for 'caseness', according to the General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979). The GHQ measures minor psychiatric disorders across four subscale (somatic symptoms, anxiety and insomnia, severe depression and social dysfunction); a cut off score is provided, indicating 'caseness' (Cushway & Tyler, 1994).

In a large scale study of mental health difficulties in UK clinical psychologists, Tay et al. (2018) found that 62.7% of participants had experienced at least one mental health difficulty at some point in their lives. Almost half of participants had experienced two or more different mental health difficulties and 12.2% had experienced three or more different mental health difficulties. Depression and anxiety were the most commonly reported mental health

difficulties. A small number of participants had experienced bipolar disorder, psychosis and addictions (Tay et al., 2018).

Charlemagne-Odle, Harmon and Maltby (2014) conducted a qualitative study into clinical psychologists in the UK who experienced mental health difficulties, with the aim of exploring their personal experiences of distress. Job related stressors (e.g. heavy workload, the pressure to be seen as coping) and personal stressors (e.g. bereavement, relationship difficulties) were identified. Participants described their distress manifesting physically, behaviourally and emotionally, with both positive and negative effects on client work. Participants attempted to understand their distress by applying their own psychological knowledge, and identifying internal or external causes. Varying experiences of what helped in response to distress were reported (Charlemagne-Odle et al., 2014).

Considering research outside of the UK, four studies in America report on the mental health of psychologists (Bridgeman & Galper, 2010; Gilroy, Carroll, & Murra, 2002; Guy, Poelstra, & Stark, 1989; Pope & Tabachnick, 1994). These studies show high levels of depressive symptoms in psychologists (Gilroy et al., 2002; Pope & Tabachnick, 1994). Distress also appears to be highly prevalent among psychologists in America (Bridgeman & Galper, 2010; Guy et al., 1989). Work stress is identified as the main contributor to distress in psychologists in America, although other factors, such as mental health problems, personal/family illness, loss and marital problems also contribute to distress (Guy et al., 1989). One study in South Africa revealed that more than 50% of clinical and counselling psychologists surveyed experienced above average levels of anxiety (Jordaan, Spangenberg, Watson, & Fouchè, 2007). Similar levels of mild depression were also found (Jordaan et al., 2007).

Looking more specifically at trainee clinical psychologists, Grice et al. (2018a) aimed to determine the incidence of mental health problems in UK trainee clinical psychologists. A

total of 347 trainee clinical psychologists completed an online survey. The results demonstrated that 67% of participants had personal experiences of mental health difficulties; 37% experienced a current mental health difficulty. The most frequently experienced mental health difficulties were anxiety and depression. A number of respondents reported experiences of social phobia and eating disorders.

Earlier studies have demonstrated that difficulties associated with self-esteem, anxiety, depression and work adjustment are prevalent in trainee clinical psychologists (Brooks, Holttum, & Lavendar, 2002; Kuyken, Peters, Power, and Lavendar, 1998; Kuyken, Peters, Power, Lavendar, & Rabe-Hesketh, 2000). Cushway (1992) found that a large proportion of trainees felt 'moderately' or 'very' stressed as a result of clinical psychology training. In addition, trainee clinical psychologists experience higher levels of perceived stress and psychological difficulties than psychiatric nursing students and PhD students (Galvin & Smith, 2015).

Although mental health difficulties are prevalent in trainee clinical psychologists, often trainees do not disclose their mental health difficulties during training, or they experience concerns about doing so to colleagues or supervisors (Grice et al., 2018a).

Disclosure Decision Making

A number of different factors are implicated in the decision to disclose, or not disclose, personal experiences of mental health difficulties (Brohan et al., 2012; Grice, Alcock, & Scior 2018b; Toth & Dewa, 2014). Brohan et al. (2012) conducted a systematic review into beliefs, behaviours and factors influencing disclosure of mental health difficulties in the workplace. Expectations and experiences of discrimination were the main deterrent to disclosure. This encompassed beliefs and experiences surrounding being treated unfairly or differently; being devalued or undermined; not being protected by legislation; becoming a target for 'gossip' and being rejected or ostracised. Other reasons for non-disclosure were: mental health being

private, having a job with natural adjustments, successfully concealing mental health difficulties previously and believing that others do not want to know (Brohan et al., 2012).

Brohan et al. (2012) identified seven themes related to reasons for disclosing mental health difficulties, within the research literature. These were: being a role model for others, to gain adjustments, having positive experiences of disclosure, to gain support, to be honest, to explain behaviour and concealing being stressful (Brohan et al., 2012). The review also identified other factors that predicted disclosure in the workplace, for example being female, having higher levels of perceived emotional support, greater familiarity with legislation, displaying symptoms at work, working in a mental health setting and experiencing work related concerns (Brohan et al., 2012).

In a more recent study, Toth & Dewa (2014) developed a model of disclosure decision-making at work. They found that fear of being stigmatised led to a default decision of non-disclosure. Feared stigmatisation involved stereotypes being applied to people with mental health problems; being treated differently and self-stigma (Toth & Dewa, 2014). Reasons for disclosure were identified as interpersonal (e.g. to help others, to challenge stigma), work related (e.g. to overcome a work challenge) and personal (e.g. eliminating the need to keep a secret). Assessing the conditions for disclosing was also an important element of disclosure decision making. This involved assessing interpersonal conditions (e.g. the potential receiver of the disclosure being open, understanding and trustworthy), work related conditions (e.g. how disclosure is handled in the work place) and personal (e.g. status of the disorder).

Mental Health Professionals' Disclosure Decision Making

Narratives of silence surrounding personal experiences of mental health problems are documented by mental health and generalist nurses (Joyce, McMillan, & Hazelton, 2009) and other mental health professionals (Moll, Eakin, Franche, & Strike, 2013). Fear of stigma

(Gough, 2016) and not wanting to jeopardise one's reputation appear to deter mental health professionals from disclosing information about their mental health (Moll et al., 2013).

Similarly, medical doctors report potential career implications; stigma; professional integrity (Hassan, Ahmed, White & Galbraith, 2009); not wanting to be labelled; and not understanding the support structures available (Cohen, Winstanley & Greene, 2016), as reasons for not disclosing personal experiences of mental health difficulties. Medical students report feelings of academic vulnerability in relation to their mental health (Roberts et al., 2001). They believe their academic performance and individual grades would be adversely affected if others were to become aware of their health problems, including mental health difficulties (Roberts et al., 2001).

Mental health professionals, from different professional backgrounds, describe experiences of stigma from colleagues and self-stigma related to their mental health difficulties (Gough, 2016). Implicit and explicit messages given by employers to be silent, reinforces the unacceptability of mental health problems in employees (Moll et al., 2013). There appears to be a conflict between mental health service providers' commitment to improve the lives of people with mental health problems; raise awareness; and reduce stigma, and the lack of openness and support for staff with mental health difficulties (Moll et al., 2013; Gough, 2016).

Research suggests that there is a perceived 'socially acceptable' level of distress, which prevents mental health professionals from disclosing when they reach a perceived 'unacceptable' level of distress (Gough, 2016). Similarly, mental health professionals feel more able to talk about their own mental health when colleagues or other professionals speak out about their own experiences (Gough, 2016).

The reasons given by mental health professionals for disclosing at work have been reported as: explaining behaviour, advocating for people with mental health problems and conveying empathy and support to clients (Moll et al., 2013). Nurses report that they require

trust and assurance of managerial support; emphasising the importance of a secure a supportive environment for mental health disclosure (Joyce et al., 2009).

Psychologists' Disclosure Decision Making

Research has consistently found that fear of stigma or discrimination deters mental health disclosure in the work place, specifically in mental health services (Brohan et al., 2012; Moll et al., 2013; Toth & Dewa, 2014). Research into mental health disclosure in UK clinical psychologists is limited to two studies (Aina, 2015; Charlemagne-Odle et al., 2014) one of which is an unpublished doctoral dissertation. Within this limited evidence base, similar themes to those of nurses and other mental health professionals have been found.

Similar to nurses and other mental health professionals (Joyce et al., 2009; Moll et al., 2013), clinical psychologists recognise a lack of openness about personal experiences of mental health difficulties, within the profession (Aina, 2015; Charlemagne-Odle et al., 2014). Clinical psychologists report that there are a lack of role models who are open about their experiences of psychological distress, within the profession (Aina, 2015).

Fear, shame and self-stigma have been shown to have an inhibitory effect on UK clinical psychologists sharing information about their own mental health and distress (Charlemagne-Odle et al., 2014; Tay et al., 2018). Fears include being seen as weak and unable to do their job well, and disclosure impacting on their career (Charlemagne-Odle et al., 2014; Tay et al., 2018). Research suggests that clinical psychologists stigmatise and criticise themselves for experiencing distress, and feel inferior to colleagues who appear to be coping (Charlemagne-Ogdle et al., 2014). Likewise, clinical psychologists expect that they should be able to manage stress. They hold assumptions around what it means to be a 'good psychologist' and express an idealised view of psychologists (Charlemagne-Odle et al., 2014; Aina, 2015).

Trainee Clinical Psychologists' Disclosure Decision Making

Grice et al. (2018a) aimed to understand some of the factors underlying trainee clinical psychologists' mental health disclosure decision making processes. They found that this is a complex process that depends on multiple factors that hold different weight, depending on the disclosure scenario. Some of the factors that influenced decision making included: type of recipient, whether the problem was past or current, anticipated stigma and 'maladaptive perfectionism'. Maladaptive perfectionism has been defined as a tendency to set very high personal standards whilst being self-critical in perceived ability to meet such standards (Rice & Stuart, 2010). Grice et al. (2018a) found that trainee clinical psychologists were more likely to disclose past difficulties than current mental health difficulties and that higher levels of anticipated stigma and maladaptive perfectionism reduced the likelihood of disclosure.

No other research has been published into trainee clinical psychologists' mental health disclosure decision making. More research is needed to gain a greater understanding of the factors motivating trainees to disclose and how disclosure is experienced (Grice et al., 2018a).

Implications of Disclosing and Concealing Identity

Concealing a stigmatised identity, such as mental health difficulties, sexuality, disability, unemployment, has cognitive, affective and behavioural implications (Pachankis, 2007). It can have a negative impact on levels of preoccupation, suspiciousness, anxiety, shame, impression management and isolation (Pachankis, 2007). Not disclosing mental health difficulties at work can limit opportunities for workplace adaptations (Toth & Dewa, 2014).

Research shows that disclosing personal information in the workplace can have positive implications, although there are potential risks to disclosure (Ignatius & Kokkonen, 2007). Disclosing mental health problems risks exposure to prejudice and discrimination from others (Corrigan, 2004; Corrigan & Roa, 2012). Sometimes, employees are subject to stigmatising behaviours from their employers (Corrigan & Lundin, 2004 as cited in Wheat, Brohan,

Henderson, & Thornicroft, 2010). Conversely, some research has shown that selective disclosure of mental health problems in the workplace optimises social support and limits stigmatisation (Bos, Kanner, Muris, Janssen, & Mayer, 2009). Disclosure of mental health problems at work appears to have the potential for cultivating supportive relationships and straining existing relationships (Jones, 2011).

Disclosing personal information has positive effects on levels of distress and depression (Frattaroli, 2006); life satisfaction and self-esteem (Halpin & Allen, 2004). Disclosure can provide an increased sense of personal empowerment (Corrigan et al., 2010). The literature suggests that disclosing mental health difficulties limits the negative effects of self-stigma on quality of life (Corrigan et al., 2010). Disclosure appears to undermine self-and public stigma and enhances feelings of courage and empowerment (Corrigan, Kosyluk, & Rüsch, 2013).

