STEPHANIE A. HECKERT BSc Hons

UNDERSTANDING MENTAL HEALTH DIFFICULTIES AND DISCLOSURE WITHIN PSYCHOLOGY PROFESSIONS

Section A:
Understanding the relationship between supervisee nondisclosure and the supervisory working alliance within clinical and counselling psychology
Word Count: 7,946 (8,209)

Section B:
Exploring how trainee clinical psychologists and their supervisors and training providers understand and navigate mental health difficulties, support, and time off.
Word Count: 7,999 (8,052)

Overall Word Count: 15,945 (16,261)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

MAY 2022

SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I would like to thank my participants for sharing their time and being open with me about sensitive and personal topics, I am very grateful for your support and trust. I am indebted to Sue, my research supervisor, for being the most supportive and kind mentor I could have asked for. I would also like to thank my family and friends, for waiting patiently for me to finish this project and offering me their support when I needed it. Finally, I would like to thank Rikus, my husband, for almost never complaining about this process and for feeding me and providing me with love when I needed it.

Summary of major research project

Section A: Supervision is critical in the psychological professions for the development of knowledge and therapeutic skills, as well as for monitoring the safety and effectiveness of interventions. However, supervisee nondisclosure is common and may impact negatively upon the supervisory process and client outcomes. This literature review systematically examined the relationship between supervisee nondisclosure and the supervisory working alliance within the professions of clinical and counselling psychology. Findings relate to content of nondisclosure, psychology culture and expectations, compatibility and supervisory competence, power dynamics, weighing risk, aiding disclosure, alternative strategies, supervisory reactions and the cycle of nondisclosure and the changing supervisory relationship. Practice implications and future research are discussed.

Section B: The prevalence of mental health difficulties among trainee clinical psychologists is reported to be high, with low disclosure rates. Clinical psychology training can be stressful, and it has been suggested that trainees are more likely to experience distress and self-doubt because of their inexperience. Despite this, little is known about how mental health issues are navigated within training. This study explored how trainees, clinical supervisors and training facilitators understand and navigate mental health difficulties, support, and time off. Seven main categories were created, using grounded theory methodology: trainee and staff histories and stressful life events, personal attitudes towards mental health difficulties, power and autonomy, questioning workplace competence, complex systemic issues, navigating access to support and time out, mental health in the psychological trenches and learning and hindsight. The culture within clinical psychology and unclear processes and communication may be implicated and are discussed in relation to practical implications.

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Section A: Literature Review

Understanding the relationship between supervisee nondisclosure and the supervisory working alliance within clinical and counselling psychology

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April 2022

Abstract

Background: Supervision is critical for the development of knowledge and therapeutic skills in the psychological professions, as well as for monitoring the safety and effectiveness of interventions. However, supervisee nondisclosure is widespread and can have a detrimental effect on the supervision process and client outcomes. This research was the first to systematically review the relationship between supervisee nondisclosure and the supervisory working alliance within the professions or clinical and counselling psychology. **Method:** The PRISMA method was used, to conduct a systematic search, screening, and selection of literature. Four databases were searched. The articles were critically evaluated using paired appraisal tools, and the outcomes were determined using thematic synthesis. **Outcomes:** Findings relate to content of nondisclosure, psychology culture and expectations, compatibility and supervisory competence, power dynamics, weighing risk, aiding disclosure, alternative strategies, supervisory reactions and the cycle of nondisclosure and the changing supervisory relationship. **Discussion:** The review had some limitations, such as studies consisting of predominantly trainee samples and therefore perhaps not reflecting the wider workforce. The bond element of the supervisory working alliance appeared heavily implicated in maintaining a supervisory relationship that maximises disclosure. Nevertheless, a level of nondisclosure was present even within relationships that had a strong alliance. The culture of clinical psychology and power dynamics were also implicated and discussed further in relation to practical implications and future research.

Keywords: Nondisclosure, Clinical Supervision, Supervisory Working Alliance, Clinical and Counselling Psychology, Psychology culture, Power

Introduction

This review will be examining the relationship between supervisee nondisclosure (ND) and the supervisory working alliance (SWA) within clinical supervision in the professions of clinical and counselling psychology. As the literature looking at the combination of these factors has focussed largely on therapy specific supervision and on developing therapy competence and feeling contained, supervision has been defined and considered from a therapy specific perspective.

Supervision

The term supervision will hereafter be used to refer to both trainee and qualified supervision, unless otherwise specified. Supervision is considered an essential underpinning of safe and effective practice within psychology professions (BPS; British Psychological Society, 2017). It is evaluative, seeking to protect both client and practitioner welfare through ensuring fitness to practice and providing an outlet for the processing of therapeutically related emotional material (Inskipp & Proctor, 1993). It also monitors the quality of interventions being provided and promotes evidence-based practice (APA; American Psychological Association, 2006) and has been linked to the acquisition of knowledge and therapeutic abilities (Watkins, 2011) and improved client outcomes (Bambling et al., 2006). It is widely considered imperative and is supported by practice guidelines (BPS, 2006). Transparency within the supervisory relationship (SR) is essential for effective supervision because the process is hindered without clear communication and collaboration to address and reflect on areas of difficulty (Knox, 2015).

Supervision is often considered as a relationship based upon unequal power and this imbalance can exacerbate feelings of vulnerability often inherent in the process of being assessed (Murphy & Wright, 2005). Although an imbalance exists within the SR throughout the career span, this is perhaps most notable in the early stages of a practitioner's career, particularly during training, when the evaluative nature of the relationship is perhaps at its zenith (Spence et al., 2014). This stage in a psychologist's career may also be very formative, where individuals may learn a great deal from the experience of their supervisors and be more reliant upon them for clinical guidance than later in their career when they are more established and have amassed higher levels of therapeutic competence (Rønnestad & Skovholt, 2003). Supervisors may also feel this imbalance more keenly and may wish to have greater oversight of the trainee's therapeutic work, as they are responsible for the client outcomes and may worry about their professional reputations or potential legal ramifications (Singh-Pillay and Cartwright, 2021).

Nondisclosure

Despite this, research has indicated that a certain degree of nondisclosure (ND) may be unavoidable (Farber, 2006). ND in supervision has been described in a variety of ways within literature and can encompass a wide range of omissions, such as therapeutic mistakes (Ladany et al., 1996; Hess et al., 2008), feelings towards the client (Yourman & Farber, 1996; Rodolfa et al., 1994), supervisory challenges (Banks & Ladany, 2006; Pisani, 2005), or topics deemed too personal, inappropriate, or uncomfortable (Banks & Ladany, 2006; Ladany et al., 1996). Individual supervision styles as well as expectations and attitudes regarding supervision appropriate content also varies across individuals and non-disclosure can be affected by the existing dynamic between the supervisory dyad (Spence et al., 2014). NDs may happen unintentionally or purposefully (Farber, 2006). Unintentional NDs may occur due to the supervisee not being able to convey the full complexity of a situation or through being uncertain

of how to appropriately use supervision (Farber, 2006). ND is considered intentional when the supervisee has made a conscious decision to distort or withhold significant information from their supervisor (Ladany et al., 1996). Unintentional NDs may occur due to the supervisee not being able to convey the full complexity of a situation or through being uncertain of how to appropriately use supervision (Farber, 2006). ND is considered intentional when the supervisee has made a conscious decision to distort or withhold significant information from their supervisor (Ladany et al., 1996). Research suggests that NDs are common within qualified and trainee populations (Spence et al., 2014; Mehr et al., 2010). Indeed, Yourman and Farber (1996) found that 91.3% of supervisees withheld or obscured information from their supervisor with 30 to 40% of them admitting that they frequently withheld information. Furthermore, Ladany et al. (1996) found that 44% of supervisees had withheld information about clinical errors. Gabbard (1996) suggests that it is those experiences that supervisees choose to hide, which are the most vital to disclose, as they may bring development opportunities or negatively impact the supervisory process or clients. Intentional withholding may be exacerbated by individual factors such as anxiety or shame or may be resultant of the evaluative nature of supervision (Farber, 2006).

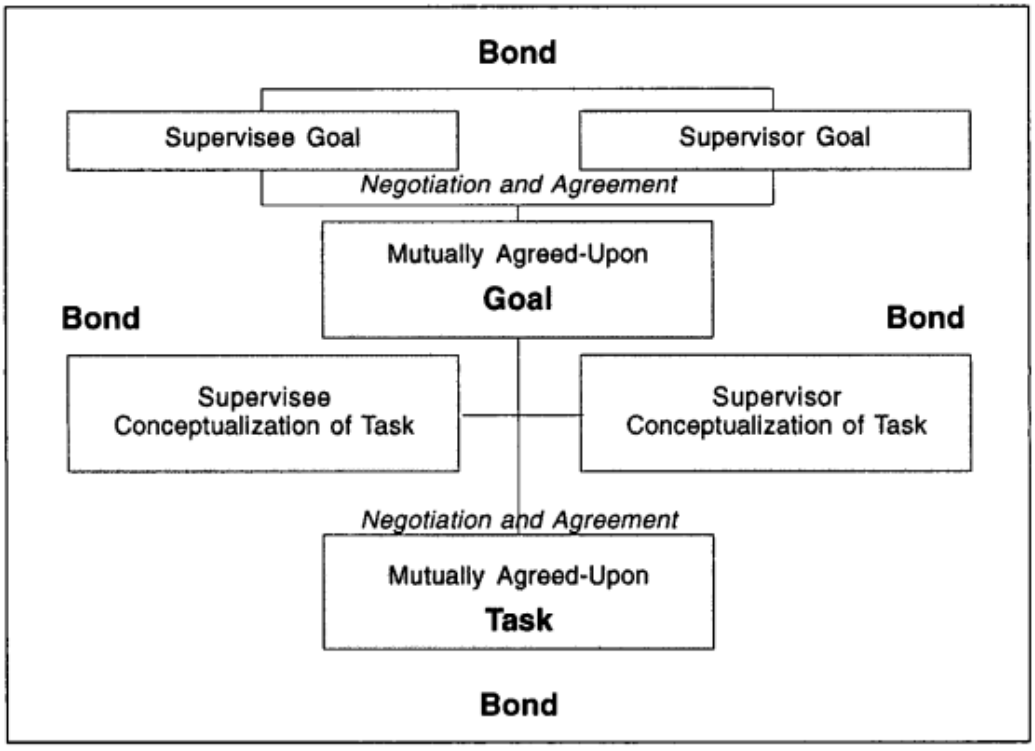
Supervisory working alliance

Individuals may engage in ND for many reasons such as to protect their personal and professional reputations, because they think the information is irrelevant or too personal, or because they think it is pointless, for example if they do not trust their supervisor's ability to listen, be supportive or helpful (Knox, 2015). As ND is often understood to have a protective function, it is commonly believed that feeling safe within supervision is a prerequisite to disclosure (Singh-Pillay & Cartwright, 2021) and that building a strong supervisory working alliance (SWA; Bordin, 1983) may help to achieve this and limit ND's. The SWA is

conceptually founded on working alliance theory (Bordin, 1979), which explores the therapeutic alliance and suggests three main components: bond, task, and goal. The SWA has adapted and applied these principles to the supervision process (Figure 1). The SWA is considered the "heart and soul" of supervision, upon which the supervisee change process is built (Ladany & Inman, 2012). The bond element (for example mutual care, respect, or trust) of the SWA has been found to be uniquely related to feeling comfortable and satisfied within supervision (Ladany et al., 1999). This is important as satisfaction with the SWA has been related to the content, reasons for and frequency of ND (Ladany et al., 1996). Despite this, it seems that ND also occurs, although at a lower frequency, within SRs that are founded upon a strong alliance (Hess et al., 2008), leaving some supervisors feeling betrayed and wondering what they could have done differently (Sing-Pillay & Cartwright, 2021).