Corrigan and Wassel (2008) identify three ways in which people can benefit from being publicly open about their mental health. They suggest that being open brings about a sense of relief, facilitates identification with others who have similar experiences and challenges public stigma about mental health.

Considering the potential benefits of disclosure, deciding whether to disclose personal experiences of mental health problems appears to be a complex, individual and personal process (Corrigan et al., 2013). Barnett, Baker, Elman and Schoener (2007) highlight that understanding psychological therapists' reasons for not disclosing personal experiences of distress, might promote ethical practice, reduce stigma and instil values related to ongoing self-care. To help facilitate disclosure, O'Connor (2001) recommends creating a professional environment of openness, sharing and peer support.

Aims and Rationale

The current study aimed to extend the work of Grice et al. (2018a) by exploring the factors involved in UK trainee clinical psychologists' mental health disclosure decision

making. The research question was: ‘What factors affect trainee clinical psychologists’ decision to disclose, or not disclose, their own mental health difficulties during clinical training?’ The main objectives were to:

1. Explore UK trainee clinical psychologists’ own experience of mental health difficulties.

2. Explore what factors affect trainee clinical psychologists’ decision to disclose, or not disclose, their own mental health difficulties during clinical training.

3. Develop a model that describes the decision making process involved in trainee clinical psychologists’ decision to disclose, or not disclose, their own experiences of mental health difficulties during clinical training.

Method

This study employed a constructivist grounded theory methodology, to develop a detailed theoretical understanding of the decision making process.

Participants

Twelve clinical psychologists (nine females, three males) participated in the study. Participants were required to meet the inclusion criteria of:

- Qualifying from a HCPC approved and BPS accredited UK DClin programme within the two last years
- Identifying as having experienced mental health difficulties before or during their clinical psychology training.

Clinical psychologists who trained at the University of Liverpool were excluded from the study, to reduce the likelihood of the researcher knowing the participants in another capacity.

In line with the inclusion criteria, all but two of the participants self-identified as having experienced some kind of mental health difficulty before starting training. Participants described experiencing difficulties related to anxiety, low mood, eating, obsessions and compulsions, relationships and coping styles. All of the participants identified as having experienced some form of distress or difficulty during training. In addition, all but two participants had made some form of disclosure, about their mental health experiences, to their tutors, peers, and/or their supervisors during training.

Given the low levels of disclosure in this population and the research team's affiliation with a DClin programme, it was deemed particularly important to create a safe forum where participants felt able to openly discuss their mental health experiences. With this in mind, the researcher strived to preserve participants' anonymity (as far as possible) and gave participants a choice over the location of their interview, provided it was in a public building. Information about participants' demographics, or their DClin study programme was not collected. Whilst the researcher did not collect information about the participants' programme of study, a number of participants reported where they studied. The researcher understood that participants were recruited from at least six different courses, spanning the UK.

It was decided that recently qualified clinical psychologists would be recruited, rather than trainee clinical psychologists, for a number of reasons. Those currently in training may be faced with ongoing disclosure decisions and different factors may influence disclosure decisions at different points in training. It was hoped that recruiting recently qualified clinical psychologists would enable discussion around all the factors involved in disclosure decision making throughout training. Recruiting qualified clinical psychologists also eliminated the chance that the research could affect participants' disclosure decisions during training. In addition, it was thought that recently qualified clinical psychologists may be more comfortable discussing their experiences during training, as potential fears of the research impacting on

training were removed. It was deemed important to recruit clinical psychologists who qualified within the previous two years, to increase the likelihood of participants accurately recalling details of their experiences during training.

Data Collection

Data were collected and analysed in accordance with Charmaz's (2014) guidance on constructing a grounded theory. Grounded theory involves simultaneously analysing and collecting data.

A semi-structured interview guide was used for the first nine interviews (Appendix E). The interview schedule was designed based on guidance from Charmaz (2014) in line with the principles of grounded theory methodology. The researcher considered the questions that would help focus the interview and fulfil the research objectives. Gathering information about participants' mental health experiences, experiences of disclosure and factors influencing disclosure was thought to be pertinent to the research objectives. The interview guide was used flexibly in order to pursue new ideas that occurred during the interview (Charmaz, 2014).

The interview guide was altered as interviews progressed (Appendix F) to advance the theoretical analysis. For example, initial interviews broadly explored participants' reasons for disclosing, or not disclosing. During the middle stages of recruitment participants were asked additional questions around the course culture, attitudes within the profession, perceptions of clinical psychologists and resilience. These questions reflected the emerging analysis and required further exploration in order to progress the theory. Interviews 10 and 11 were used to explore and refine the emergent categories, and the relationships between them. The final interview was used to obtain the participant's perspective on the draft of the model.

Design

Grounded theory is a systematic method of qualitative data analysis, which aims to develop an inductively driven theory of a social or psychological process, grounded in the

research data (Glaser & Strauss, 1967). Constructivist grounded theory assumes a relativist epistemology and acknowledges the researcher's and research participants' multiple standpoints, roles, and realities in constructing language, meaning and action (Charmaz, 2017).

Consideration was given to a number of qualitative approaches (see Appendix G) and grounded theory methodology was chosen for a number of reasons. Considering the research aims, it was anticipated that grounded theory would enable the development of a theory which specifies the situations in which disclosure occurs or does not occur, and the conditions under which it changes or is maintained (Harper & Thompson, 2012). In addition, given the researcher's background, values and relationship with the research topic it was deemed particularly important to adopt a reflexive stance, as well as considering the historical, social, and situational conditions of the research. These factors are consistent with constructivist grounded theory (Charmaz, 2017).

Procedure

Recruitment. Participants were recruited via UK DClin programmes. The study advertisement (Appendix H) and information sheet (Appendix I) were emailed to DClin programmes in England, Scotland and Wales, along with a request to disseminate to clinical psychologists who qualified from that programme within the previous two years. The research project was also advertised at the BPS's DCP 2017 annual conference, at a supervisor training workshop and through the North West Psychological Professions Network (PPN) mailing list.

Individuals who expressed an interest in participating in the study were provided with the opportunity to contact the researcher to ask any questions. Interviews were organised with those who met the inclusion criteria and wished to participate in the study. Three people expressed an interest in participating in the study but did not meet the inclusion criteria and were, therefore, excluded from taking part in the study. Individual interviews were conducted

in private rooms within public buildings. Nine interviews were held at participants' place of work, two interviews were held in universities and one interview was held in a library. Interviews were audio recorded and lasted approximately 75 minutes (ranging from 66-112 minutes). Prior to each interview participants were given the opportunity to re-read the information sheet and ask any questions, before signing a consent form (Appendix J).

Following initial interviews, theoretical sampling was used as a way of "seeking and collecting pertinent data to elaborate and refine categories in your emerging theory" (Charmaz, 2014, p.192). The research team considered narrowing the focus of recruitment (e.g. recruiting men; trainees who did not disclose; trainees from different regions), however variation across participants naturally arose and this was not deemed necessary. Theoretical sampling involved continuing to recruit participants in the same way, but refocusing the lens within interviews; collecting more data to explore emerging categories and the relationships between them (Charmaz, 2014).

Ethics. The study was approved by the University of Liverpool's Ethics Committee (Appendix K). All participants gave informed consent to participate in the study. There were limits to confidentiality, which were outlined in the information sheet. Participants were not required to provide personally identifiable information or the name of their training programme during the interview. However, they were required to sign a consent form and provide contact details in case a second interview was required. Any personally identifiable information provided was anonymised during the transcription process. The primary researcher assigned pseudonyms to each participant, these were used in the write up to preserve anonymity.

The researcher acknowledged that participants may experience distress when discussing their own mental health. Participants were required to provide the contact details of a friend, spouse, family member or health care professional that could be contacted in case of ongoing distress following the interview. Participants were made aware that they could

terminate the interview at any point and they could withdraw from the study up until one week after the interview. Upon completion of the interview participants were debriefed; they were signposted to support services and given the opportunity to ask any questions (Appendix L).

Reflexivity. A number of strategies were implemented to remain mindful of the researchers' impact on the research process and to demonstrate transparency. At the beginning of the research journey the primary researcher reflected on her position in relation to the focus of this study. The primary researcher is a trainee clinical psychologist on the University of Liverpool DClin programme. She became interested in the research topic primarily as a result of her own mental health experiences, namely her social anxiety. Starting the DClin was both exciting and anxiety-provoking for her, bringing about many changes. She noticed high levels of anxiety, particularly in performance related situations (e.g. role plays, presentations, observations). However, her fellow trainee cohort did not appear anxious or distressed and seemed to be coping well with the start of the programme.

The primary researcher believed that, being on a training programme leading to becoming a clinical psychologist, she should not be experiencing anxiety; she should not display anxiety and she should be able to cope. Whilst she applied these ideas to herself she did not apply them to other trainees or clinical psychologists.

As she was becoming increasingly distressed by her anxiety on the course, the primary researcher decided to disclose her experiences, initially to her placement supervisor and then to her personal tutor. Her reasons for this were to gain support and reassurance. The primary researcher had a positive experience of disclosure; receiving a normalising, accepting and supportive response. This was extremely helpful for the remainder of her training as it began to instil a sense of acceptance around her own mental health challenges. The primary researcher's experiences of anxiety and disclosure sparked an interest in the area of trainee mental health disclosure and motivated her to undertake the project.

The researcher and research supervisors had a reflective discussion about their own positions in relation to the study topic early on in the design of this research. This enabled a shared reflection on their assumptions, experiences and epistemological positon related to the research topic. They remained mindful of these factors throughout the research process and held regular reflexive discussions during supervision. Throughout the research process, the primary researcher reflected on her own thoughts and feelings in relation to the research process through the use of reflective journal entries.

Data analysis. The first step of the analysis involved 'initial coding'. This entailed examining each line of data and labelling the processes occurring in the data, using a gerund (where possible). A gerund is a noun form created by adding the "ing" suffix to a verb; this invokes the idea of a process, which is important for developing a theory which centres on actions and processes (Bryant, 2017). 'Initial coding' was followed by 'focused coding', this involved synthesising and analysing initial codes by selecting the most frequent or significant codes and developing the analysis. From focused coding 'conceptual categories' were developed; incorporating common themes and patterns across codes. The researcher aimed for categories to have abstract power and analytic direction and to explain ideas, events and process within the data (Charmaz, 2008). Theoretical sampling enabled the researcher to elaborate and refine the categories in the emerging theory (Charmaz, 2014), which formed 'theoretical categories'. The properties of categories were defined by considering the conditions under which different categories operate and change, and how different categories relate to one another. Constant comparative methods (Glaser & Straus, 1967) were used at each level of analysis; comparing data with data, codes with data and codes with codes. 'Memos' were kept during the analysis; capturing the researcher's thoughts, ideas, questions and lines of enquiry to pursue in relation to the data and codes, and relationships within and between them. Memos

facilitated the development of emergent codes, categories and draft versions of the model (Appendix M).

A number of validation procedures were adopted in order to ensure credibility of the grounded theory model, codes and categories (Yardley, 2017). In order to ensure rigour in qualitative research, multiple coding is recommended; for example, by independently coding excerpts of data or checking emergent frameworks (Barbour, 2001). During the initial coding phase of the research, the primary research supervisor independently coded segments of the research transcripts as a way of cross checking the coding framework. The research supervisors also checked the emerging coding frameworks during the different stages of data-analysis. As a way of validating the theoretical framework an independent researcher checked draft versions and the final account of the theoretical framework. Examples of the data analysis are presented in Appendix N.

Results

This study aimed to understand what factors affect trainee clinical psychologists' decision to disclose, or not disclose, their own mental health difficulties during clinical training. Nine theoretical categories were constructed as part of the theoretical framework ('Having Past Mental Health Difficulties'; 'Experiencing Distress During Training'; 'Having a Reason to Disclose', 'Anticipating a Negative Outcome', 'Anticipating a Supportive Response', 'Situation Encouraging Disclosure', 'Feelings Affecting Disclosure', 'Factors Influencing Feelings about Disclosure' and 'Response to Disclosure') and one core category ('Disclosure Continuum'). All of the theoretical categories contributed to the 'Disclosure Continuum'; this category was therefore seen as core to the theoretical framework as it was central for the integration of other categories (Hallberg, 2006).

The theoretical categories contained within the theoretical framework are presented in Table 2. The theoretical categories and associated subcategories are presented in Table 3

Within Table 2, the theoretical categories have been structured under the following descriptive headings: content of disclosure, reasons to disclose, factors inhibiting disclosure, factors enabling disclosure, feelings about disclosure and outcome of disclosure. These descriptive headings did not form part of the analysis; rather, they have been used purely as a descriptive tool to aid the reader in understanding how the theoretical categories are related to disclosure. The researcher selected headings that would best describe how the theoretical categories related to disclosure (e.g. 'factors inhibiting disclosure', 'factors enabling disclosure').

A narrative summary of the model is provided along with a visual representation of the theoretical framework (Figure 2). The theoretical categories and associated subcategories are then presented, along with participant quotes and the interplay between different factors and categories, in order to explain the theoretical framework.

Table 2

Theoretical Categories within the Theoretical Framework

Factors Affecting Disclosure/Non-Disclosure	Theoretical Category
Content of Disclosure	Having Past Mental Health Difficulties
	Experiencing Distress During Training
Reasons to Disclose	Having a Reason to Disclose
Factors Inhibiting Disclosure	Anticipating a Negative Outcome
Factors Enabling Disclosure	Anticipating a Supportive Response
	Situation Encouraging Disclosure
Feelings about Disclosure	Feelings Affecting Disclosure
	Factors Influencing Feelings about Disclosure
Outcome of Disclosure	Disclosure Continuum
	Response to Disclosure

Table 3

Theoretical Categories and Subcategories

Theoretical Category	Subcategory
Having Past Mental Health Difficulties	Life Experiences
	Experiencing Distress During Training
	Learning to Cope
	Fluctuating Mental Health
Experiencing Distress During Training	Training Being Stressful
	Training Stressors
	Personal Stressors
	Internal Factors
Having a Reason to Disclose	Wanting Course Related Support
	Justifying DClin Performance
	Reaching a Personally Significant Medical Threshold
	Valuing Openness
Anticipating a Negative Outcome	Implicitly Stigmatising Course Culture
	Lack of Trustworthy Recievers
Anticipating a Supportive Response	Supportive Course Culture
	Suitable Receivers
Situation Encouraging Disclosure	
Feelings Affecting Disclosure	Feeling Shame and Fear
	Feeling Acceptance and Comfort
Factors Influencing Feelings about Disclosure	Experiences of Openness
	Individualised or Shared Distress
	Trainee Culture
	Idealised Perceptions of Clinical Psychologists
	Recruitment Pressure
	Psychology Culture
	Societal Views
	Lack of Information about Fitness to Practice
Disclosure Continuum	Not Disclosing
	Leaking Information

	Reframing Experiences
	Making a Measured Disclosure
	Being Actively Open
Response to Disclosure	Negative Response
	Positive Response

Narrative Summary of the Model

Participants experienced past mental health difficulties and/or distress during training. These experiences formed the content of their potential disclosure. Participants were motivated to disclose if they have a reason to disclose. Reasons for disclosing included: wanting course related support, justifying DClin performance, having met a personally significant medical threshold (e.g. taking medication) and valuing openness. When participants had a reason to disclose, whether or not they disclosed depended on what they anticipated the response to their disclosure to be, and whether or not the situation encouraged disclosure. If participants had a reason to disclose, and they anticipated a supportive response (based on the course culture being supportive and/or suitable receivers being available) they were more likely to disclose. In addition, when the situation encouraged disclosure participants were more likely to disclose. However, if participants had a reason to disclose, and they anticipated a negative response (based on the course culture being implicitly stigmatising and/or there being a lack of trustworthy receivers) they were less likely to disclose.

Participant's feelings about disclosure were found to permeate all disclosure decisions; largely influencing disclosure. This is reflected by the blue shading in the figure. As displayed by the colour bar, feelings about disclosure lie on a continuum ranging from acceptance and comfort to shame and fear. Light blue shading reflects feelings of shame and fear, whereas dark blue shading reflects feelings of acceptance and comfort. Blue shading surrounds the model; showing that participants' feelings affect disclosure at all levels of the decision making process.

When participants felt shame in relation to their mental health experiences, and feared disclosure, they were less likely to disclose. Conversely, when participants felt acceptance in relation to their mental health experiences, and felt comfortable with disclosure, they were more likely to disclose.

A number of factors were found to influence participants' feelings about disclosure. When participants had positive past experiences of being open about their mental health; when the distress was a shared experience among the cohort; and when the trainee culture was characterised by openness, participants were more accepting of their mental health difficulties and more comfortable with disclosure. However when participants had negative past experiences of openness; when their distress was individualised; when the trainee culture was characterised by an 'unspokenness' about personal mental health experiences; when there was a lack of information about fitness to practice; and when participants held idealised views about clinical psychologists based on the recruitment pressure, psychology culture and societies views, they were more likely to feel shame in relation to their mental health difficulties and more likely to fear disclosure. The course culture also contributed to feelings about disclosure. When the course culture was experienced as implicitly stigmatising participants were more likely to feel fear and shame in relation to their mental health difficulties and disclosure. Whereas, when the course culture was experienced as supportive participants were more likely to feel acceptance and comfort in relation to their mental health difficulties and disclosure.

As described above, the presence (or absence) of a reason to disclose, along with the anticipated response, situational factors and the participants feelings about disclosure influenced whether participants disclosed and the type of disclosure they made. Disclosure fell on a continuum ranging from not disclosing; through to leaking information, reframing experiences, making a measured disclosure and being actively open. The response participants received to their disclosure influenced their future disclosure decisions. Positive responses to

disclosure instilled acceptance around mental health difficulties and comfort with disclosure, increasing the likelihood of disclosing again. Negative responses to disclosure instilled a sense of shame around mental health difficulties and fear of disclosure, reducing the likelihood of disclosing again.

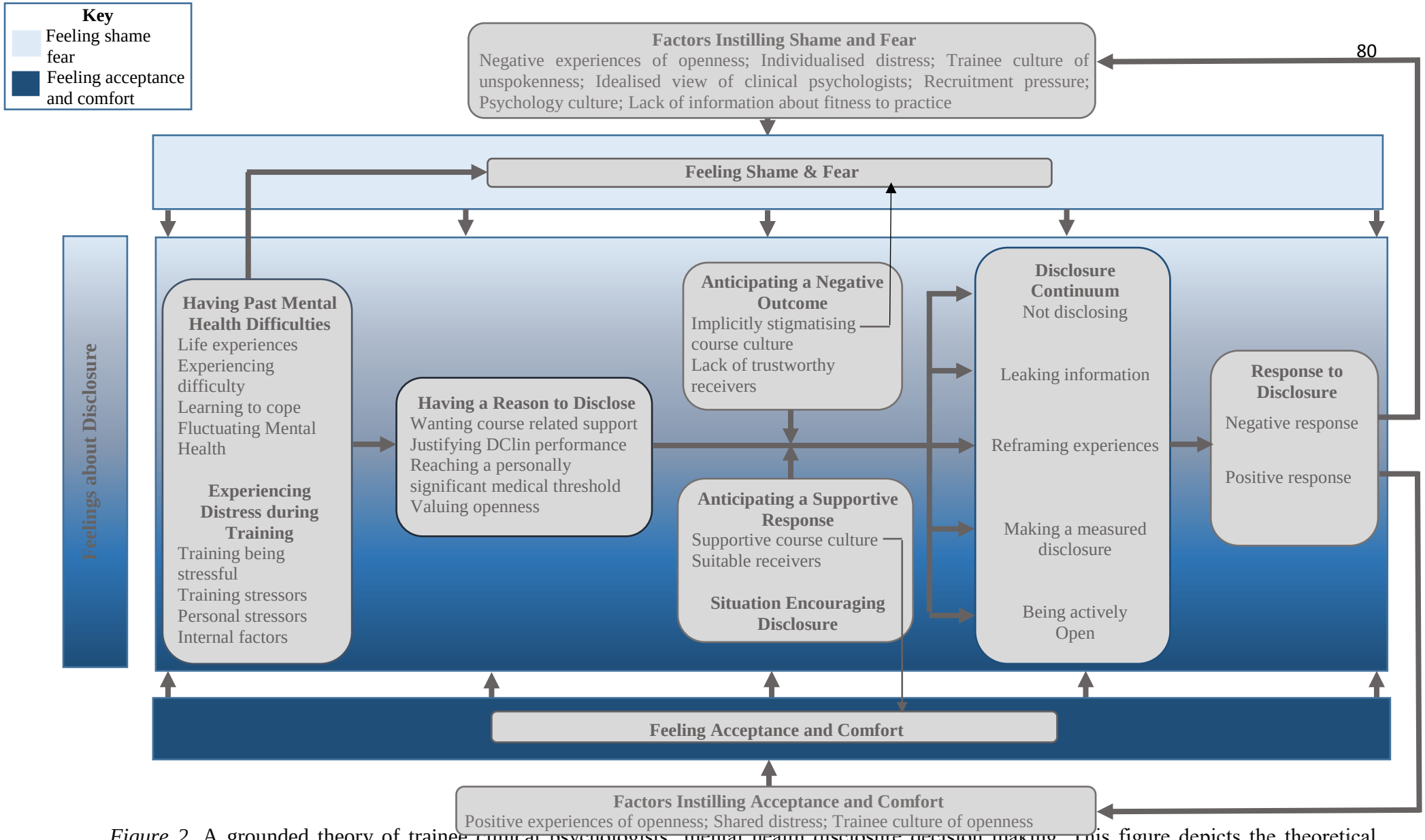

Figure 2. A grounded theory of trainee clinical psychologists' mental health disclosure decision making. This figure depicts the theoretical framework

Theoretical Categories and Subcategories

1. Having Past Mental Health Difficulties

Most participants described experiencing mental health difficulties before starting training. Four subcategories emerged relating to this theoretical category. These were: 'Experiencing Difficulty', 'Life Experiences', 'Learning to Cope' and 'Fluctuating Mental Health'.

1.1 Experiencing Difficulty

Participants described experiencing a range of mental health difficulties such as difficulties relating to anxiety, low mood, eating, obsessions and compulsions, relationships and coping styles. For example, Chris spoke about experiencing "depression" as a teenager, "it was to the point where I was miserable and there were occasions when I felt suicidal" (p. 1, 30-31).

1.2 Life Experiences

Participants' difficulties stemmed from various 'Life Experiences', such as discrimination, bullying, relationship break ups and family difficulties.

1.3 Learning to Cope

Participants used various coping strategies in response to their difficulties, including seeing their GP, taking medication, isolating and withdrawing, engaging in personal therapy and using psychological techniques.