Figure 1

The supervisory working alliance model (Wood, 2005)



Furthering our knowledge about nondisclosure within supervision is important, because although not all nondisclosures are detrimental to client outcomes, some NDs can also result in poorer clinical care and outcomes (Farber, 2006) and in some cases can lead to breaches that are serious enough to lead to disciplinary hearings or mal-practice lawsuits (Singh-Pillay & Cartwright, 2021). Additionally, nondisclosures may lead to poorer professional development (Wallace & Alonso, 1994), increased anxiety (Singh-Pillay & Cartwright, 2018; Hess et al., 2008), and a loss of confidence in the self or supervisory process. This may have particular relevance for trainees who may feel more vulnerable and scrutinised as they begin their careers and is important as negative disclosure experiences may lead to increased hypervigilance in future SRs, priming supervisees to withhold information (Solomon & Priem, 2016, p.699). Having greater awareness of the decision-making processes of supervisees relating to nondisclosure could therefore add valuable insight and help us to build on our understanding of how to maximise the chances of disclosure in supervision.

Rationale and Aims for this Review

The literature in this area is sparse and has not yet been compiled or reviewed in a systematic manner. The purpose of this systematic review is to examine, synthesise, and critique peer-reviewed published research exploring the relationship between the SWA and supervisee nondisclosure in the clinical and counselling psychology professions. Consideration will also be given to the implications for clinical practice and future research.

The following questions will be addressed by this review:

a) What does the research tell us about how ND is defined?

b) What does the research tell us about the decision-making process supervisees employ to decide whether to disclose?

c) What does the research tell us about factors within the supervisory relationship that aid or limit disclosure?

Method

Systematic literature search

In October 2021, an electronic database search was conducted using the following databases: PsycINFO Web of Science, ASSIA and PubMed. As there were no systematic reviews conducted in this specific area to date, no time-limit was placed upon this search. The search terms used were (supervisory working alliance OR supervisory alliance OR supervisory relationship) AND (disclosure OR nondisclosure). The following journals were also searched: The Clinical Supervisor, Psychoanalytic Psychology, Counseling Psychology, Consulting and Clinical Psychology, Clinical Psychology, and Professional Psychology: Research and Practice. The references of selected studies were manually searched for any outstanding publications, and a Google Scholar search was also conducted to identify any pertinent missing papers. Three hundred and ninety-three papers were identified and systematically screened through their titles, abstracts, and full texts. Please see Table 1 for inclusion criteria.

Table 1

Table of inclusion and exclusion criteria

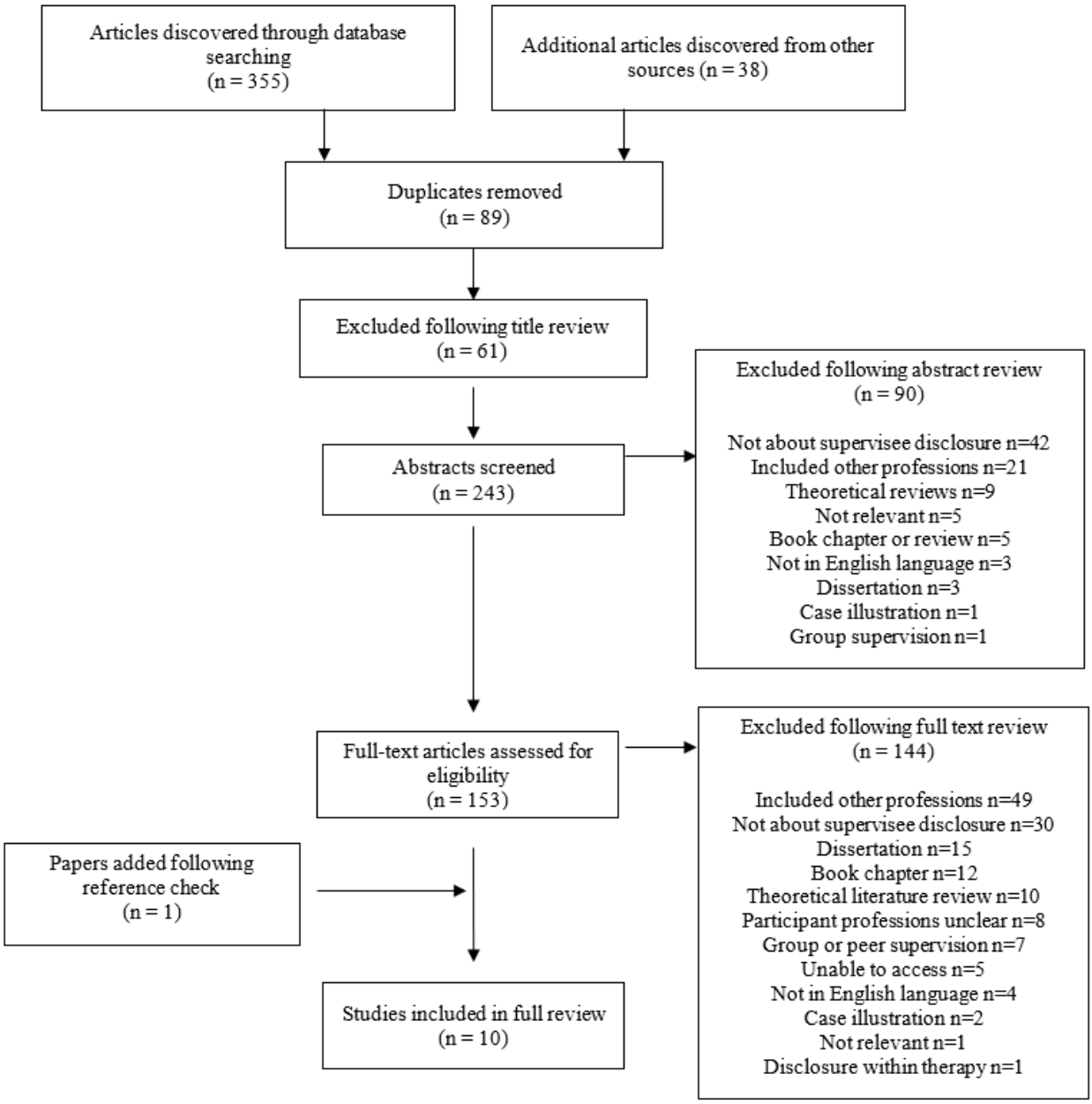
Inclusion Criteria	Exclusion Criteria
• Articles must solely focus on clinical and / or counselling psychologists • Must be exploring the relationship between supervisee nondisclosure and the SWA	• Not empirical research (e.g., no methodology, informal case illustrations, book chapters or discussion pieces).

• 1-1 supervision experiences	• Empirical research exploring supervision, but where supervisee disclosure or SWA are not a key focus. • Empirical research exploring SWA and nondisclosure but containing participants outside the profession of clinical and counselling psychology. • Articles that have not been published in peer-reviewed journals. • Articles that have not been published in English.

Three different quality assurance tools were used, to ensure the three different methodologies were robustly assessed. Qualitative studies were assessed using the Joanna Briggs Institute Critical Appraisal Checklist (JBICAC) for Qualitative Research Checklist (Lockwood et al., 2020), and quantitative studies were assessed using the JBICAC for Analytical Cross-Sectional Studies (Moola et al., 2020). The Mixed Methods Appraisal Tool was used to evaluate mixed study designs (MMAT; Hong et al., 2018). See Appendix A. Findings from the articles capturing qualitative data have been analysed using thematic synthesis (Thomas and Harden, 2008) through line-by-line coding before grouping the codes together to allow central themes to emerge (Table 5). This was undertaken with the aid of a computer-assisted qualitative data analysis software called "Delve" (Ho & Limpaecher, 2017). This software allowed for categories to emerge across studies, in an organised manner and kept track of how often codes were repeated across studies and across different participants and job roles. This added an element of quality assurance as it allowed for greater oversight and confidence in the strength of assertions made in the synthesised findings. The PRISMA flowchart depicting the organisation of the literature search and included studies is shown in Figure 2.

Figure 2

Prisma diagram of systematic literature search



Review

Summary of articles

Table 2

Overview of included studies

Study	Aims of study	Sample	Design/Analyses	Procedures
Ladany et al., 1997 USA	Explore trainee psychologists' sexual attraction towards clients, whether this phenomenon was disclosed and how the SRy relationship affected this.	13, clinical (=4) and counselling psychology (n=9) trainees. 61.5% female, 27 – 39 years. M=45.23 months of therapy experience since entering doctoral programmes.	Consensual Qualitative Research	One initial 45 min interview followed two weeks later by a 15 min interview.
Gray et al., 2001	Explore and understand counterproductive events within supervision and how these are addressed or not within supervision and the effects upon the SWA.	13 trainees in counselling psychology masters - doctoral programmes. 76.9% female, 23 – 29 years. M=19.92 months supervised experience and seen M=65.85	Consensual Qualitative Research.	30 - 45-minute interviews. Completed Supervisory Satisfaction Questionnaire and rated importance of counterproductive events in supervision using a Likert scale during the interview.

Study	Aims of study	Sample	Design/Analyses	Procedures
		clients. M=14.38 current supervision sessions.		
Hess et al, 2008 USA	Explore trainee psychologists' experiences of nondisclosure and what might have facilitated disclosure.	14, clinical (n=1) and counselling psychology (n=13) trainees, 78.6% female. 27 – 38 years.	Consensual Qualitative Research, t-tests used to compare if problematic and good supervisory groups differed in ratings regarding supervision	45 – 60-minute interviews. Two outcome measures provided after the interview. The Supervisory Styles Inventory and the Supervisory Satisfaction Questionnaire.
Mehr et al., 2010 USA	Explore content and reasons for nondisclosure and examine relationship between trainee anxiety, SWA, willingness and amount of nondisclosure.	204, clinical (67%) and counselling psychology (23%) trainees. Mdn=16 months counselling experience, mdn=25 clients. M=20.62 supervision sessions.	The Discovery-Oriented Method is used to create mutually exclusive categories from the survey's content and reasons for nondisclosure. Multivariate analyses tested for confounding variables, Goodness-of-fit chi-square testing for difference in disclosure content categories, multi-variate multiple regression analyses examined influence of SWA and trainee anxiety on ND and willingness to disclose.	Anonymous online link to survey and outcome measures. Supervisee nondisclosure survey, Trainee Disclosure Scale, Working Alliance Inventory/Supervision-Short and Trainee Anxiety Scale.

Study	Aims of study	Sample	Design/Analyses	Procedures
			Priori power analysis confirming the study's power.	
Pakdaman et al., 2014 USA	Examine the influence of SWA on trainee psychologists' countertransference disclosures.	332 clinical or counselling psychology trainees. 80.7% female.	Cross-sectional self-report survey design. Correlational analysis assessing relationship between SWA and trainee comfort disclosing, Multiple regression analyses tested which components of SWA accounted for comfort levels with disclosure, Multivariate analyses of variance assessed if there were differences in comfort levels regarding different countertransference content areas, repeated measures multivariate analyses of variance tested if there were difference in likelihood of disclosure for those content areas. T-tests assessed if matching demographic variables in SR influenced disclosure, post hoc analyses - one-way analysis of variance and Dunnete T3 post hoc Levene's, explored matched variable further through assessing if gender or theoretical pairings influenced disclosure, Simple Linear Regression analyses assessed whether	Anonymous online survey using an analog approach involving countertransference vignettes and outcome measure. Working Alliance Inventory–Supervisee form and the Countertransference Reaction Disclosure Questionnaire.