1.4 Fluctuating Mental Health

This subcategory describes how participants saw their mental health as changeable; experiencing periods of difficulty, learning to cope, feeling better and different/similar difficulties re-emerging at different time points. For example, in relation to her difficulties with eating Hannah described "they're probably as resolved as they ever have been although they creep up from time to time and like something that I've kind of had since I was about 11 and kind of still going on today really" (p. 1, 12-14).

2. Experiencing Distress during Training

Participants described experiencing some form of distress or difficulty during training, which presented differently for different participants. Feelings of stress, anxiety and low mood were described, along with a sense of feeling overwhelmed.

2.1 Training Being Stressful

Participants described training as stressful and demanding, with limited time for self-care, particularly when facing additional challenges. This is illustrated by Sam:

> The course is, I didn't find it the most stressful thing I've ever done by a long shot but it is stressful and there are times when if you're struggling with other things actually you really don't have the reserves, it does get really difficult. (p.2, 54-56)

2.2 Training Stressors

Training stressors contributed to participants' distress during training, alongside personal stressors. Training Stressors included challenging supervisory relationships, difficulties on placement, discrimination, coursework, commuting and presentations.

2.3 Personal Stressors

Personal stressors contributed to participants' distress during training, alongside training stressors. Personal Stressors included relationship difficulties, traumatic experiences and family illness.

2.4 Internal Factors

In addition to personal and training stressors, participants explained that internal factors contributed to their stress and coping during training. For example, being attuned to their own distress, being perfectionistic and tendencies to strive or avoid.

3. Having a Reason to Disclose

Participants described four primary reasons for disclosing their mental health experiences. These were: ‘Wanting Course Related Support’, ‘Mental Health Affecting DClin Performance’, ‘Reaching a Personally Significant Medical Threshold’ and ‘Valuing Openness’.

3.1 Wanting Course Related Support

Numerous participants spoke about wanting support from course staff and/or their cohort when experiencing distress. This included practical support (e.g. time off training/work, problem solving, change of placement) and/or emotional support (e.g. reassurance, validation, normalising). This is described by Hollie: “I wanted her support and I wanted her to change something about my upcoming placement” (p. 7, 212-213). Jessica explained how she wanted to “share the burden” (p. 14, 407) through disclosing, “just by someone else hearing it I think I almost like wanted them to know because it made my like load a little easier” (p. 13, 390-391).

3.2 Justifying DClin Performance

When participants felt like their work or behaviour was affected by their mental health and others noticed [their altered performance], or there was a risk of others noticing, participants were motivated to disclose in order to justify their performance. For example, Hannah felt she should disclose in order to explain her behaviour at university to a tutor “my motivation to do that at least initially is feeling like I needed to explain myself a little bit” (p. 6, 161-162).

3.3 Reaching a Personally Significant Medical Threshold

Some participants explained that when their mental health met a certain threshold, they had a reason to disclose. This threshold was medically orientated (e.g. having a diagnosis, being prescribed medication) and was personally determined (e.g. one participant was motivated to

disclose after being prescribed medication, whereas another participant was not). Georgia explained "I needed someone to say this isn't ok for me to then and then get the medication to then feel like I have enough now to say ok there is something going on for me" (p. 19, 632-634). Emma delayed a diagnostic assessment until after completing her training, "I was afraid to go down that route and then I think because I felt like I would have to disclose if I had the formal diagnosis and … I didn't feel safe to do that." (Emma, p. 1, 77-79).

3.4 Valuing Openness

Participants spoke about valuing openness, for helping other trainees who were experiencing difficulty; to reduce the stigma around mental health difficulties; to increase connectedness with others; and as part of their role as reflective practitioners. This is described by Georgia:

> It then became about ok now I want to share my experience with other people so that they're able to kind of take take that, learn from it, use that and think about it in terms of their own experience as well. (p. 15, 498-500).

4. Anticipating a Supportive Response

When a participant had a reason to disclose, they were likely disclose if they anticipated a supportive response.

4.1 Supportive Course Culture

Participants had differing perceptions of their course culture; some spoke about their course culture being supportive. For example, "they are very supportive and open minded and they're really reflective and they really encourage that and they really practice what they preach that was my experience of them" (Lauren, p. 3, 121). When the course culture was perceived as supportive, despite any fears of disclosure, participants anticipated support and disclosed.

4.2 Suitable Receivers

Participants explained that when trustworthy, empathic people were available (either within the course team or their cohort) they felt more able to disclose in order to gain support, justify their performance, report their mental health experiences or in line with their values of openness. In relation to speaking openly with trainee friends Jessica explained "I think it is about that that they're trustworthy, they're not going to judge you. They might have a more similar mind-set to you because you've chosen them to be friends" (p.19, 556-558). Close trainee friends and trustworthy course staff or supervisors were often considered to be suitable receivers.

5. Situation Encouraging Disclosure

Participants were more likely to disclose if a relevant situation naturally arose. For example, during teaching sessions or conversations with other trainees that were related in some way to their mental health experiences, or during discussions with personal tutors. Steve talked about his mental health when relevant situations naturally occurred. "I didn't want to just bring that stuff up unless the right sort of time happened. So it could have been the right time never happened and then maybe I wouldn't of" (Steve, p. 24, 1112-1113). Other situations that encouraged disclosure included being asked about performance or a perceived risk of failing.

6. Anticipating a Negative Outcome

6.1 Implicitly Stigmatising Course Culture

Whilst some participants experienced their course culture as supportive, others described their course as being implicitly stigmatising. Some, described implicit 'them and us' messages, implicit suggestions that trainees should not experience mental health difficulties and a lack of support for trainees. For example:

> It's almost a sense of this more implicit judgement and this more implicit sense that people, trainees, aren't supposed to have mental health difficulties and that it might be a sign that they're not resilient enough to complete the training. (Jennifer, p. 16, 492-495).

When the course culture was perceived as implicitly stigmatising, participants did not feel safe to disclose, and thus they did not disclose, even if they had a reason to (e.g. wanting support).

6.2 Lack of Trustworthy Receivers

Some participants explained that during their training there was an absence of trustworthy, empathic people that were accessible. When this was the case, participants did not feel safe to talk about their experiences of mental health difficulties. For example, "I couldn't have talked to him about it. I had no trust in him whatsoever and it was so personal and um I really needed to talk to someone about it" (Sam, p.9, 327-328). The sense of whether someone was trustworthy, or not, appeared to depend on whether they would listen, understand, support, validate and maintain confidentiality or whether they would dismiss and blame the participant.

7. Feelings Affecting Disclosure

The findings of this study suggest that participants' feelings about disclosure lie on a continuum ranging from 'Feeling Shame and Fear' to 'Feeling Acceptance and Comfort'. Participants move along the continuum at different points in training, depending on factors such as the trainee culture, responses to openness and the course culture. Feelings about disclosure affected disclosure decisions.

7.1 Feeling Shame and Fear

A number of participants described a strong sense of shame relating to their difficulties; stigmatising, criticising and blaming themselves. Kate explained "the word that comes to mind

for me so strongly and throughout the whole process was shame" (p. 12, 369-370). Shame and self-stigma generated a sense of feeling not good enough; this created fear and inhibited disclosure. Considering her sense of shame, Jennifer described, "that almost made it impossible for me to talk about it because that would of just been admitting some fault of mine" (p. 13, 400-401).

The majority of participants feared disclosure. Lauren explained "It felt yes really very scary" (p. 19, 928). Participant's described fears of judgement, such as "incompetent" (Hannah, p. 10, 306; Lucy, p. 6, 208); "I wouldn't be good enough as a as a clinical psychologist" (Emma, p. 9, 405) and "not coping" (Lucy, p. 6, 207). Some participants feared that, by disclosing their mental health difficulties, a narrative would be created of them as a problem trainee. A number of participants described fears of disclosure negatively impacting on their trajectory through clinical psychology training, "I think the major factor erm in not disclosing… is about as not wanting to be seen as incompetent and not wanting anything to affect your trajectory through training" (Hannah, p. 10, 304-306).

Feelings of fear and shame inhibited disclosure. For example when participants experienced shame and fear, seeking support from the course was not seen as a workable option and alternative coping mechanisms were utilised, where possible.

7.2 Feeling Acceptance and Comfort

Accepting one's own mental health experiences and feeling comfortable with disclosure increased participants' likelihood of disclosing. Two participants described feeling acceptance and comfort in relation to their mental health difficulties. For example, "I would happily talk about it with anyone" (Steve, p. 9, 418).

Whilst some participants initially experienced fear and shame about their mental health experiences, they became more accepting and comfortable with disclosing after receiving a positive response to disclosure.

8. Factors Influencing Feelings about Disclosure

Participants' feelings of shame and fear or acceptance and comfort were influenced by a number of factors. These are described in the following sub-categories.

8.1 Experiences of Openness

A number of participants had been open about their mental health within the work environment, either before or during training. Some participants had not been open about their own experiences but had been exposed to other trainees being open about their mental health.

Positive experiences of openness, entailing validation and normalising, engendered a sense of personal acceptance. Steve had positive experiences of being open prior to training, "I had the learning of, if you're having difficulty you need to be open and talk about it that's how you'll actually be able to do something about it and figure stuff out" (p. 7, 299-301, Steve).

Experiences of being dismissed and pathologised, led to shame and fear around disclosing. Hannah was open about her mental health with her colleagues in the past, however, after having her competence and emotional resilience questioned she became more guarded, "I became erm extremely guarded and I just didn't talk about it at all erm and that's had anybody asked me… I probably would of just completely denied it, in the work place" (p. 14, 422-424).

8.2 Individualised or Shared Distress

Experiencing distress shared by trainees (such as that related to completing the thesis) was more normalised, reducing fear and shame. For example, "I'm very happy talking about my emotional distress and I suppose exposing myself in that way when that fears gone, when the shame has gone…when it's a shared experience" (Jennifer, p.13, 386-389).

However, when distress was individualised, for some participants, feelings of shame and fear were elicited. For example, "when it becomes something that's less common … that's

when it starts getting difficult to talk about… it becomes something that's seen as different or other" (Lucy, p. 14, 484-486).

8.3 Trainee Culture

Participants spoke about the trainee culture influencing their thoughts and feelings around disclosure. When the trainee culture was characterised by 'unspokenness', whereby trainees did not talk about their own emotional experiences, participants felt shame around their own difficulties and feared disclosing. For example, "I was ashamed that I was anxious erm I felt there was a sense in the cohort because it was unspoken and yet you could feel it everywhere and I and I don't just think it was me" (Kate, p. 6, 160-161).

Conversely, when other trainees were open about their own mental health, a more open culture among trainees was encouraged; "it was part of the culture of our cohort to like talk in that way" (Hollie, p. 6, 245).

8.4 Idealised Perceptions of Clinical Psychologists

When participants held idealised perceptions of psychologists being a certain way (i.e. without mental health difficulties) they experienced shame about their own difficulties and feared disclosure. Talking about the perception she developed of clinical psychologists, based on her course's portrayal, Emma said: "I felt like you know at some level to be you know gosh a clinical psychologist almost like erm pedestal type scenario where you are the epitome of wellness" (p. 7, 299-300). Perceptions of clinical psychologists seemed to stem from recruitment pressure, perceptions of the culture within psychology and societal views. These were considered further subcategories within the category 'Factors Impacting on Feelings about Disclosing', which specifically caused shame and fear around disclosure.

8.5 Recruitment Pressure

A number of participants spoke about the DClin selection process creating competitiveness, pressure and expectations around needing to be 'resilient', 'perfect' and academic. In turn,

being unable to meet those standards (in part due to their own mental health experiences), led participants to feel like an imposter and created anxiety. For example:

> there is so much pressure at the recruitment stage to be perfect being you know resilient and erm academically developed and all these because it's so erm competitive… so then you almost have to keep up this pretence you know because nobody is perfect but the worry that we're all imposters. (Jennifer, p. 10, 298-304).

8.6 Psychology Culture

Participants identified a lack of openness within the profession. There was a sense that the wider psychology culture gives a message that trainees need to be 'resilient', 'robust' and in perfect mental health. Talking about a lack of openness within the profession, Sam said "there's a kind of, almost a sense that you have to be really robust and you know mentally on it, otherwise ya know, you're not gonna be a good psychologist" (p. 18, 686-688, Sam).

Although a lack of openness within the profession was recognised, participants identified that this was changing. Lucy, for example, described "it feels like there is almost like a movement happening where people are going psychologists experience mental health difficulties and that's ok and it does feel quite new" (p. 19, 651-652).

8.7 Societal Views

Some participants spoke about society expecting psychologists to be a certain way, i.e. robust, resilient and in perfect mental health. Viewing society's expectations in this way appears to instil a sense of shame about personal experiences of mental health difficulties and a fear of disclosure:

> I think there's a bit of a view that you should be able to manage everything yourself you don't get stressed, you don't get x, y and z you should just be, you're not human you're kind of like you're able to do all your mind reading all the time … and that you shouldn't be vulnerable to struggling with your own stuff … I saw it was I should just be able to figure this out and sort if out myself erm felt a bit of a failure that I wasn't able to. (Georgia, p. 22, 714-720).

8.8 Lack of Information about Fitness to Practice.

This subcategory reflects how when participants do not fully understand the relationship between fitness to practice and mental health, they are more likely to fear disclosure. Emma spoke about how, at the time of training, BPS and HCPC guidelines instilled a sense of fear around disclosing mental health difficulties. For some participants, the relationship between fitness to practice and mental health was not discussed openly in their training programme:

> Do you know what's really funny though is like the difference between now and then is I feel like I'm really clued up erm with the HCPC… I think if I'd had that depth of understanding… then erm maybe it might of it might of helped me be less fearful about disclosing (p. 27, 1255-1272, Emma).

9. Disclosure Continuum

Disclosure appears to be a dynamic construct; with different levels of disclosure occurring at different time points in training. Participants spoke about different levels of disclosure ranging from 'Not Disclosing'; 'Leaking Information'; 'Reframing Experiences'; 'Making a Measured Disclosure' and 'Being Actively Open'. When checking the idea of the 'Disclosure Continuum' with Georgia (after this category had emerged from the data'), she explained:

> I think I was very much in the kind of active non disclosure for quite a long time … and then the next step was then kind of making I guess in terms of the course yes active disclosures...yes to certain people… and then eventually it became quite open about it. (p. 15-16, 513-516).

9.1 Not Disclosing

This involved trainees not sharing information about their experiences of mental health difficulties. Two participants had not disclosed to anybody over the course of training. For some, not disclosing involved an element of concealing. Emma and Hollie actively concealed their difficulties when taking time off work relating to their mental health; providing a physical reason which they deemed would be more acceptable. For example, "I still took the odd day off here and there for times when I just couldn't face going into work or whatever but like I'd just put a physical health reason instead" (Hollie, p. 8, 382-383).

9.2 Leaking Information

This involved trainees inadvertently revealing information about their mental health or distress, usually through behaviour. For example "I don't recall ever sitting down very kind of meaningfully and saying these are the difficulties I have and these, this is the way that it affects me. I think it probably erm psychologically and verbally kind of leaked" (Hannah, p. 5, 144-146).

9.3 Reframing Experiences

Some participants shared information about their mental health, but reframed the experience. Trainees described reframing experiences when they feared disclosure; reframing in a way that they deemed would be more acceptable to the other person. For example, "I would basically

tell them I was struggling but without naming that I feel like I have anxiety or I'm struggling with OCD" (p. 1, 63-64, Lucy).

9.4 Making a Measured Disclosure

This involved trainees sharing some details about their mental health to certain people. Most participants who disclosed spoke about making a measured disclosure. They talked about their mental health difficulties but limited the detail, or spoke about current experiences of distress but not past difficulties. For example, Chris, spoke about giving a "nutshell" (p. 13, 464) version of his difficulties when talking to his tutor.

9.5 Being Actively Open

This involves trainees being indiscriminately open about their mental health experiences and not concealing aspects of their mental health experiences. One participant (Steve) was actively open throughout his training. Whilst Steve took an open approach to talking about his mental health, he had rules around disclosure, "So sort of my approach was is that I'm quite open about it if it comes up and it's relevant to that situation or if people ask me about it I'm happy to talk about it" (p. 5, 219-220).

Participants' level of shame and fear or acceptance and comfort, along with the presence of a reason to disclose and the anticipated response/ the situational context, influenced where they fell on the disclosure continuum. Some participants remained at fixed points on the disclosure continuum throughout training. However, most participants moved along the continuum, becoming more or less open, at different times in training.

10. Response to Disclosure

Other people's response to participants' disclosure determined participants' feelings about disclosure (shame, acceptance, fear, comfort) and thus, determined where they moved along the disclosure continuum.

10.1 Negative Response

Participants who had received a dismissive, blaming, unsupportive or even discriminatory response to their disclosures became more guarded with the information they shared. Sam, Jennifer and Hollie all had negative experiences of being open about their mental health during training; feeling dismissed, unheard and misunderstood. This led to reduced openness with the original receiver, for example "after that experience with my clinical tutor where I felt a bit dismissed and not heard… I was more discerning after that and I didn't go to him with those sorts of difficulties" (Jennifer, p. 26, 791-792).

10.2 Positive Response

Participants who had received a supportive, normalising, validating and calm response to disclosure became more accepting and less fearful, encouraging them to disclose again. For example, "one of the things that, that I just generally got from, I think, the course, and my tutors and my cohort as well was actually just a lot of validation … and I think that, more than anything else just really helped me" (Chris, 9.12, 426-430).

As described above and depicted in the model, the 'Response to Disclosure' during training fed back into disclosure decisions through 'Experiences of Openness'. Positive experiences of disclosure during training led to increased acceptance and comfort; increasing the chances of future disclosure. Negative experiences of disclosure during training led to increased shame and fear; limiting the likelihood of future disclosure.

Discussion

The aim of this study was to develop a theoretical framework to describe trainee clinical psychologists' decision to disclose, or not disclose, their own mental health difficulties during clinical training. Twelve recently qualified clinical psychologists were interviewed about their experiences of mental health disclosure during training. Data were collected and analysed in accordance with grounded theory methodology (Charmaz, 2014); a theoretical framework was developed, describing the decision making process. When participants had a reason to disclose

they were motivated to do so. However, whether or not they disclosed depended on the anticipated outcome and whether the situation encouraged disclosure. Participants' feelings largely affected disclosure decisions; fear and shame inhibited disclosure. All of these factors impacted where participants fell on the 'Disclosure Continuum'.

The findings of the current study are supported by the broader literature into mental health disclosure. Consistent with the finding that fear and shame deter trainees from disclosing, previous research has shown than fear of stigma and discrimination inhibits disclosure of mental health difficulties within the workplace (Brohan, 2012; Moll et al., 2013; Toth & Dewa, 2014) and outside of the workplace (Grice et al., 2018). Within the current study, four reasons for disclosing were identified. These were: valuing openness, to gain practical and emotional support, to justify performance on the training programme and reaching a personally significant medical threshold. The broader literature shows that people disclose mental health problems in the workplace for similar reasons. For example, in order to be open, to help others and to challenge stigma (Toth & Dewa, 2014); to gain support or adjustments (Brohan et al., 2012; Toth & Dewa, 2014); and to explain their behaviour (Brohan, 2014; Moll et al., 2013). Similar to the current findings, past experiences of openness (Brohan, 2012) and the interpersonal (e.g. personal characteristics of the receiver) and work (culture of the workplace) conditions affect disclosure decisions (Toth & Dewa, 2012).

Disclosing after reaching a personally significant medical threshold, was a particularly novel finding, which has not been highlighted in previous research regarding mental health disclosure in the workplace, including by mental health professionals. This finding is surprising given that trainee clinical psychologists tend to value psychosocial, rather than biological, perspectives on mental health difficulties (Read, Moberly, Salter & Broome, 2017). The threshold being both medically and personally determined perhaps reflects the diversity within

the profession in relation to beliefs about the medical model of mental health difficulties and understanding about policy in relation to mental health disclosure.

The results of this study show that similar processes underlie decisions to disclose to different course related personnel, e.g. course staff, supervisors and fellow trainees. During the interviews, the researcher collected information about participants' reasons for disclosing to different people. The resultant analysis demonstrated that similar factors influence trainees' decisions to disclose to other trainees, supervisors and course staff. As a result, one decision-making model was developed for disclosure to all course related personnel, rather than producing disaggregated models of disclosure.

Participants experienced a range of mental health difficulties before starting their training. Distress was commonly experienced during training; stressors related to training were often cited. This is consistent with previous research which has demonstrated that stress and mental health difficulties are commonly experienced during DClin training (Cushway, 1992; Grice et al., 2018a). Within the current study, participants described training as stressful and demanding. Understandably, when faced with additional challenges, trainees may struggle to cope. Accessing support from course staff, supervisors and other trainees appears to be one way of coping, although this requires some form of disclosure.

The current study suggests that disclosure lies on a continuum; ranging from 'Not Disclosing', through to 'Being Actively Open'. Some participants did not disclose to anyone related to their training programme, whereas others spoke openly about their mental health when relevant situations arose. The idea that disclosure lies on a continuum has been discussed in previous research (Brohan et al., 2012; Corrigan & Matthews, 2003). Corrigan and Matthews (2003) suggested there are five different levels of mental health disclosure: social avoidance, secret, selective disclosure, in-discriminant disclosure, and broadcasting. Whilst this did not apply to trainee mental health disclosure specifically, the concepts of 'secret', 'selective

disclosure' and 'in-discriminant disclosure' appear to map on to 'Not Disclosing', 'Making a Measured Disclosure' and 'Being Actively Open' within the current study. Similarly, in a systematic review of disclosure in the workplace, Brohan et al. (2012) concluded that there are four dimensions to disclosure. Their concept of 'Inadvertent Disclosure', involving accidentally disclosing, appeared to be akin to 'Leaking Information', within the current study. The current research adds to the literature pertaining to mental health disclosure existing on a continuum, rather than being a binary construct.

The level of shame and fear or comfort and acceptance participants felt surrounding disclosure seemed to underlie all disclosure decisions. This is consistent with the findings of Tay el al. (2018), which demonstrated that shame and fear discouraged clinical psychologists from disclosing. The potential for negative judgement, disclosure impacting on career and a negative impact on self-image were important factors in disclosure decisions (Tay et al., 2018). Similarly, fear has been found to inhibit clinical psychologists' self-disclosure within supervision (Spence, Fox, Golding, Daiches, 2012). Within the current study, fears of judgement, dismissal from the training programme and creating a problem narrative were described by participants. Shame and self-stigma around personal mental health experiences deterred disclosure. Some participants felt as though they should not experience mental health difficulties as a trainee psychologist and they criticised and blamed themselves for their experiences of distress. Fear and shame were exacerbated by a number of factors, including perceptions of clinical psychologists.