Study	Aims of study	Sample	Design/Analyses	Procedures
			amount of supervised experience predicted comfort or disclosure.	
Spence et al. 2014 UK	Develop a theoretical knowledge of supervisee's self-disclosure process across the career span.	10 clinical psychologists 80% female, 0 – 11+ years post qualification	Grounded Theory	45–71-minute interviews
Sweeney & Creaner, 2014 Ireland	Examine nondisclosure in retrospect during individual supervision throughout training.	6 counselling psychology graduates, 50% female, two years post-training, age range 28 – 55.	Consensual Qualitative Research.	50 – 60-minute interviews.
Schweitzer & Witham 2018 Australia and South Africa	Compare a new measure of SWA to an existing measure. Examine if SWA is associated with supervisory satisfaction and disclosure. Examine whether one measure of SWA is superior at measuring the	125 post-grad clinical psychology trainees, 86.4% female. 21 - 55 years. Master's degree (50.4%), doctoral degree (38.4%), remainder completing combined master's/ PhD programme.	Cross sectional self-report questionnaire design. Pairwise analyses, Pearson's product moment correlations assessed relationship between SWA, satisfaction and trainee disclosure, Shapiro Wilk test assessed normality of distribution	Anonymous questionnaire packs containing 4 measures. Supervisory Working Alliance Inventory – trainee version, Supervisory Relationship Questionnaire, Supervisory Satisfaction Questionnaire, Trainee Disclosure Scale

Study	Aims of study	Sample	Design/Analyses	Procedures
	relationship between various outcome variables.	SRy relationship M=5 months.		
Singh-Pillay & Cartwright, 2018 South Africa	Explore trainee psychologists' experiences of non-disclosure in clinical supervision.	8, clinical (n=4) and counselling psychology (n=4) trainees. 63% female, age range of 43 years.	Interpretative Phenomenological Analysis.	90-minute interviews.
Singh-Pillay & Cartwright, 2021 South Africa	Explore supervisor's experiences of non-disclosure in clinical supervision.	8, clinical (n=5) and counselling psychology (n=3) supervisors. 88% female, 31 – 60 years, range 3 – 13 SRy experience.	Interpretative Phenomenological Analysis.	90-minute interviews.

An overview of central aspects of the reviewed articles, such as design, procedure, and participant and data sampling are provided, a critique offered, and findings presented.

Design

Six studies utilised a qualitative design, two were quantitative cross-sectional studies and two utilised a mixed methods design. None of the studies reviewed were randomised or used any form of control design, one study was retrospective in nature (Sweeney & Creaner, 2014). Four studies used consensual qualitative research methodology (CQR; Hill et al., 1997; Hill et al., 2005; Hill, 2012), identifying and coding domains into core ideas before utilising a cross-analysis to capture frequency of all data in each domain. To ensure consistency, all data analysis decisions were made by consensus within the study team, with the assistance of 'judges' and 'auditors'. Hess et al. (2008) and Sweeney and Creaner (2014) split the data into two emergent groups, the "good" and "problematic" SR groups. Two studies employed interpretative phenomenological analysis (Smith et al., 2009) seeking to understand how individuals interpreted and made sense of experiences. One study employed grounded theory methodology (GTM; Charmaz, 2006) progressing through open and focussed coding until data sufficiency was reached before synthesising conceptual categories into a theoretical model through axial coding. Mehr et al. (2010) developed mutually exclusive categories around the reasons and content of nondisclosure using the discovery-oriented method (Hill, 1990; Mahrer, 1988).

Procedures

Three studies were conducted using anonymous online or paper-based questionnaires. Seven studies conducted audio-recorded interviews, that were then transcribed verbatim; two of these

additionally asked participants to fill out measures (Hess et al., 2008; Gray et al., 2001). All but one of the seven held a single interview per participant, the other held a follow-up interview within two weeks. The range of interview times was 30 – 90 minutes. Six studies used a semi-structured interview approach, while Spence et al. (2014) used open ended and exploratory questions that evolved based upon emerging theory and reflexivity. Three studies conducted pilot interviews and updated their interview schedule based upon feedback (Ladany et al., 1997; Sweeney & Creaner, 2014; Gray et al., 2001) and Hess et al. (2008) revised their questions after colleague feedback.

Ten outcome measures were employed across five studies (Table 3). The Supervisory Satisfaction Questionnaire (SSQ; Ladany et al.,, 1996) which assesses the perceived satisfaction with supervision was the most used. Four studies measured the likeliness of disclosure with two studies using the Trainee Disclosure Scale (TDS; Walker et al., 2007), one study using the Supervisee Nondisclosure Survey (SNS), which was slightly adapted from the SSQ and the final study using the Countertransference Reaction Disclosure Questionnaire (CTRDQ; Daniel, 2008) based on hypothetical countertransference situations. Three studies used measures designed to assess the supervisees' perception of the SR or working alliance. One used the Supervisory Relationship Questionnaire (SRQ; Palomo et al., 2010) and the Supervisory Working Alliance Inventory – Trainee version (SWAI-T; Efstation et al., 1990) and two studies used related but distinct measures; the Working Alliance Inventory/Supervision-Short (WAI/S-Short; Ladany, Mori, & Mehr, 2007) and the Working Alliance Inventory–Supervisee Form (WAI/S; Bahrick, 1990). Finally, one study assessed the perception of the supervisor's style with the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) and one assessed the level of anxiety experienced by trainees in supervision with the Trainee Anxiety Scale (TAS; Ladany, Walker, Pate-Carolan, & Gray-Evans, 2007).

Table 3

Summary of outcome measures

	Schweitzer & Witham, 2018	Hess et al., 2008	Mehr et al., 2010	Pakdaman et al., 2014	Gray et al., 2001
SSQ	✓	✓			✓
SNS			✓		
TDS	✓		✓		
WAI/S-Short			✓		
WAI/S				✓	
CTRDQ				✓	
TAS			✓		
SWAI-T	✓				
SRQ	✓				
SSI		✓			

Note. SSQ = Supervisory satisfaction questionnaire, SNS = Supervisee Nondisclosure Survey, TDS = Trainee Disclosure Scale, WAI/S-Short = Working Alliance Inventory/Supervision-Short, WAI/S = Working Alliance Inventory–Supervisee Form, CTRQ = Countertransference reaction disclosure questionnaire, TAS = Trainee anxiety scale, SWAI-T = Supervisory Working Alliance Inventory – Trainee version, SRQ = Supervisory Relationship Questionnaire, SSI = Supervisory Styles Inventory.

Participant / Data sampling

Recruitment

All studies recruited participants using purposive sampling strategies. Over half of the participants were recruited through authors contacting staff at psychology programmes or counselling centres, seeking these to either distribute physical packs (Schweitzer & Witham, 2018; Ladany et al., 1997; Hess et al., 2008; Gray et al., 2001) or online links to questionnaires (Mehr et al., 2010; Pakdaman et al., 2014). Three studies did not clearly outline their recruitment processes (Singh-Pillay & Cartwright, 2018; 2021; Sweeney & Creaner, 2014). Spence et al., (2014) gained ethical approval to recruit within NHS trusts and additionally advertised within a newly qualified CPD scheme within the NHS. The total participants

included within quantitative studies ranged from 125-332, with qualitative studies recruiting between 6 – 13 individuals. The mixed methods articles had a broad range of 14 – 204.

Demographics

Seven studies consisted of over 75% female participants, with only one study having an equal split. Two studies reported other gender classifications, Mehr et al. (2010) reported 4 participants with "unspecified" genders and Pakdaman et al. (2014) reported 3 participants who were transgender, intersex or androgenous. Two studies did not provide data regarding age (Spence et al., 2014; Pakdaman et al., 2014) and one article merely stated that the age range was 43 years (Singh-Pillay & Cartwright, 2018). The ages of participants from the remaining studies ranged between 21 – 60 with most falling in the late twenties to early thirties. Studies spanned the UK, Ireland, US, South Africa, and Australia. Three articles did not identify ethnicity (Spence et al., 2014; Schweitzer & Witham, 2018; Sweeney & Creaner, 2014).

All studies included participants who were either training or qualified in clinical or counselling psychology. Six studies recruited participants from both professions and four studies (Spence et al. 2014; Schweitzer & Witham 2018; Sweeney & Creaner, 2014; Gray et al., 2001) contained one or the other, exclusively. Only one article examined experiences of being supervised post training (Spence et al. 2014). Similarly, only one contained supervisors reflecting upon their experience of supervisee nondisclosure (Singh-Pillay & Cartwright, 2021). All non-qualified participants were engaged in competence-based placements and consisted of doctoral level trainees (Ladany et al., 1997, Hess et al., 2008; Pakdaman et al., 2014) and a mix of masters and doctoral participants (Schweitzer & Witham, 2018; Mehr et al., 2010; Gray et al., 2001). Finally, Singh-Pillay and Cartwright (2018) recruited trainees on

a one-year supervised internship, which is an accredited program and requirement for professional registration as a psychologist in South Africa.

Critique

Design

The study designs were all non-experimental, therefore causation cannot be inferred from the findings as other potentially confounding or causal variables were not controlled for. However, the study designs used were appropriate to meet their objectives. Most studies used at least an element of qualitative methodology, which is appropriate when seeking to answer questions about meaning and experiences (Hammarberg et al., 2016), particularly if they are not yet well understood. The studies that drew upon quantitative methodologies were seeking to measure the potential interactions between various elements, such as the SWA and disclosure, or to compare outcome measures to recommend one over the other. Using quantitative methodology was apt in these instances, particularly as they sought to make generalisations to the wider population (Coghlan & Brydon-Miller, 2014). It is worth noting how studies were designed regarding how supervision experiences were examined. For example, the retrospective study may have been influenced by 'narrative smoothing' (Spence, 1986) and Mehr et al. (2010) only focussed on a single session, which may not have been representative, as subject matter withheld in one session may have naturally arisen in a subsequent session.

Spence et al. (2014) made a valuable contribution, as the first to develop a theory of the supervisee self-disclosure process and of the impact the SR might have upon disclosure (Figure 3 and 4). GTM has been criticised for inviting too much researcher subjectivity to shape outcomes (Schonfeld & Mazzola, 2013) and Thomas and James (2006) suggest caution due to

the possibility of theoretical creation as opposed to discovery. However, Charmaz (2006) writes about a level of richness to the data that quantitative association studies are unable to replicate. The authors also incorporated many direct quotes from participants, suggested to enable transparency and show the basis of their conclusions (Lockwood et al., 2020). Schweitzer and Witham (2018) also added to the field by comparing and recommending a relatively new instrument, designed specifically for supervision and with greater ability to examine the SR in detail than previous measures. This is pertinent as developing robust instruments is an area of continuing need within supervision literature (Watkins, 1998).

Figure 3

Theory of supervisee self-disclosure (Spence et al., 2014)

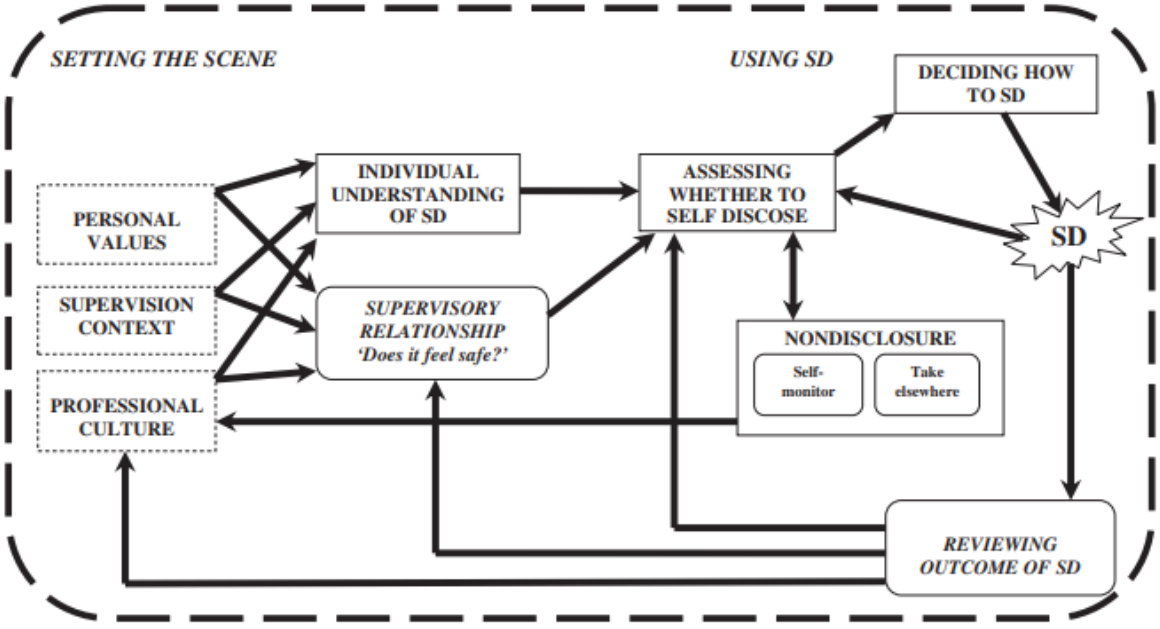
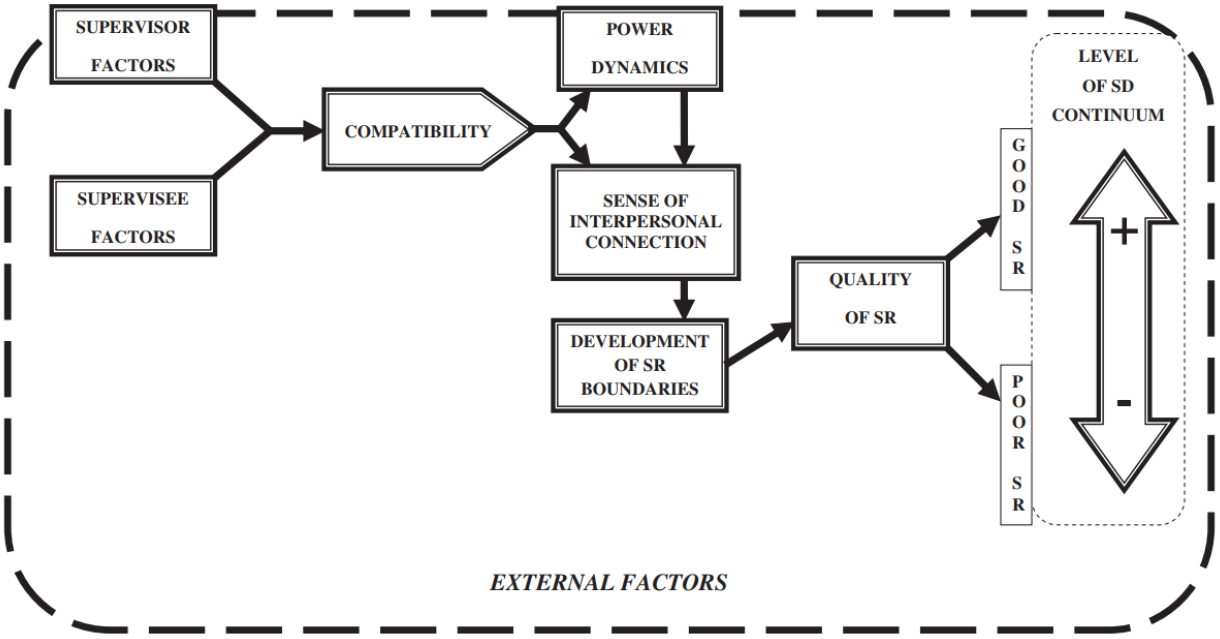


Figure 4

Theory of impact of SR on supervisee self-disclosure (Spence et al., 2014)



Outcome measures

All outcome measures reported internal reliability except for the SNS and the CTRDQ and all reported face or construct validity, except for the SNS and SSQ, although the SSQ is noted to be widely used and viewed as a good measure of supervisee satisfaction with supervision within the literature (Schweitzer & Witham 2018). However, the SSQ was directly adapted from an existing measure of client satisfaction with therapy (Larsen et al., 1979) and terms such as 'counselling' were switched with 'supervision'. As this measure was initially developed to measure the therapeutic relationship, it is unclear how sensitive it is to the specific components unique to supervision. Furthermore, the SNS and TDS were adapted from the SSQ, so it is also unclear how this may have affected the development of these measures. A similar consideration exists with the WAI/S-Short and the WAI/S, which were adapted from two measures used to measure the therapeutic alliance with clients, the WAI-S (Tracey &

Kotovic, 1989) and WAI (Horvath & Greenberg, 1989) respectively. The original paper from which the WAI/S-Short stems is an unpublished and inaccessible paper and so could not be assessed. The WAI/S was adapted in a dissertation with a limited number of participants and through switching terms such as 'client' to 'supervisee'.

Self-report measures can be vulnerable to various biases such as awareness or social desirability (Devaux & Sassi, 2016). Of note are the three studies that were entirely anonymous (Schweitzer & Witham, 2018; Mehr et al., 2010; Pakdaman et al., 2014), through paper pack or online link as participants in these studies may have felt more able to respond freely. Additionally, a potential limitation lay within studies using measures of hypothetical scenarios of non-disclosure (TDS; CTRDQ), as these findings are based upon anticipated behaviours rather than actual outcomes and as such should be viewed with an element of caution as individuals often have difficulty accurately predicting their behaviour (Persky et al., 2007; Vallone et al., 1990). Finally, Schweitzer and Witham (2018) were the only authors to address the potential limitations of their selection of outcome measures.

Rigour

All qualitative and mixed methods studies demonstrated varying degrees of reflexivity (Table 4). Most commented upon their own perspectives and potential biases to minimise the influence that these might have on their participants and data, however, it is impossible to know how effective these safeguards were. Two authors kept a reflective journal and three pre-emptively discussed potential biases within the research team. The CQR studies used a high level of 'quality control' through utilising a number of 'judges' to cross check coding decisions and to audit the cross-analyses; Hess et al., (2008) utilised external individuals to conduct the audit. A consensus on CQR studies also had to be reached by all involved members before

making decisions about categories; these measures may have helped to limit personal biases and to improve the validity of the studies. However, it is still possible the findings may be unique to how certain groups designed the research questions and interpreted the data, but Glaser and Strauss (1967) suggest that it is necessary for researchers to have a perspective to analyse data. One author drew upon their research supervisor to cross-check a selection of codes (Spence et al., 2014), and additionally, along with another study (Hess et al., 2008), sought feedback from their participants regarding their emerging data, further strengthening their ability to reflect the phenomena being described to them.

Four studies utilised a single interviewer (Spence et al., 2014; Singh-Pillay & Cartwright, 2018; 2021; Pakdaman et al., 2014) and one study using multiple interviewers provided training from an experienced interviewer to reduce differences in style (Gray et al., 2001); this study additionally adhered to a semi-structured interview format with predetermined probes. These efforts may have increased the consistency of data collection and internal reliability of these studies. However, through adherence to predetermined probes, they may have also limited their data. Three studies (Ladany et al., 1997; Hess et al., 2008; Gray et al., 2001) made the interview questions available prior to the interview and the latter two also made the measures available beforehand and administered them during the interview process. Doing so may have increased the risk of responding in a socially desirable way (Hill et al., 1997) and of biasing the responses to the measures, respectively. All qualitative articles explained their analytical processes, with most explaining them well. Of distinction were Ladany et al. (1997) and Gray et al. (2001) who described their analytical processes very clearly and maximised the potential for a reliable replication of the analysis stage, as far as is possible within qualitative designs. Hess et al. (2008) and Sweeney and Creaner (2014) only explained their processes minimally, not enabling the reader to establish a clear sense of their procedure. Of the quantitative and

mixed method study designs all explained their analytical processes well. Of the studies using statistics, only two conducted a power analysis and noted that they had sufficient participants to effectively conduct their statistical analyses (Mehr et al., 2010; Pakdaman et al., 2014). Finally, Pakdaman et al. (2014) and Singh-Pillay and Cartwright (2018) did not acknowledge any limitations within their studies, which limits transparency and reduces the readers ability to clearly understand the challenges encountered or how to improve upon the quality and validity of the research in future (Ross & Zaidi, 2019).

Table 4

Table Summarising strategies employed to maximise rigour

Type of rigour employed	**Articles**							
	Spence et al., (2014)	Ladany et al., (1997)	Hess et al, (2008)	Mehr et al., (2010)	Singh-Pillay & Cartwright (2018)	Singh-Pillay & Cartwright (2021)	Sweeney & Creanear (2018)	Gray et al., (2001)
Reflective Journal	✓						✓	
Documenting own biases	✓	✓	✓		✓	✓	✓	✓
Pre-emptively discussing biases within team		✓	✓	✓				
Judges		✓	✓				✓	✓
Supervisor cross-checking codes	✓							
Audit external		✓	✓					✓
Audit internal							✓	
Category consensus		✓	✓				✓	✓
Sought feedback from participants	✓		✓					
Single interviewer	✓				✓	✓	✓	
Interviewer training								✓

Sample

As the participants for all studies self-selected, those who participated may have had greater interest in the topic, or more prominent experiences than other individuals within the sample, which could skew the data away from generalisable findings, particularly in the studies with small sample sizes. All studies utilised purposive sampling, which was appropriate given the distinct population required to conduct the research. However, purposive sampling may involve greater researcher bias (Sharma, 2017). Three papers did not provide a clear overview of the selection process, making it difficult to replicate the study and to evaluate potential biases (Singh-Pillay & Cartwright, 2018;2021; Sweeney & Creaner, 2014). A further limitation common to eight of the studies (Singh-Pillay & Cartwright, 2018 and 2021 were a separately written dyad study), were their homogenous sample selections, for example, selecting only trainees or supervisees, limits the completeness and generalisability of the findings. However, having a homogenous sample may also reduce certain potential confounds often found within heterogenous samples.

Most studies had a female to male ratio of over 75%. This may make the data less generalisable to men within the profession, however it may not affect the representativeness of views within the field of clinical or counselling psychology, as the profession is 80% female led in the UK (Health and Care Professions Council (HCPC), 2016). Studies may lack generalisability across racial identity as participants ranged from, 71 – 92% white across all but one study, which reported 50% white participation (Singh-Pillay & Cartwright, 2018). Finally, six studies included participants from both professions (Ladany et al., 1997; Hess et al, 2008; Mehr et al., 2010; Singh-Pillay & Cartwright, 2018; Singh-Pillay & Cartwright, 2021; Pakdaman et al., 2014) and three studies had a mix of master and doctoral participants (Schweitzer & Witham,

2018; Mehr et al., 2010; Gray et al., 2001), however this is not separated out in the findings making it unclear which elements may be influencing the data.

Findings

The quantitative findings are presented first, and the two mixed method studies are presented across both quantitative and qualitative sections.