Participants described discrepancies between their experiences of mental health difficulties or distress and their perception of how a clinical psychologist should be. This is consistent with previous research, which has revealed a perception of the 'ideal' clinical psychologist; psychologists feel inferior when they are unable to live up to this ideal (Aina, 2015; Charlemagne-Odle et al., 2014). Aina (2015) found that clinical psychologists'

perceptions of the idealised psychologist was one of being professional, neutral and detached. Within the current study, participants often used the words ‘resilient’ and ‘robust’ to describe how they believed they should be, as trainees. This perception was, in part, created by the challenging DClin selection process. Galvin and Smith (2017) found that the process of applying and gaining a clinical psychology training place was reported as one of the most stressful aspects of pre-qualification clinical psychology. The process of getting on to clinical psychology training has been described as “long and precarious” with competition being “intense” (Williams, 2001). This arduous process seems to instil a sense of needing to be robust and resilient in trainees. Needing to live up to such ideals, particularly when experiencing distress, unsurprisingly creates anxiety.

Participants in this study described how a lack of openness within the profession influenced their thoughts and feelings about their own mental difficulties and disclosure, and their perception of clinical psychologists. Similarly, Tay et al. (2018) suggest that the culture within the broader mental health workforce may lead mental health professionals to believe they should be psychologically resilient and able to cope, resulting in feelings of weakness when they are struggling and feeling distressed.

A number of participants had not been exposed to supervisors, lecturers or course staff who modelled acceptance and openness about personal mental health experiences. A lack of openness within the profession could be detrimental to trainees’ perceptions of themselves (as future clinical psychologists with experiences of mental health difficulties) and their willingness to disclose their own mental health experiences and access help. Students struggling with their mental health may be more willing to seek help in an environment where disclosure is modelled and supported (Buchholz, Aylward, McKenzie, & Corrigan, 2015). Within the current study, those participants who had been exposed to clinical psychologists

who role modelled openness, found an increase in their sense of personal acceptance of their own mental health difficulties.

Despite lacking exposure to role models during training, a number of participants noticed ‘a movement’ occurring more recently, particularly on social media. They noticed open discussions about psychologists’ lived experience taking place. Given the apparently detrimental effects of a lack of openness within the profession (creating a sense that clinical psychologists do not experience difficulties), this movement provides hope for creating a more open culture within clinical psychology training. Corrigan & Wassel (2008) suggests that, the more people are open about their mental health experiences, the more stigma is challenged. Increasing access to role models may be one way of reducing self-stigma. In addition, some research has shown that self-compassion reduces the self-stigma of help seeking (Heath, Brenner, Lannin, & Vogel, 2018).

The finding that one of the primary reasons for disclosing was to access support is consistent with previous research into disclosure in the workplace (Brohan et al., 2012). Some participants felt their course culture was supportive, and empathic listeners were available; this enabled them to disclose and access support. It is concerning that, despite wanting practical and emotional support, some participants did not disclose because they perceived that the required support would not be provided. Some participants felt that their course was implicitly stigmatising; endorsing a ‘them and us’ culture and not supporting or acknowledging trainee mental health.

It needs to be acknowledged that UK clinical psychology training programmes may not be aware of how their culture is perceived, so their intention may not be to stigmatise. However, more needs to be done to create a culture of openness and support around trainee mental health across UK DClin programmes. Trainee clinical psychologists are NHS employees who are being trained to work in the NHS. Consistent with the BPS’s commitment to inclusivity and

NHS staff wellbeing initiatives, it is important that trainees feel able to access support around their mental health, when needed, and to access this without fear of stigmatisation.

The current study highlights a need for more guidance from professional and regulatory bodies in psychology in relation to supporting staff wellbeing and mental health. The GMC provides a national framework for supporting medical students with mental health difficulties (GMC, 2015). These guidelines are designed for medical schools, medical students and those involved in postgraduate medical training. There is an absence of such guidance in the training of other healthcare professionals, such as nurses, social workers and clinical psychologists. However, the BPS provides good practice guidelines for clinical psychology training and disability, which encompasses mental health difficulties.

The GMC guidelines highlight the importance of normalising mental health problems in medical students and creating an open environment, in order to reduce stigma. It is recommended that mental health is explicitly normalised and openly discussed throughout medical training. Students are encouraged to seek help for their mental health; the GMC states that students should be supported and advice is given as to how this should be done. The issue of fitness to practice is clearly discussed, including what should happen if this should come into question. As well as supporting students with mental health difficulties, the guidelines highlight the importance of promoting wellbeing among students, and offers examples of ways this can be achieved (GMC, 2015).

This research has highlighted that some trainees experience a negative response to disclosure, feeling dismissed and discriminated against. Responses to disclosure seem to largely affect trainees' thoughts and feelings about their own mental health and future disclosure. Normalising and validating trainees' mental health is important for increasing personal acceptance and creating an environment where it feels safe to talk about personal mental health experiences.

This study has the potential to influence mental health service users. In order to support trainee clinical psychologists' mental health disclosures, a number of recommendations have been made. Research has shown that concealing a stigmatised identity (e.g. a mental health difficulty) can negatively impact on an individual's level of preoccupation, suspiciousness, anxiety, shame and impression management (Pachankis, 2007), as well as limiting opportunities for workplace adaptations (Toth & Dewa, 2014). Conversely, disclosing personal information can reduce distress and depression (Frattaroli, 2006); and increase life satisfaction, self-esteem (Halpin & Allen, 2004) and an individual's sense of personal empowerment (Corrigan et al., 2010). Therefore, finding ways to enable trainees to disclose could increase their sense of personal empowerment and self-esteem, as well as reducing any feelings of shame, preoccupation, anxiety and suspiciousness. This has the potential to have positive implications for trainees' work with clients, although this needs to be supported by empirical research. In addition, researchers suggest that being open about mental health difficulties challenges public stigma. Therefore, supporting trainee clinical psychologists to be open about their mental health experiences could challenge public stigma around mental health.

Strengths

This is the first study to explore, in-depth, the factors underlying trainee clinical psychologists' decision to disclose their own mental health difficulties during clinical psychology training. The findings reflected many similarities to the literature relating to mental health disclosure in the workplace. The study also introduced novel findings, particularly in relation to personally significant medical factors influencing disclosure decisions and the importance of understanding rules around fitness to practice for reducing shame and fear. A new model for understanding the processes underlying trainees' mental health disclosure decision making, has been developed.

This study contributes to the developing research into the mental health of trainee clinical psychologists, as well as that of the wider mental health workforce. The importance of the research topic was noted by many of the research participants. An explanatory model has been developed, describing trainees' decision making as to whether, or not, to disclose their own experiences of mental health difficulties. This model clearly identifies trainees' reasons for disclosing; factors that encourage disclosure and factors that deter trainees from disclosing. Understanding these factors provides an opportunity to implement change. A number of recommendations have been made to help foster a more supportive culture within clinical psychology training, which enables trainees to talk about their mental health experiences, should they wish to.

The active role of the researchers within clinical psychology training were seen as a strength of the research as well as a potential limitation. Their reflexive stance is considered a particular strength of the research. Documenting personal reflections; holding in depth reflective discussions during research meetings and considering their role in the research process throughout brought awareness to the researchers' preconceptions and enriched the research process. For example, by stimulating further lines of enquiry, questioning assumptions and formulating the implications of the research.

A further strength of the study was the recruitment strategy. By recruiting from across the UK, the researcher was able pursue lines of enquiry which emerged through the analysis and to recruit participants with different experiences of training and disclosure.

Limitations

There are some limitations to this study. Some participants struggled to remember specific aspects of their disclosure decision making; this may have impacted on their ability to recall information relevant to the study. Whilst this is considered a limitation, there was a clear rationale for including recently qualified clinical psychologists in the study.

A number of participants spoke about a recent shift in the culture, involving increased openness, around clinical psychologists' mental health. Whilst this 'shift' in culture reflects a positive change, it may mean that current trainees have a different context to their disclosure decision-making than the participants in this study. However, it is likely that the model of disclosure and the factors involved in disclosure are likely to remain the same, but with, perhaps, an increased sense of acceptance and comfort with disclosure, if a more open culture is experienced.

Whilst there were clear reasons for not collecting demographic information, this is considered a limitation. Collecting demographic information, such as participants' age or DClin programme, may have stimulated further lines of inquiry during interviews and analysis. However, information participants provided within the interview did not suggest that this information would have increased the researchers' understanding of their mental health disclosure decision making. A further limitation was that there was a lack of ethnic diversity within the sample.

Although validation checks were completed, through multiple coding and checking the emerging framework with an independent researcher, further validation checks could have been completed. For example, the researcher could have returned to the original participants and gained their feedback on the model.

The current research was conducted as part of a DClin programme, for the primary researcher's doctoral dissertation. This can be seen as a strength and limitation of the research. Although a number of participants described feeling safe and comfortable talking about their experiences within the interview, the primary researcher's status as a trainee may have affected what participants were prepared to say in the interview.

Participants self-identified as having experienced mental health difficulties before or during their clinical psychology training. A definition of mental health difficulties was not

provided as the research was aimed at capturing experiences which participants felt were significant enough to identify as 'mental health difficulties', rather than being determined by a diagnostic threshold. Whilst this means the research captures personally significant experiences of distress, a limitation is that the research reflects broad, subjective, definitions of 'mental health difficulties'. This may also mean that people who have had particular mental health experiences, who do not identify with the term 'mental health difficulties' did not participate in the research. Similarly, a definition of disclosure was not provided and so this research reflects broad, subjective definition of disclosure.

Language. Over the course of the research process, the researchers reflected on the use of the word 'disclosure'. Some participants naturally used the words 'share' or 'tell', rather than 'disclose'. To understand how the word 'disclosure' was received, the primary researcher asked participants about this term. A number of participants felt that 'disclosure' had negative connotations, implying something shocking and secretive. However, participants noted that the use of the word disclosure did not seem negative in the interview and they recognised the need for using certain language to covey ideas. Most participants preferred the term 'share' as this is a more neutral term and conveys a mutual process.

Deconstructing the word disclosure, the Oxford English dictionary defines the word disclosure as "The action or fact of disclosing or revealing new or secret information" ("Disclosure" 2018). Using the word 'disclosure' may therefore imply the disclosed material is typically kept secret. Within psychology, the word disclosure is often used when describing the process of reporting abuse (e.g. BPS, 2016). More broadly, 'disclosure' is used to in relation to reporting crimes (e.g. Crown Prosecution Service, 2018).

The researchers recognise the possibility that they may have been inadvertently stigmatising, through the use of the word 'disclosure'. It is recommended that future research and discussions in this area should consider using the more suitable language of 'share'.

Recommendations for Training and Practice

In light of the findings of this study, a number of recommendations are made. These particularly relate to the finding that trainee clinical psychologists often experience fear and shame around disclosing their own mental health difficulties during training. More needs to be done to create and sustain culture of support, openness and sharing, where trainees feel free to discuss their own mental health without shame or fear.

This research highlights the need for DClin programmes to make their views on the mental health of trainees explicit and to understand the culture within their own programme. It is recommended that DClin programmes openly acknowledge and discuss mental health difficulties in clinical psychologists and trainees; their views and responses to this; and available support. This may include teaching on 'the wounded healer' (Jung, 1995) and the myth of untroubled therapist (Adams, 2014) in order to develop similar narratives for trainees. In addition, initiatives such as HOP-MHP (Mills & Scior, 2017) are welcomed.