Quantitative findings

Mixed methods studies will be covered both in this section as well as under qualitative findings. Mehr et al. (2010) reported an average of 2.68 NDs in supervisees' most recent supervision session. Significant content areas for ND were suggested to be negative supervision experiences, negative perceptions of supervisor or client, personal life and concerns about the supervisor's perception of the supervisee. The significant reasons for ND were deference, impression management, perceived negative consequences, negative feelings about the topic and perceived irrelevance or appropriateness of the topic to supervision. Hess et al. (2008) divided their participants into 'good' and 'problematic' supervision groups. Supervisees in the 'good' group expressed significantly higher levels of satisfaction with their supervision and rated their supervisors as significantly more interpersonally attractive and sensitive than those in the 'problematic' group. This finding was echoed by Schweitzer and Witham (2018) who reported significant, large positive correlations between the SWA and supervisee satisfaction and disclosure. Mehr et al. (2010), similarly reported that the perception of the SWA was significantly related to the volume of NDs as well as to the overall willingness to disclose, as was trainee anxiety. Pakdaman et al. (2014) evaluated the SWA's bond, task, and goal components and discovered a large and significant positive association between the bond and

task components and comfort with and likelihood of disclosing countertransference issues, whereas being goal focused predicted significantly lower levels in both.

Qualitative findings

Table 5

Thematic themes synthesised from articles

Core Themes	Sub-Themes
Context	Content of ND
	Psychology culture and expectations
Security in the SR	Compatibility and supervisory competence
	Power dynamics
Avoiding or approaching	Weighing risk
	Aiding disclosure
	Alternative strategies
Consequences	Supervisory reactions
	Cycle of ND and the changing SR

Context

Content of ND

The content of ND's was categorised into issues relating to supervision, clinical work, or personal life. Issues relating to supervision included negative, and in some cases, positive perceptions of supervisory dynamics, differences in theoretical orientation, concerns about supervisors' perception and evaluation and worries about professional inadequacies. Client related topics included feelings that were perceived to be unprofessional, such as, sexual attraction or clinical mistakes. Some people also reported not disclosing therapeutic successes. There was a common theme of only discussing material that was related to work and a sense of the emotional being private and inappropriate for supervision (Spence et al., 2014; Mehr et al., 2010; Ladany et al., 1997; Singh-Pillay & Cartwright, 2018; Sweeney & Creaner, 2014). Mehr and colleagues' (2010) findings supported previous research suggesting that supervisees tend to withhold issues with supervision more than clinical concerns (Pisani, 2005; Yourman & Farber, 1996). Hess et al., (2008) found that the 'good' supervision group typically withheld information about clinical issues whereas the 'problematic' group tended to withhold issues related to the SR. The findings across studies seemed largely consistent.

Psychology culture and expectations

The impact of clinical psychology culture was described explicitly by Spence et al., (2014) who explored the perspectives of supervisees, of whom 90% were also supervisors. Many individuals believed there to be a discrepancy between personal values, such as utilising self-reflection, and professional values, which were described as the scientist practitioner role, understood to be related to the scientific and non-subjective 'expert position'. Supervisee disclosure was seen as synonymous to admitting difficulties, which raised fears of appearing

incompetent. Singh-Pillay and Cartwright (2021) reported that many supervisors felt that the responsibility to supervise was imposed upon them and felt powerless to refuse and thus reluctant to supervise. They suggested that this may have impacted upon the motivation of those who experienced it as an 'unavoidable obligation' and raised concerns about the ability of some supervisors to genuinely engage with their new roles and their supervisees. Supervisors felt expected to be 'all-knowing', proficient and described an 'authoritative power' that was perceived to have been granted to them by their institutions. Despite this investiture of power, supervisors reported feeling ill-prepared for the role of supervision and described a lack of relevant training, mentoring or consultation. Most individuals were unaware of different supervisory models and as they did not have access to guidance, they often relied upon their own experiences of supervision to lead them. The lack of personal motivation and relevant training was suggested to have had an impact on supervisors' abilities to identify and address instances of ND in supervision.

Security in the SR

ND was often described as a reaction to feeling vulnerable, unheard, or unhelped in supervision and openness appeared mediated through supervisory functions such as compatibility, competence, and power, that relied upon mutual trust and collaboration.

Compatibility and supervisory competence

Spence et al., (2014) reported that the quality and connectedness of the SR was associated with the individual compatibility within the dyad. A 'good enough' fit was suggested to rely on flexibility and be essential to disclosure. This included theoretical style, which was seen as an important variable in the experience of supervision, as it was understood to facilitate attitudes

towards self-disclosure. Some participants spoke about feeling dismissed when raising transference or experiencing the supervisor as too invested in their own style of therapy as curtailing disclosure (Hess et al., 2008). Supervisory interpersonal competence was understood to be important, by most papers, when considering disclosure. This included therapeutic skills such as, warmth, validation, and collaboration whereas those perceived to be less competent were described as insensitive, critical, distant or in one case, sexually harassing towards their supervisee. Supervisees reported these non-facilitative behaviours to be detrimental to both the SR and disclosure and as often resulting in supervisees feeling silenced. Some supervisees found it reparative when supervisors acknowledged and apologised for counterproductive supervisory events (Gray et al., 2001).

The perceived clinical competence of supervisors influenced the decision-making process: for example, previous unsuccessful disclosure attempts led to ND (Sweeney & Creaner, 2014; Hess et al., 2008) and some supervisees decided to manage alone, for example relying upon their own knowledge to privately correct clinical mistakes, or decided to disclose elsewhere, if they thought it would be unhelpfully managed by their supervisors (Spence et al., 2014). Furthermore, some supervisors were described as reluctant to disclose their own errors, which was perceived as having a negative impact on supervisee disclosure (Sweeney & Creaner, 2014) and was posited to have modelled a process of withholding, which was sometimes copied by trainees (Singh-Pillay & Cartwright, 2018) and was thought to have legitimised their own use of strategic presentation in the form of subsequent NDs.

Power

Spence et al., (2014) characterised power by the degree of collaboration, distribution of responsibility and comparative rank difference within the relationship. The way in which

power was utilised within the SR was portrayed as having the ability to either facilitate greater openness (Singh-Pillay & Cartwright, 2018) or as more commonly described, was perceived to result in the supervisee experiencing a sense of powerlessness often creating fear of negative evaluation and a need for self-protection. Not feeling safe was commonly related to ND and Hess et al., (2008) linked safety within the SR to an open, respectful, non-judgemental, and non-intimidating environment. Some trainees connected being evaluated with supervisor omniscience and power and Singh-Pillay and Cartwright, (2018) conceptualised ND as being a conscious and determined act, used by trainees to subvert the power balance, and regain control within the supervisory experience, particularly relating to information that had the potential to reflect poorly on their professional competency. They reported that disclosure was determined by the amount of control that trainees felt they had, with less control leading to greater ND.

Avoiding or approaching

Weighing risk

Disclosure was commonly seen as risky and exposing, with supervisees worrying about a range of things, such as, being removed from a case, being viewed as having boundary problems, or fearing that disclosing frustrations with a supervisor would lead to a negative appraisal. Mehr et al., (2010) reported that 14.3% of participants were concerned about being seen as professionally inadequate. Some studies described supervisees wishing to maintain a boundary between their personal and professional lives, with one study reporting fears that acknowledging personal anxiety could cause individuals to be seen as inadequate (Singh-Pillay & Cartwright, 2018). Personal factors influencing this process included assertiveness, feeling unsure how to use supervision and aversion to uncomfortable feelings and topics. Furthermore,

Spence et al., (2014) reported differences in the extent to which participants perceived disclosure to be encouraged within clinical psychology. Therefore, there was also disagreement about what individuals thought to be appropriate boundaries for disclosure, which was mediated by personal values. Despite these differences, all individuals agreed that appropriate disclosures were linked to an individual's ability to effectively fulfil their roles.

Spence et al., (2014) reported that clinicians carefully weighed up when and how much to disclose. The context, such as the physical supervision environment, stage of the SR or whether supervision was both clinical and managerial, was also seen as relevant for assessing risk. Disclosure was also proposed to change over the career span with participants unanimously agreeing that they had limited self-disclosure during training due to its evaluative nature, and most newly qualified psychologists increasing their levels of disclosure before typically reducing it with experience. The ability to self-monitor was suggested in part to play a role in lessening disclosure over time as it was depicted as a developmental skill that gained proficiency over the career span however it was also linked by participants to the increasing pressure to appear competent and therefore suggested to not always be entirely helpful.

Aiding disclosure

Most articles suggested strategies that might maximise disclosure. These spanned emotional strategies such as making the supervision environment feel containing, empathetic and less anxiety provoking, as well as practical strategies such as providing role induction, balancing challenging and supportive behaviours, supervisors not being too invested in their own style and aiding supervisees to maintain a sense of control within supervision. Strategies such as making space within supervision to process emotions in relation to the work and modelling the disclosure of relevant personal experiences were also discussed (Sweeney and Creaner, 2014).

The strength of the SR was considered important as some participants assessed whether the relationship could withstand the disclosure without becoming compromised (Singh-Pillay & Cartwright, 2018). Knowing when to probe was considered a necessary requirement for disclosure in several articles (Ladany et al., 1997; Hess et al., 2008; Sweeney & Creaner, 2014), but could also be experienced negatively if not done sensitively (Ladany et al., 1997).

Alternative strategies

Some articles reported that participants attempted to self-manage their situations where possible. Spence et al., (2014) described participants as assessing their own ability to self-monitor and only disclosing if they felt this was no longer viable and Singh-Pillay and Cartwright (2018) found that reliance on the self, resulted in supervision becoming devalued in some cases. In some instances, if supervision was not perceived helpful, supervisees decided to disclose elsewhere, such as to colleagues, peers, family or in personal therapy. Furthermore, Hess et al, (2008) reported supervisees giving up and 'going through the motions' after feeling unheard. Gray et al., (2001) similarly found that following a counterproductive supervision event, some trainees began to censor themselves and to only give 'watered down' feedback as a way of managing and that others addressed the issue indirectly, for example requesting supervision be used to discuss feelings more generally but not mentioning feeling invalidated by the supervisor.

Consequences

Supervisory reactions

Singh-Pillay and Cartwright (2021) reported that ND's had serious ramifications for some supervisors, such as malpractice lawsuits. Supervisors were reported to be worried about

disciplinary hearings and their professional reputations and commonly reported feeling betrayed and angry at supervisees who withheld information. Most supervisors shared the belief that feeling unsafe and having a poor supervisory alliance was the reason why supervisees did not disclose, and many were unwilling to consider the possibility that their trainees may have made deliberate NDs, regardless of feeling safe, and maintained that any ND on their trainee's behalf was unintentional. Their strong personal reactions were understood to be a consequence of their efforts to create safety having gone unnoticed or due to questioning their abilities to effectively supervise.

Cycle of ND and the changing SR

Lessening self-disclosure within SRs that had a poor alliance or in those where supervisors were perceived as modelling withholding behaviours and a 'wait and see' approach was commonly spoken about. Several participants across two studies (Hess et al., 2008; Singh-Pillay & Cartwright, 2018) worried that each act of ND was potentially creating a structure that allowed them to repeat further NDs and add to the existing cycle of ND within their SRs. Supervisees with problematic SRs typically described many instances of ND within their relationship and understood ND as leading to further ND and decreasing investment in supervision (Hess et al., 2008). Gray et al., (2001) reported positive effects of breaking the cycle of ND such as, allowing one participant to experience that 'nothing bad happened' when they disclosed and another to be able to eventually resolve and receive support for a previously nondisclosed and upsetting counterproductive experience.

Spence et al., (2014) reported that any self-disclosure affected the quality of the SR, regardless of the outcome, even if the disclosure was not related to the relationship. Articles described a mix of positive and negative effects upon the SR following disclosure. ND was related to

negative or neutral effects on the SR, with negative effects appearing linked to SRs that were perceived as problematic and neutral affects linked with those relationships perceived to have been 'good' (Hess et al., 2008). Some articles discussed the negative impacts reporting increasing distance (Ladany et al., 1997; Hess et al., 2008; Sweeney & Creaner, 2014). Some studies described disclosing and addressing events in supervision as having strengthened or confirmed a strong relationship or aided an alliance to recover after a counterproductive event. However, some individuals also related disclosures with negative outcomes, such as in one case an irreparable breakdown of the SR leading to a change in supervisor (Gray et al., 2001).

Discussion

Outcome

The findings of this review suggest that the decision-making process that supervisees employ when deciding how to navigate disclosure are complex, individual and dynamic. Studies indicated that a level of ND is inevitable (even in SRs with a strong alliance), and in line with Bordin's theory (1983), the SWA, particularly the bond element, appeared heavily implicated in maintaining a SR that maximised supervisee disclosure. The fear of being negatively evaluated or viewing a supervisor to lack interpersonal or clinical competence was suggested to have a negative impact on supervisee's willingness to disclose. Furthermore, feelings of powerlessness within the SR may cause some supervisees to limit disclosures in an attempt to retain control over their experience. This appears to further align with Bordin's theory, as negotiation, collaboration and mutual agreement are presented as laying at the heart of developing a strong SWA, (Wood, 2005). This may be particularly relevant to this review as most of the studies consisted of trainees, who may experience power imbalances more keenly than more experienced practitioners. Similarly, the processes involved in disclosure may vary

over the career span, with findings from this review suggesting that disclosure may decrease as practitioners gain in seniority and experience. The culture of clinical psychology was also implicated within this process and was suggested to implicitly discourage disclosure due to a perceived pressure that psychologists felt to appear aligned with the 'expert' scientist-practitioner position.

Strengths and Limitations

This review's primary strength is that it is the first to combine all relevant papers on supervisee nondisclosure in clinical and counselling psychology. It also contributed findings from qualitative, quantitative, and mixed methods designs, providing a range of outcome data. Important limitations of the review include that due to the lack of research into this area, the review only contained one study examining the perspectives of supervisors (Singh-Pillay & Cartwright, 2021), reducing its ability to provide a representative picture of the situation. Furthermore, this study was based in South Africa where supervision practices may differ from the UK. The review also only contained one study examining qualified psychologists' experiences with nondisclosure in supervision (Spence et al., 2014), this is important as supervision experiences may shift across the career span and the review may not accurately reflect this as most participants were trainee psychologists. The following implications should be considered with some caution as there were limitations with the outcome measures used in some of the studies, and all studies were cross-sectional with many also having small sample sizes.

Implications for practice

The studies highlighted the importance of therapeutic skills such as warmth, empathy and holding behaviours, reinforcing previous research suggesting that the bond element of the SWA should be emphasised to help supervisees feel satisfied with the SR and increase the likelihood of disclosure (Ladany et al., 1996). Striving to normalise and validate a supervisee's feelings or being open about own past experiences or mistakes, were also described as important in helping supervisees feel comfortable when they might be feeling exposed. Supervisees described assessing how helpful previous disclosures within the SR were when deciding whether to disclose. They also spoke about experiencing supervisors as unhelpful when they were unable to admit not having knowledge of certain areas and instead attempted to vaguely advise the supervisee. It is therefore also important for supervisors to remain aware of gaps in their knowledge, to be transparent and willing to say, "I don't know", and to source additional supervision if necessary (BPS, 2017). This is doubly important as strategic self-presentation by supervisors was reported in some studies to be mirrored by supervisees and implicated in the cycle of ND (Farber, 2003). Therefore, being honest about gaps in knowledge may help to experientially convey to supervisees that they are not expected to be perfect, which may make disclosing mistakes easier.

Supervision has been described as a relationship with an unequal distribution of power (Murphy & Wright, 2005) and some studies found that the more powerless that supervisees feel, the more they may rely on ND to regain control to re-address this imbalance, particularly as a mechanism of self-protection in evaluative contexts. It is therefore important for supervisors to be aware of how the power imbalance may affect their supervisee (even within strong SWAs) and impact ND. Incorporating a sense of mutuality through collaboratively deciding upon the tasks of supervision, being as transparent as possible and emphasising an empathic style over an expert position, may increase a supervisee's sense of control and reflect

respect for their experiences (Bradley & Ladany, 2001). Supervisee anxiety may impact upon ND and studies showed that various factors may help alleviate this. For example, it was suggested that role induction, such as orientation to the processes of supervision, its effective use and appropriate topics as well as structured supervision that strikes a balance between support and challenge may limit trainee anxiety and maximise chances of open disclosure (Singh-Pillay & Cartwright, 2018; Bernard & Goodyear, 2009).

It is important to consider how well-equipped, supported and willing supervisors may feel to supervise. Supervisors described having little choice, training or support and needing to balance their sense of unpreparedness with the perceived expectations of the institution that they be all-knowing. Juggling such competing feelings may shed some light upon why some supervisors feel the need to strategically self-present. As self-disclosure has been suggested to be at odds with being an "expert scientist-practitioner" (Spence et al., 2014) perhaps addressing the culture of psychology explicitly within supervision might be useful to shift supervisory relational patterns away from the need to manage impressions and welcome more open disclosure.

Finally, as there are few instruments specifically designed to measure the SWA, Schweitzer and Witham (2018) compared the newly developed SRQ and the more widely used SWAI-T to determine their effectiveness. Although both measures were comparable, they recommended the SRQ for use in supervision due to its sounder psychometric properties and conceptual basis derived from qualitative supervision research. Additionally, the SRQ has the advantage of allowing for a more detailed examination of the SR via its six subscales, as well as a long and short form and a companion measure, the supervisory relationship measure (Pearce et al., 2013), designed to aid supervisors to provide feedback to trainees.

Future research

There are many potential avenues for the expansion of the existing research. For example, there is a need to further examine the changing SWA and use of ND across the career span, as the typically lessening evaluative nature of supervision and increasing competency may impact upon these factors (Rønnestad & Skovholt, 2003). It might also be useful to investigate the use of ND within peer supervision, where the elements of power and evaluation may be lessened, as this may indicate how supervisees react before the introduction of these elements and may also further expand upon other potential factors that may be at play in ND such as maintaining social or professional rank or competitiveness. To better understand why individuals choose not to disclose information, it might also be helpful to investigate the consequences of instances when difficult information was disclosed, and which supervisory processes were involved. Additionally, some trainee participants in the review expressed feeling afraid of disclosing mental health related experiences, such as anxiety, for fear of being viewed as inadequate. This may be an area where more research is warranted, as not much is known (Grice, et al., 2018), and it may involve additional processes to those reviewed here, such as stigma (Corrigan & Matthews, 2003).

Other areas of further interest may include research into detecting the supervisor competencies that enrich the SR and may encourage supervisee disclosure. Identifying and incorporating this knowledge into training for supervisors is an area that is widely cited as a necessity in the literature (Milne, 2010; Watkins, 2012). Additionally, although not touched upon by the studies in this review, racial identity and culture can have an impact upon the SR (Tummala-Narra, 2004) and are areas that are often overlooked that warrant further exploration, as research

suggests that issues regarding race or culture may sometimes be supressed in supervision due to experienced or feared unfavourable reactions (Burkard et al., 2006). Similarly, further examining the professional culture might lead to greater understanding of how SRs are formed and how and why NDs occur in this setting. Additionally, as having a strong bond within supervision appears to be of paramount importance to disclose, it might be particularly useful to study the interplay of topics such as countertransference or power within the SR. It would be particularly useful to understand how dyads have successfully and unsuccessfully managed complicated countertransference or power dynamics. Finally, as mentioned above, there are limited measures designed specifically for supervision (Schweitzer & Witham, 2018). Developing sound measures, may contribute to advancing our understanding of this topic and to improve professional development and supervision experiences.

Conclusion

This review explored the decision-making process that supervisees engage in regarding whether to disclose and which supervisory factors aid or limit disclosure. Balancing therapeutic skills with challenge within sessions was found to be important for disclosure. Engaging in relevant self-disclosure was also described as normalising and modelling a safe supervision environment by some participants. The decision-making process regarding disclosure appeared complex and involved considerations such as judging the strength and quality of the SR, navigating power dynamics and self-protection or non-facilitative supervisory behaviours such as experiencing a lack of therapeutic skills and positive regard and feeling dismissed or criticised. Other factors included whether the dyads individual styles were compatible, the supervisees perceived ability to self-monitor, stage of career and wanting to be viewed as competent as well as personal and practical factors, such as supervisee anxiety

or personal beliefs regarding disclosure or having a contained physical environment for supervision. Additionally, gaps in the research were identified, including a need for greater understanding of the perspectives of supervisors and qualified supervisees across the career span.

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Section B: Empirical paper

Exploring how trainee clinical psychologists and their supervisors and training providers understand and navigate mental health difficulties, support, and time off

Overall Word Count: 7,999 (8,052)

April 2022

Abstract

Background: The prevalence of mental health difficulties (MHDs) has been reported to be high and often undisclosed within the field of clinical psychology, by both qualified and trainee practitioners. Clinical psychology training can be stressful, and it has been suggested that trainees may be more prone to distress and self-doubt due to their inexperience. Despite this, little is known about how mental health issues are navigated within training. This study is the first to explore how trainees, clinical supervisors and training facilitators understand and navigate MHDs, support, and time off, aiming to improve the understanding of this process and influence the clarity surrounding such situations and the support available. **Method:** Grounded theory methodology was utilised to create a theory, grounded in data. Semi-structured interviews were conducted with ten participants and analysed using grounded theory. **Analysis:** Seven main categories were created, using grounded theory methodology: trainee and staff histories and stressful life events, personal attitudes towards mental health difficulties, power and autonomy, questioning workplace competence, complex systemic issues, navigating access to support and time out, mental health in the psychological trenches and learning and hindsight. **Discussion:** Findings highlighted a complex and individual process, along with systemic and organisational issues that may make this process more difficult to navigate and suggested that the culture within clinical psychology may implicitly discourage the disclosure of MHDs. Implications may include working towards a cultural shift and proactively clarifying and communicating relevant mental health procedures.

Keywords: Mental Health Disclosure, Clinical Psychology, Trainee Clinical Psychologists, Clinical Supervisors, Clinical Psychology Doctorate Training, Lived Experience, Stigma, Support

Introduction

Mental health difficulties within clinical psychology

A high prevalence of mental health difficulties (MHDs) has been reported amongst NHS staff, with many experiencing stigma upon disclosure (Morgan & Lawson, 2015). MH disclosure and navigation within clinical psychology (CP) has been largely unstudied, despite recent UK research indicating that up to 62 percent of qualified practitioners may have lived experience, (Tay et al., 2018). Another study found that 67% of CP trainees reported having had experience of MHDs, with 29% experiencing at least one MHD at the time of the study (Grice et al., 2018). These figures suggest that the prevalence of MHDs could be higher than in the general population, who are estimated to have a lifetime prevalence of 41% (Mental Health Foundation, 2016). CPs have also been suggested to have higher incidences of difficulties in childhood, such as abuse, than the overall population (Murphy & Halgin, 1995; Elliott & Guy, 1993). Gizara and Forrest (2004) highlighted many CPs who continued to work even when too distressed to function adequately. They further stated that while this may not be infrequent among trainees, little is known. Furthermore, CP training can be a stressful experience, during which some trainees have reported an increase in interpersonal and MHDs (Kuyken et al., 2003). This has significant implications, particularly for fledgling practitioners who are inexperienced, in a highly stressful environment, and expected to provide a high level of care to vulnerable clients.