The DClin selection process appears to create pressure and expectations around needing to be 'resilient'. It is important for DClin programmes to also be clear with trainees that they are 'selected' as much for their personal qualities and experiences as for academic excellence. It is particularly important that this narrative is developed at the outset of training. Teaching on different models of resilience may also help instil a sense that resilience does not imply the absence of distress.

Given that it was found that trainees' experiences of support varied across programmes, a national framework for supporting trainee mental health is needed. It is recommended that the BPS develops specific guidelines on supporting the mental health of trainees, to ensure consistency across programmes and transparency around fitness to practice. It is important for DClin programmes to be explicit about the relationship between mental health and fitness to practice.

Training programmes need to find ways to support the mental health of trainees, given that clinical psychology training is often experienced as stressful and demanding. Some courses deliver Mindfulness Based Stress Reduction ([MBSR] Kabat-Zinn, 2013) programmes within spaces set aside specifically for the personal and professional development of trainees. This may be one way of supporting trainee mental health and wellbeing. Considering that self-compassion has been found to reduce self-stigma associated with help seeking, it is recommended that discussions/interventions around self-compassion are integrated into clinical psychology training.

In addition, it is suggested that clinical psychologists and aspiring clinical psychologists, who feel comfortable doing so, should consider modelling openness around their own mental health. This will hopefully create a more open and supportive culture within clinical psychology training, and alter the perception of how an 'ideal' clinical psychologist should be. Finally, it is hoped that, as trainees, we can afford ourselves and other people, kindness and compassion in recognising and responding to distress as part of the human experience.

Future Research

Future research should focus on understanding DClin programmes' attitudes towards trainees with mental health difficulties. This should involve exploring staff attitudes towards trainees with mental health difficulties and understanding staffs' concerns about hearing trainee disclosures.

Given that some participants described idealised perceptions of clinical psychologists being without mental health difficulties, future research into how service users, psychologists and members of the general public view the 'ideal' clinical psychologist is warranted. In addition, a more detailed understanding of the relationship between the DClin recruitment process and how trainees/aspiring trainees view themselves, as future clinical psychologists, is

needed. Having a more detailed understanding of this process may help generate ideas as to how to reduce the impact of the recruitment process on trainees' perceptions of themselves as future clinical psychologists.

Future research should also focus on evaluating interventions which are aimed at reducing distress, mental health difficulties, and self-stigma in trainee clinical psychologists, such as MBSR, compassion focused interventions and self-help initiatives (e.g. HOP; Mills & Scior, 2017). It may also be useful to quantitatively measure the effects of disclosure on training performance and trainee's levels of distress and to understand the relationship between fitness to practice and trainee wellbeing.

Summary

This study aimed to understand the factors involved in trainee clinical psychologists' decision to disclose, or not disclose, their own experiences of mental health difficulties during their clinical psychology training. Clinical psychologists were interviewed about their experience of disclosure during their clinical psychology training. A grounded theory approach to data collection and analysis was used, and a decision making model was developed. The model shows that trainee mental health decision making is a fluid process that relies on multiple factors, including whether to trainee has a reason to disclose, the anticipated response to disclosure, situational factors and feelings about disclosure. The model emphasises the importance of: fostering an open and supportive environment in clinical psychology training; eliminating shame about personal experiences of mental health difficulties and fear of disclosure; and ensuring trainees receive a validating and normalising response to disclosure. These factors are likely to enable trainees to disclose their mental health experiences, should they wish to.

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Appendix A

Training and Education in Professional Psychology Author Guidelines

Manuscripts
Manuscripts should be approximately 25 pages in length in total including tables and references (more pages must be strongly justified).
Each manuscript should conclude with a specific section on the implications of the research or theory presented.
Manuscripts should be written with the goal of enhancing the practice of education, training, and supervision.

Manuscript Preparation
Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).
Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Abstract and Keywords
All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References
List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:

Figures
Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

Appendix B

Comparison of Malpass's (2017) and the Current Systematic Review

	Malpass (2017)	**Current Systematic Review**
Databases Searches	Scopus; PubMed; EBSCO	CINAHL; psychINFO; Scopus, Web of Science; Discover
Additional Searches	Backwards referencing	Forwards and backwards referencing; Google scholar searches; grey literature searches
Search Terms	PT; Therapy; Clinical Psychologist; Trainee; Trainee Clinical Psychologists; Psychologists in Training; Counselling Psychologists; Reflective Practice, Personal and Professional Development.	"personal therapy" OR "personal-therapy" AND psycholog*
Inclusion Criteria	Peer reviewed; relevant to current research, available in English, UK based trainee clinical psychologists included, trainee clinical or counselling psychologist participants and that data from this group can be distinguished from other professional groups.	Studies that primarily explore the impact of personal therapy on trainee clinical and/ or trainee counselling psychologists; studies recruiting trainee clinical psychologists, trainee counselling psychologists, qualified clinical psychologists or qualified counselling psychologists (if the research is considering their experiences during their psychology training), participants must have some experience of personal therapy during training; qualitative studies or mixed methods studies with a relevant qualitative component.
Exclusion Criteria	Non peer reviewed; not relevant to current research; no available in English, non UK based participants in the study; unclear if participants were trainee clinical or counselling psychologists or difficult to distinguish this data from other professional groups.	Studies which do not recruit trainee clinical psychologists or trainee counselling psychologists on the formal training route to becoming qualified, studies which recruit qualified clinical psychologists and qualified counselling psychologists, if the research is regarding their experiences post-qualification; studies utilising a purely quantitative methodology; studies that do not utilise an empirical/scientific research methodology;

Appendix C

Quality Assessment

Study	Was there a clear statement of the research aims?	Is qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Avis (2010)	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes	Yes	Yes
Graham (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Grimmer & Tribe (2001)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Ivey & Waldeck (2014)	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes	Yes	Yes
Kumari (2011)	Yes	Yes	Yes	Can't Tell	Yes	No	Yes	Can't Tell	Yes	Yes
Malpass (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nikolopoulou (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wilson, Weatherhead & Davies (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix D

The Journal of Clinical Psychology Author Guidelines

Format . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the ***Journal of Clinical Psychology*** utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote . EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal:* If you already use EndNote, you can download the reference style for this journal. *How to Order:* To learn more about EndNote, or to purchase your own copy, click here . *Technical Support:* If you need assistance using EndNote, contact endnote@isiresearchsoft.com , or visit www.endnote.com/support .

Title Page . The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:
Objective(s): Succinctly state the reason, aims or hypotheses of the study.
Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.
Results: Succinctly report the results that pertain to the expressed objective(s).
Conclusions: State the important conclusions and implications of the findings.

Appendix E

Interview Schedule

I am going to be asking you some questions about your experiences of mental health difficulties and what factors affected your decision to disclose your mental health difficulties during clinical psychology training.

As outlined in the information sheet the interview will take approximately one hour. Some people find talking about their mental health difficult. If you would like a break from the interview or if you would like to terminate the interview please let me know and this will be facilitated.

Is there anything you would like to ask or comment on before we begin the interview?

1. I would like to begin by asking you about your mental health difficulties. Can you tell me about your mental health history?

   Follow up questions:

   - *When did you begin to experience mental health difficulties'?*
   - *Were your mental health difficulties a single episode, continuous or remitting?*
   - *What were the nature of your mental health difficulties?*
   - *How severe would you consider your mental health difficulties to have been?*
   - *How was your mental health when entering clinical psychology training and over the course of clinical psychology training?*

The following questions relate to disclosure of your mental health experiences to course related personnel, such as course tutors, your personal tutor, supervisor, peer group and admin staff.

2. Did you disclose your history of mental health difficulties at any point during clinical psychology training?

If yes:

3. Can you tell me about disclosing your mental health difficulties during clinical training

   Follow up questions:

   - *Who did you disclose to?*
   - *In what forum did you disclose?*
   - *Was your disclosure planned or spontaneous?*
   - *At which point during clinical psychology training did you disclose?*

4. What were your reasons for disclosing your mental health difficulties?
   - Were there any other reasons?

5. Did anything deter you from disclosing your mental health difficulties?

   Follow up questions

   - Did anything prevent you from disclosing your mental health difficulties sooner than you did?

6. What happened following your disclosure?

   Follow up questions:

   - How did you feel having disclosed your mental health difficulties?
   - How did the person receiving your disclosure respond?
   - Where there any benefits, short and long term, to disclosing?
   - Were there any negatives, short and long term, to disclosing
   - Did you disclose again, why?

7. Did you disclose your mental health difficulties to anyone unrelated to the training programme in which you were studying?

8. Did you seek professional help about your mental health difficulties prior to or during your clinical psychology training? Can you tell me about this experience?

   Follow up questions around:

   - When help was sought
   - Whether it helped
   - What the experience of seeking help was like

If no

3. Why did you choose to not disclose your mental health difficulties during clinical psychology training

   Follow up questions:

   - *Were there any other reasons*

4. Despite not disclosing, were there any factors that led you to want to disclose your mental health difficulties during clinical psychology training?

Follow up questions:

- *Did you feel there would be any benefits to disclosing?*

5. Did you ever consider or plan to disclose your mental health difficulties?

Follow up questions:

- What drew you to disclosing in this situation?
- Who would you have disclosed to?
- What prevented you from disclosing?

6. Do you feel there were any benefits of not disclosing your mental health difficulties during clinical psychology training?

7. Do you feel there were any negative consequences of not disclosing your mental health difficulties during clinical psychology training?

8. Did you disclose your mental health difficulties to anyone unrelated to the training programme in which you were studying?

9. Did you seek professional help about your mental health difficulties prior to or during your clinical psychology training? Can you tell me about this experience?

   Follow up questions around:

   - When help was sought
   - Whether it helped
   - What the experience of seeking help was like

Appendix F

Additional Interview Questions

1. Did the course give any explicit messages about mental health difficulties in trainees?

2. Did the course give any implicit messages about mental health difficulties in trainees?

3. What ideas did you have about trainee mental health before you started your training?
   What influenced those ideas?
   Did those ideas affect your decision to disclose or not disclose your own mental health?

4. Was resilience something that was discussed on your course
   What does resilience mean to you?
   What message did you get from the course around resilience?
   Did this affect your decision to disclose your mental health difficulties?

5. What were your views of psychologists with mental health difficulties

6. Did you have a sense of what attitudes were across the profession to the mental health of trainees?

7. How do you feel about the word disclosure?
   What does disclosure mean to you?
   What is your preferred language?

Appendix G

Consideration of Other Qualitative Approaches

Consideration was given to other qualitative approaches such as Interpretative Phenomenological Analysis (IPA) and thematic analysis. IPA aims to generate a rich, detailed understanding of the lived experience of a particular phenomenon, and the meanings people ascribe to this (Smith, Flowers & Larkin, 2009). Thematic analysis is aimed at identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). Whilst the current study aimed to generate an understanding of trainee clinical psychologists' experiences of disclosure, the research aims to generate a theoretical understanding of how participants decide whether, or not, to disclose their own experience of mental health difficulties. This generation of a theoretical understanding, primarily determined that grounded theory was most suited to the aims of the research.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London, England: SAGE.

Appendix H

Study Advertisement

UNIVERSITY OF LIVERPOOL

Research Study

HAVE YOU QUALIFIED AS A CLINICAL PSYCHOLOGIST IN THE LAST 2 YEARS?

We are interested in understanding the factors that influence Trainee Clinical Psychologists' decision to disclose, or not disclose, their own mental health difficulties, to course related personnel, during their Doctorate in Clinical Psychology Training.

It is hoped that the insights gained through the study will help contribute towards developing a more supportive, inclusive and de-stigmatising culture in clinical psychology training.