Navigating lived experience within CP

Individual fallibility, according to research, may impair an individual's capacity to appraise their own competency, especially if they are experiencing emotional distress (Dunning et al., 2003). This process therefore often relies upon voluntary consultation and collaboration with colleagues (Roberts et al., 2005). Despite the common experience of MHDs amongst CP populations, a recent UK study found that trainees were often unlikely to disclose their difficulties to their clinical supervisors and course facilitators (Grice et al., 2018). Stigma theory proposes that experiences of shame and the fear of being judged may cause individuals to withhold information about MHDs (Corrigan, 2004; Garelick, 2012; Goffman, 1963) and according to Ahmedani (2011) internalised MH stigma can sometimes also interfere with help-seeking behaviour. Furthermore, workplace stigma may prevent certain MH professionals from seeking treatment (Knaak et al., 2017), perhaps speaking to an implicit culture of MH nondisclosure among colleagues (Boyd et al., 2016b; Zerubavel & Wright, 2012).

However, being careful about sharing MH information and fearing stigmatisation may not be unreasonable. The term ‘kiss of death’ was coined in a study of 457 admission panel members for graduate psychology programs and refers to statements that decrease an applicant’s chances of acceptance. Disclosing personal MHDs was one such area, “Such statements could create the impression you may be unable to function as a successful graduate student” (Appleby & Appleby, 2006, p. 23). Psychologists with dual identities have also described indirect discrimination from co-workers disparaging others with MHDs, and reported professional advancements being hindered (Elliott & Ragsdale, 2020). Others have reported stigmatisation and fearing their fitness to practice (FTP) being questioned (Tay et al., 2018; Dearing et al., 2005). Workplaces can also foster harmful narratives like the “impaired healer” discourse (Adame, 2011).

As a result of these experiences, people may be less open about their employment experiences and requirements, making it difficult to receive workplace adjustments (Boyd et al., 2016b; Harris et al., 2016) under the Equalities Act (2010). Finally, it may be difficult to ignore unfavourable discourses from other English-speaking countries, such as America, where reporting MHDs can affect professional licensure, as they are often equated with professional impairment (Appelbaum, 2015; Boyd et al., 2016a). This may be important for trainees who are conscious of being closely scrutinised (Rønnestad & Skovholt, 2003) and aware that FTP regulations could be invoked if their MHDs be deemed concerning.

Navigating conversations about MH with supervisors and trainers

The purpose of supervision is to ensure the well-being of both trainee and client through aiding the trainee to process clinical work-related emotions and develop competency (Inskipp & Proctor, 1993; Watkins, 2011). Nondisclosure of MHDs can therefore be challenging as supervision is hindered without open and trusting communication (Knox, 2015). The quality of the relationship (Ignatius & Kokkonen, 2007), perceived stigma (Rüsch et al., 2014), and the type (Brohan et al., 2012) and recency of the MHD (Bushnell et al., 2005) have all been linked to trainee disclosure. Additionally, 'maladaptive perfectionism' has been associated with MH nondisclosure (Kawamura & Frost, 2004). Maladaptive perfectionism is a term used to describe the pursuit of unattainable standards accompanied by elevated self-criticism (Frost et al., 1990). This is relevant for trainees because gaining a training place is highly competitive and may select individuals prone to high standards (Grice et al., 2018).

There is a scarcity of research on how trainees, clinical supervisors, and trainers manage the complex processes involved regarding MHDs, support, leave or competence questions (Grice et al., 2018). Despite its central role in organising and establishing the landscape for both the

practical and emotional experiences of training, the training institution's contribution to the management of MHDs or the integration of dual identities has not previously been explored. Stigma theory (Goffman, 1963) could be used to hypothesise that as trainees' function within a wider psychological culture that appears to avoid openly acknowledging MHDs, this behaviour may be modelled and internalised by trainees entering that environment.

Study rationale and aims

While the culture of nondisclosure within CP is understandable, it may be disadvantageous to both individual and profession. Given the lack of research in this area, researching how trainees, supervisors, and trainers navigate and manage conversations and situations regarding MHDs could help increase workplace understanding and support. This research is important as trainees have been suggested to be at greater risk of distress and experiencing self-doubt, due to their inexperience (Skovholt & Rønnestad, 2003) and reluctance to disclose may, in some instances, put themselves and others well-being at risk (Grice et al., 2018). However, practitioners with lived experience have also been found to hold fewer stigmatising views of service users and show no greater levels of professional impairment (Harris et al., 2016) and are often very professionally successful (Boyd et al., 2016b). Breaking the silence about lived experience may therefore also help combat stigma, serve as a positive model for others in the profession (Boyd et al., 2016b), and shape services through improved research and understanding of service user needs (Banfield et al., 2018; Lewis & Hasking, 2019).

Finally, investing in research to understand the processes involved in disclosing and managing MHDs at the stage of training may be invaluable, as if we are able to better understand and provide positive experiences and narratives relating to MH then this could shape the future of psychology as trainees will go on to impact and shape psychology culture. This study therefore

aimed to develop a grounded theory (GT) to explore how MHDs, extra support and time off may be navigated between trainees and their supervisors and training facilitators.

To assist in building the GT, this study focused on the following questions in relation to participants' experiences:

1. How is it determined when to ask for or offer extra support due to MH difficulties?
2. How is it determined when the difficulties are interfering too much with practice and the support is no longer enough?
3. What are the factors that help or hinder this process?

Method

Design

This research utilised a qualitative framework, using GT methodology, which was first introduced by Glaser and Strauss (1967) and has undergone constant evolution. GT is particularly useful when applied to phenomena that are not well understood, as it seeks to construct explanatory theories grounded in data (Birks & Mills, 2015; Creswell & Creswell, 2018). This research was approached from a critical realist epistemological stance, which surfaced through the works of Bhaskar (1975) as an alternative to positivism and constructivism (Denzin & Lincoln, 2011) and operates under the assumption that ontology (reality) cannot be reduced to epistemology (human knowledge about reality), that our knowledge can only capture elements of reality, and that some knowledge is closer to reality than other knowledge (Fletcher, 2017; Danermark et al., 2002).

This study employed Corbin and Strauss' (2015) methodology of GT, which is coherent with this stance and could be summarised as, "The world is a complex place. There are no simple explanations […] for why events occur… The actions and interactions that follow are often unpredictable, subject to change, and based on the meanings given to those events" (Corbin & Strauss, 2015, p. 28). A self-reflective stance was taken throughout the research process which aligned with the methodology, "we don't separate who we are as persons from the research […] we must be self-reflective about how we influence the research process and […] how it influences us" (Corbin & Strauss, 2015, p. 27).

Ethical considerations

As this research did not recruit via the NHS, it only required ethical approval from the Canterbury Christchurch University ethics panel, which was granted (Appendix B). This research was designed in accordance with the NHS values of Respect and dignity, Improving lives and Compassion (NHS, 2021). Participants were made aware of the nature of the study, confidentiality and how their data would be handled and stored through an information sheet (Appendix C), were given the opportunity to ask questions and then indicated their consent via a consent form before any participation in the study took place (Appendix D). Participants were informed of the limits of confidentiality, to only offer as much information as felt comfortable, that they could stop the interview at any time, and their data could be withdrawn from the study for two weeks after the interview. None of the participants terminated an interview or withdrew their data. Risks would have been managed following conversations with the academic supervisor and in line with organisational policies, however no such risks were reported. Individuals were also informed that they might be contacted to provide feedback on the emerging theory, but they were not required to participate.

Participant information was stored on an encrypted memory stick and was password protected. The participants were given pseudonyms that were used with their interviews, transcripts, and notes and were stored in a separate password protected document. During interviews, participants were advised not to use identifiable information such as names or locations, and the researcher edited the transcripts to remove any identifiable information. The original interview recordings were destroyed after they were transcribed. Only the researcher and her academic supervisor had access to participant transcripts. The study sought to minimise potential distress by recruiting individuals who wanted to share historical (rather than current) experiences. Participants were sent a debrief sheet (Appendix E) following the interview.

Data collection

The study tried to reach as many UK trainee CPs and supervisors as possible. An email requesting permission to recruit was sent to every training course director in the UK (Appendix F). Thirteen of the 29 institutions contacted, agreed to circulate the recruitment email (Appendix G) to their trainees, and three agreed to distribute it to their supervisors. Recruitment may have been influenced by the start of the COVID-19 pandemic, as some institutions stated they did not want to place extra burdens upon their staff. Due to difficulty recruiting this way, the study also advertised on Twitter and the UK CP Facebook group with over 6,300 members (Appendix H). GT entails collecting and analysing data and theoretical sampling strategies concurrently (Glaser & Strauss, 1967); consequently, sampling pool decisions were altered following earlier interviews, and the study was later expanded to include course staff, as all participants noted the critical role of training institutes. These were also recruited via Facebook and re-contacting training institutions that had previously responded positively. Participants were also asked to complete a demographic form (Appendix I).

Due to COVID-19 all interviews were conducted using videoconferencing and were recorded on a Dictaphone. The interview schedule (Appendix J) was developed in consultation with CPs who had lived experiences and used a semi-structured interview format using open ended, non-leading questions. In keeping with GT, the format allowed for deviations from the schedule and relevant follow-up questions or prompts. The interview schedule was also modified in line with theoretical sampling, to allow gaps in the emerging theory to be explored (Glaser, 1978). Interview times varied between 55 - 102 minutes. The study relied upon theoretical sufficiency (Dey, 1999) to determine when enough participants had been recruited. This occurred once sufficient depth had been reached in the categories to be able to create the concepts and theory in an attempt to understand the underlying reality.

Participants

The researcher recruited 10 participants: 4 trainees, 4 supervisors and 2 course staff. Two of the trainees had been qualified for under one year and the remainder were in their final stages of the last year. All participants met the inclusion criteria (Table 6).

Table 6

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• UK based trainee CPs or newly qualified CPs (2 years post qualification maximum) who wish to reflect on historical experiences of MHDs whilst on training that resulted in a period of leave from training. • Placement supervisors or course facilitators who have supervised and	• Any past or present trainees, facilitators or supervisors wishing to speak about the experiences of trainees originating from Salomons. • Trainees or newly qualified CPs who are currently experiencing MHDs to such an extent that a period of leave is likely or imminent.

	navigated a relevant process with a trainee in the last 3 years.	• Supervisors or facilitators managing a trainee who is in the midst of experiencing MHDs to such an extent that a period of leave is likely or imminent.

Present experiences of MHDs to the extent of likely or imminent leave were excluded to limit participant distress as well as to minimise the potential risk of participant confidentiality needing to be compromised if the participants shared any information indicating present risk to themselves or clients. Connections to Salomons were excluded to preserve confidentiality as the researcher is based there. The identities of the DClinPsy courses were only known for 8 of the 10 participants. Of these 8, all were distinct courses spread across varying parts of the United Kingdom. Participants were 80% female and their ages ranged from 28 – 52. Table 7 outlines the demographic characteristics of each participant.

Table 7

Participant demographics

Participant	Age	Gender	Ethnicity	Role	Theoretical orientation at the time
Elaine	36	Female	White European	Trainee *(Pre-qual, final year)*	CAT and CBT
Skylar	28	Female	White European	Trainee *(Pre-qual, final year)*	CBT, CAT and narrative
Jean	30	Female	White European	Trainee *(>1 year post-qual)*	CBT and systemic
Kate	28	Female	White European	Trainee *(>1 year post-qual)*	CAT and CBT
Matt	36	Male	White European	Supervisor	CBT, DBT, ACT and mindfulness

Participant	Age	Gender	Ethnicity	Role	Theoretical orientation at the time
Joni	40	Female	White European	Supervisor	Eclectic and ACT
Leona	32	Female	White European	Supervisor	Eclectic
Trixie	35	Female	White European	Supervisor	CBT and psychodynamic
Jeremy	51	Male	White British	University Tutor	Eclectic
Sandy	52	Female	White European	University Tutor	N/A

Data analysis

Interviews were analysed using open, axial and selective coding, which are outlined in Table 8 as supported by Corbin and Strauss' (2015) methodology. See Appendices K - N for examples of open, axial and selective codes and the memos and diagrams that helped form and integrate the theory.