Who will be invited to participate in the study?

Clinical Psychologists who qualified within the last two years, who experienced mental health difficulties during or prior to their clinical psychology training.

What does participation involve?

Attending an individual interview about personal experiences of mental health difficulties and disclosure related decision making. In line with grounded theory methodology participants may be invited to attend a second interview.

What about confidentiality?

During the interview, participants will not be asked to provide any information which may identify them personally, or their programme of study. However, prior to the interview, participants will be asked to sign a consent form and identify a contact in case of on-going distress following the interview.

If you are interested in participating in this study or if you have any further questions please contact the researcher, Laura Willets, via: L.willets@liverpool.ac.uk.

Appendix I

Information Sheet

Am I eligible to take part?

You are eligible to take part in the study if you:

- Consider yourself to have experienced mental health difficulties prior to, or during, your clinical psychology training *and*
- Qualified from a UK Doctorate in Clinical Psychology training programme within the last two years (Please note that Clinical Psychologists who trained at the University of Liverpool, Doctorate in Clinical Psychology Programme will not be allowed to participate in the study. This is to avoid the likelihood of the researcher knowing the research participants in a different capacity).

What will happen if I take part?

The primary researcher for this study is Laura Willets, a trainee clinical psychologist, who is completing a Doctorate in Clinical Psychology at The University of Liverpool. The research is being supervised by Dr Laura Golding (Primary Supervisor) and Dr Beth Greenhill (Secondary Supervisor), who are both clinical psychologists working on the University of Liverpool Doctorate in Clinical Psychology Programme and in NHS settings. The roles of Dr Golding and Dr Greenhill in the research project are to oversee the research project and provide advice where necessary. Any research data that the primary and secondary supervisors have access to will be anonymised; they will not have access to any personally identifiable data. Dr Katrina Scior is an advisor to the project; she will provide general advice on the project but will not have access to the research transcripts. Dr Scior is a clinical psychologist working on the Doctorate in Clinical Psychology Programme at University College London.

If you agree to take part in the research study you will be asked to sign a consent form. A suitable time and location for an interview will be decided by you and the researcher; this will be based on your preference and availability of appropriate interview locations. This may be at a university, or some other mutually agreed confidential and private setting. During the interview you will be asked a series of questions related to your experiences of mental health difficulties and the factors that affected your decision to disclose or not disclose your mental health difficulties during clinical training. The interview will take approximately one hour. Your interview will be audio recorded. Following the interview the audio recording of your interview will be transcribed verbatim (word for word) and any personally identifiable information will be anonymised. Your research will be transcribed by the researcher or a professional transcribing service that are bound by rules of confidentiality. Your interview transcript will be analysed along with other interview transcripts. After interviews have been transcribed you may be invited to a second interview to clarify information and gather further information. You will be contact by email or telephone (whichever you prefer) if this is the case.

After all interviews are complete and data analysis has taken place the research will be written up for partial fulfilment of the researcher's Doctorate in Clinical Psychology award.

Expenses and / or payments

You will be reimbursed for any travel costs incurred as a result of participating in the research project.

Am I eligible to take part?

You are eligible to take part in the study if you:

- Consider yourself to have experienced mental health difficulties prior to, or during, your clinical psychology training *and*
- Qualified from a UK Doctorate in Clinical Psychology training programme within the last two years (Please note that Clinical Psychologists who trained at the University of Liverpool, Doctorate in Clinical Psychology Programme will not be allowed to participate in the study. This is to avoid the likelihood of the researcher knowing the research participants in a different capacity).

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If you agree to take part in the research study you will be asked to sign a consent form. A suitable time and location for an interview will be decided by you and the researcher; this will be based on your preference and availability of appropriate interview locations. This may be at a university, or some other mutually agreed confidential and private setting. During the interview you will be asked a series of questions related to your experiences of mental health difficulties and the factors that affected your decision to disclose or not disclose your mental health difficulties during clinical training. The interview will take approximately one hour. Your interview will be audio recorded. Following the interview the audio recording of your interview will be transcribed verbatim (word for word) and any personally identifiable information will be anonymised. Your research will be transcribed by the researcher or a professional transcribing service that are bound by rules of confidentiality. Your interview transcript will be analysed along with other interview transcripts. After interviews have been transcribed you may be invited to a second interview to clarify information and gather further information. You will be contact by email or telephone (whichever you prefer) if this is the case.

After all interviews are complete and data analysis has taken place the research will be written up for partial fulfilment of the researcher's Doctorate in Clinical Psychology award.

Expenses and / or payments

You will be reimbursed for any travel costs incurred as a result of participating in the research project.

Are there any risks in taking part?
You may find it distressing discussing aspects of your mental health. If this is the case you should inform the researcher immediately. You will be given the opportunity to terminate the interview and the researcher will signpost you to further support services if you wish to access them. Prior to completing the interview the researcher will ask you to provide the name and telephone number of someone (e.g. a friend, relative or healthcare professional) who can be contacted if you experience on-going distress upon completion of the interview.

Are there any benefits in taking part?
There may be no direct benefit to you of participating in the research project. However it is hoped that the research will help identify barriers and facilitators to trainee clinical psychologists disclosing their own mental health difficulties during their clinical training. It is hoped that this understanding will help contribute towards developing a more supportive, cohesive and de-stigmatising culture in clinical psychology training.

What if I am unhappy or if there is a problem?
If you are unhappy, or if there is a problem, please feel free to let us know by contacting Laura Golding, the primary research supervisor, on goldlau@liverpool.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?
During the interview you will not be asked to provide any personally identifiable information or any information that may indicate which Doctorate in Clinical Psychology programme you completed. However if you do disclose any personally identifiable information this will be anonymised during the transcription process and remain confidential. There are exceptional circumstances in which your personal details may need to be passed on to a third party. If, during the interview process, you disclose any information that indicates that you, or another person, are at risk of harm, confidentiality cannot be assured. Your GP, social services or the police may need to be informed, depending on the risk. In addition, prior to the interview you will be asked to sign a consent form, provide an email address or telephone number in which you can be contacted for a second interview, and provide the contact details of someone who can be contacted if you experience any on-going distress following the interview.

As the research is being conducted by a trainee clinical psychologist there is a chance that you may meet the researcher in a different capacity in future, e.g. in a work setting. If this is the case confidentiality will remain and the researcher will not acknowledge your engagement in the research project, unless instigated by you.

What will happen to the results of the study?
The results of the study will be submitted for publication in a peer reviewed journal. The findings of the study may also be disseminated elsewhere such as Clinical Psychology Forum.

You, or individual Doctorate in Clinical Psychology programmes, will not be identifiable in the write up of the study.

At the end of the study you will be asked if you would like a copy of the write up of the research findings. If so, you will be asked to provide contact details to send this to, e.g. your email address.

What will happen if I want to stop taking part?
You are free to withdraw from the study at any point without explanation. However your interview data can only be withdrawn up until one week after the interview. Until this point you can request for any information you have provided to be destroyed. After this point withdrawal of your interview data cannot be guaranteed as the interview may have been transcribed and analysed along with other research participants' information.

Who can I contact if I have further questions?
If you have any questions please contact:
Laura Willets on email address: l.willets@liverpool.ac.uk

Thank you for taking the time to read this information sheet.

Appendix J

Consent Form

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Title of Research Project:	Disclosure of mental health difficulties during clinical training	
Researcher(s):	Laura Willets (Trainee Clinical Psychologist)	**Please initial box**

1.	I confirm that I have read and have understood the information sheet dated 07 December 2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3.	I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information, up until one week after I have participated in the interview, if I wish.	☐
4.	I understand that confidentiality and anonymity will be maintained however if I disclose a risk of harm to myself or another person confidentially cannot be assured. I understand it will not be possible to identify me, or my course of study in any publications.	☐
5.	I understand and agree that my participation will be audio recorded and I am aware of and consent to the use of these recordings for the following the purpose of allowing interview data to be transcribed verbatim.	☐
6.	I give permission for members of the research team to have access to my anonymised responses. I understand that my name or course of study will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐
7.	I understand and agree that after one week following my interview the information I have provided will become anonymised and I will therefore no longer be able to withdraw my data.	☐
8.	I agree to take part in the above study.	☐

The results of the study will be written up and published as a report; please indicate whether you would like to receive a copy. ☐

If applicable, please provide details of the email address you would like this sending to.

Email Address:.....

As outlined in the information sheet you may be invited to attend a second interview to clarify information and gather further information. You will be contact by email or telephone (whichever you prefer) if this is the case. Please indicate a telephone number or email address in which you can be contacted for a second interview:

.....

Sometimes, people experience distress when discussing their own mental health difficulties. If you, or the researcher, feel that you are experiencing significant levels of distress following the interview the researcher will contact a member of your family, a friend, or healthcare professional (identified by you). This is to ensure your safety and wellbeing. Please identify the name and contact telephone number of someone the researcher can contact in case you experience ongoing distress following the interview.

Name: .....

Telephone Number:.....

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

Principal Investigator:
Laura Golding
The University of Liverpool
The Whelan Building
Brownlow Hill
Liverpool L69 3GB
L.golding@liverpool.ac.uk
Tel: 07970247441

Student Researcher:
Laura Willets
The University of Liverpool
The Whelan Building
Brownlow Hill
Liverpool L69 3GB
L.Willets@liverpool.ac.uk

Version 2 Date: 07.12.2016

Appendix K

University of Liverpool Ethical Approval

Research Ethics Subcommittee for Non-Invasive Procedures

12 January 2017

Dear Dr Golding,

We are pleased to inform you that your application for research ethics approval has been approved. Details and conditions of the approval can be found below:

Reference:	0691
Project Title:	What factors affect trainee clinical psychologists' decision to disclose, or not disclose, their own experiences of mental health difficulties during clinical training?
Principal Investigator/Supervisor:	Dr Laura Golding
Co-Investigator(s):	Miss Laura Willets, Dr Beth Greenhill
Lead Student Investigator:	-
Department:	School of Psychology (including DClinPsych)
Reviewers:	Dr Jo Harrold
Approval Date:	12/01/2017
Approval Expiry Date:	Five years from the approval date listed above

The application was APPROVED subject to the following conditions:

Conditions

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Research Ethics Subcommittee for Non-Invasive Procedures

ethics@liverpool.ac.uk

Appendix L

Debrief

UNIVERSITY OF LIVERPOOL

Debrief

Thank-you for participating in the interview, your participation is greatly appreciated. Your interview data will be analysed, using grounded theory methodology, along with other research participants' data. It is hoped that this will help generate a greater understanding of the factors that influence trainee clinical psychologists' decision to disclose, or not disclose, their mental health difficulties during clinical psychology training. It is hoped that understanding these factors will help encourage thinking around ways to overcome such barriers and facilitate disclosure, and create a more open, cohesive and supportive culture within clinical psychology training.

If you experienced any distress during the interview, or if you experience distress subsequent to the interview, you may wish to speak to your friends, family or a healthcare professional such as your GP. Alternatively you may wish to speak to someone confidentially at the Samaritans, who offer confidential support for people experiencing distress, 24 hours a day. The telephone number for the Samaritans is 116 123.

If you have any questions please feel free to contact the researcher or the research supervisors.

Thank you for you participation.

Laura Willets (Researcher)
Contact: l.willets@liverpool.ac.uk

Research Supervisors:
Dr Laura Golding
Contact: l.golding@liverpool.ac.uk

Dr Beth Greenhill
Contact: bethg@liverpool.ac.uk