Table 8

GT stages of data analysis

Coding stage	Explanation
1. Open coding	Inductive identification of initial tentative concepts via line-by-line coding. Application of descriptive / analytical labels that capture actions, emotions, perspectives, conditions, wider contexts, and any other explanation of what may be happening in this section of the transcript. See Appendix K for an example.

2. Axial coding	Emerging concepts were grouped together into tentative categories that appeared congruent with the emerging data and relevant to the research questions. This stage utilised a constant comparative process whereby the categories were fluid and were regrouped as new concepts emerged and were compared to the existing concepts and categories. See Appendix L for an example excerpt.
3. Selective coding	Existing categories were compared to understand how they relate to each other and were integrated further until only a few core concepts remained. The development of theory was aided by the axial codes and the diagrams (Strauss, 1987) and memos (Appendix M and N) that attempted to summarise and synthesise ideas regarding relationships between concepts (Glaser, 1978). The theory was then created through constant comparison of these elements developing an explanation of the relationships, interactions and consequences between these concepts and sub-concepts, grounded in the data (see Appendix O for stages in formation of the theory).

Credibility evaluation

As part of the research preparation process, guidelines for high quality GT studies (Elliot et al., 1999) and the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2020) were taken into consideration. Furthermore, the quality was monitored via various subsequent processes (Yardley, 2000).

The researcher acknowledges that her worldview will influence the research process. To establish reflexivity, identify underlying assumptions, and increase transparency, a bracketing interview was held prior to conducting research. See Appendix P for the resultant positioning statement. Throughout the process, the researcher additionally kept a reflective diary, noting assumptions and identifications with certain viewpoints, which she discussed with her research supervisor, who also coded and compared codes from several transcripts to screen for possible data reading bias. To ensure transparency throughout the research process, memos, diagrams, and the presentation of relevant participant quotes were used. Finally, the emergent theory (Appendix Q) was circulated to a subset of participants for feedback (Lincoln & Guba, 1985). This feedback was then considered and incorporated into the final theory, as shown in the results section (Appendix R contains an excerpt).

Results

Overview

During the analysis, seven main categories were created, based on the data: 'Trainee and staff histories and stressful life events', 'Complex systemic issues', 'MH in the psychological trenches', 'Personal attitudes towards MHDs, power and autonomy', 'Questioning workplace competence', 'Navigating access to trainee support and time out' and 'Learning and hindsight'. The analysis was synthesised into a diagrammatic model (Figure 5), with each box representing a category and suggesting how these may influence each other. To avoid the model appearing too crowded and confusing, all but the essential arrows, and main categories, have been withheld from the diagram. It is therefore recommended that readers hold the closely interrelated nature of the categories, as well as the sub-categories in mind while studying the diagram. The categories and sub-categories can be found in Table 9.

Figure 5

A model of disclosure and management of MHDs within the UK DClinPsy

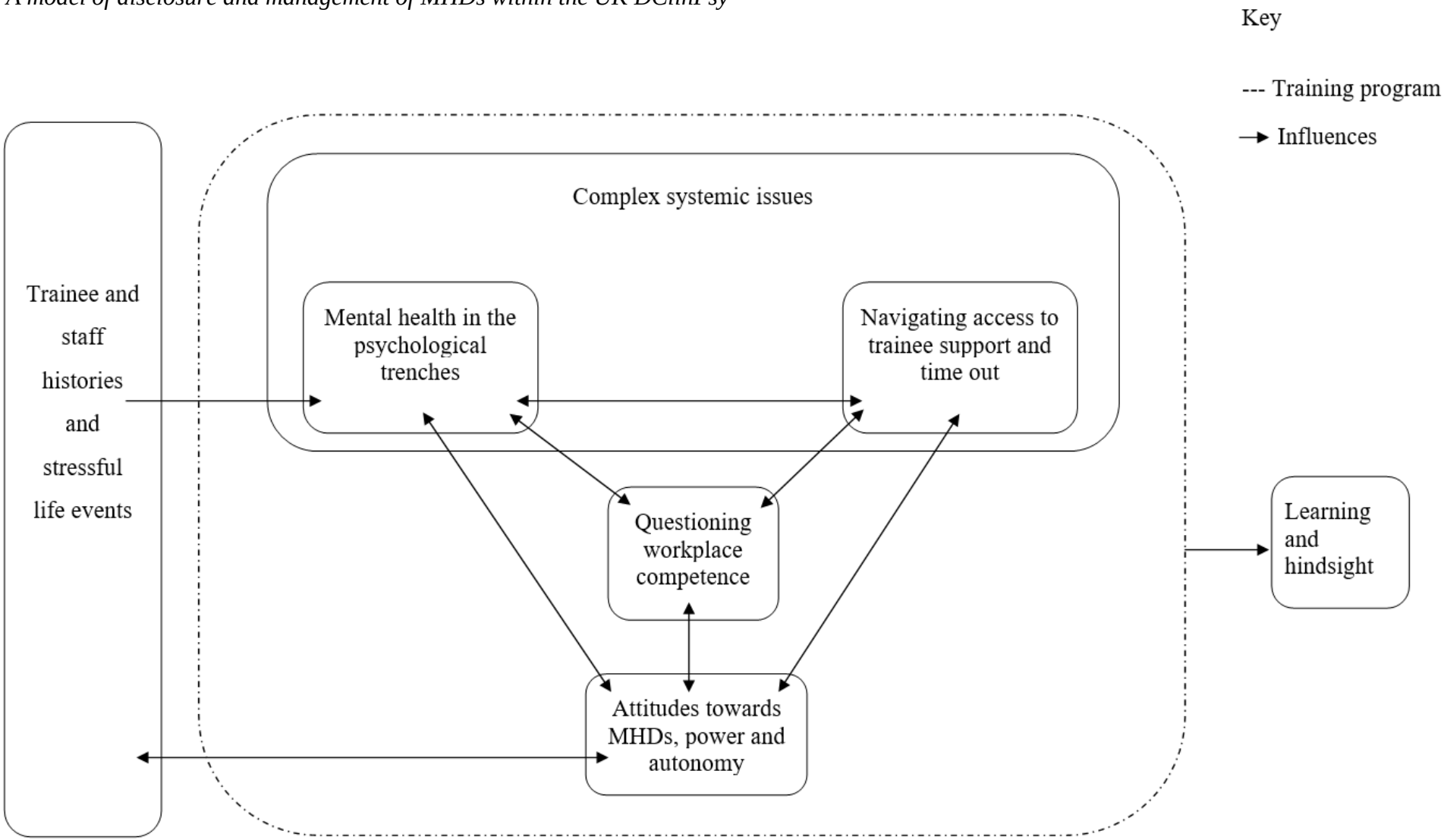

Table 9

Table of categories and sub-categories

Category	Sub-categories
Trainee and staff histories and stressful life events	COVID-19
	Life events
Personal attitudes towards MHDs, power and autonomy	Own experiences shaping management of MHDs
	Level of trust within trainee and staff relationship
	Navigating power differentials
Questioning workplace competence	Balancing emotional experience
	Maintaining resilience reserves
	Maintaining autonomy and questioning competence
Complex Systemic issues	Practical course limitations
	Unclear procedural communication
	Disjointed communication across the system
Navigating access to support and time out	Navigating time out

Category	Sub-categories
	Navigating support
MH in the psychological trenches	Tokenistic MH engagement
	Binary attitudes, stigma, and openness
	Trainee identity: is imperfect acceptable?
	Boundaries between personal and professional
Learning	Helpful, unhelpful, and missing support avenues
	Hindsight
	Change in attitudes towards managing MHDs

The findings will now be presented as they relate to each of the categories and sub-categories. The relationships between the categories will also be discussed and participant quotes presented in support of the suggested theory.

Trainee and staff histories and stressful life events

This category referred to the wider experiences that were happening in participants' lives that may have influenced their MH or ability to navigate discussions regarding mental health, support or taking time off.

COVID-19

The COVID-19 pandemic seemed to affect the participants' experiences of training and mental health. Participants indicated that social isolation and lack of connection with their cohort affected their abilities to access social support, “The relationships between the training course and trainees […] feels more distant. (Leona, supervisor)”. Others suggested the lack of physical presence, or masked presence, undermined their ability to spot deviations from their trainees' usual ‘baselines: “I've missed something here with the mask (Trixie, supervisor)”. Remote working may have hindered the building of solid supervisory foundations, which may have impacted the relationship's ability to handle challenges, “If you need to challenge anything within that supervisory relationship… you haven't necessarily got that foundation (Joni, supervisor)”.

Life events

Participants described current life events that impacted trainees MH, “There was also stuff happening outside of training… to do with isolation… and they were experiencing some physical… difficulties as well (Jeremy, tutor)” or the ability of trainees or staff to manage the situation, “I always felt like, because of the role I was in, and our service being… so busy at the time, and really limited in a managerial capacity, that I wasn't able to give her enough (Trixie, supervisor)”. Participants also described past experiences related to their mental health, “Honestly, that [clinical psychologists’ responses] was the most stigmatised I've felt in my entire life (Matt, supervisor)”, “My support system was my family… who were very cruel to me for experiencing emotions (Skylar, trainee)”. Some past experiences appeared to shape participants' future engagement with managing MHDs, both within themselves and with others, and will be discussed in 'own experiences shaping MHD management'.

Personal attitudes towards MHDs, power and autonomy

This category referred to the impact that individuals past experiences had on their personal attitudes towards MHDs and their management. It also encompassed the impact that interpersonal styles, power, and relational trust had upon the experience, sharing and management of MHDs.

Own experiences shaping the management of MHDs

This sub-category focussed on participants' experiences and how these appeared to influence their approaches to their own and others' MH.

> "I tried to be quite compassionate… towards my mental health… what I was wanting to transfer onto the trainee […] I was keen to create that secure base… I had that from the course. So that probably informed kind of how I approached things (Leona, supervisor)"

Some participants linked trainees' openness to whether they trusted the intentions of the staff or institutions, "Whether the trainee really believed I actually did have their best interests at heart… it probably does link to their experiences of hierarchy (Jeremy, tutor)" and some participants were guided by their past experiences of their MHDs and what was helpful, such as staying in work, "It would be more helpful for me to stay working (Kate, trainee)". This appeared to serve a helpful, protective function, however sometimes this strategy could also become unhelpful, "it got to the point where the balance had completely shifted, and work was all I had... I was no longer looking after myself (Elaine)".

Level of trust within trainee and staff relationship

This sub-category referred to the relational and practical aspects between trainees and staff that increased or decreased the safety and trust for either party within these relationships, “They were just really supportive and really lovely (Skylar, trainee)”, “I'll have… some idea about how we'll do this. You could just go off and look after yourself and not have to think about all the details (Leona, supervisor)”, “I was being kind of micromanaged and criticised constantly (Kate, trainee)”, “The trust was gone. I… was worried of looking in the files, like what am I going to find? (Trixie, supervisor)”. These elements appeared to impact the ease with which individuals were able to address the topic of MH “I think if we had had a difficult relationship, that would have made it exponentially more difficult (Leona, supervisor)”, and in some cases, appeared to exacerbate the trainees MH, “it felt like she was trying to bring me down… […] there's still a small part of me that still feels that loss of confidence… nearly, two years later… I'm still healing from that (Jean, trainee).”

Navigating power differentials

This sub-category discussed complex power dynamics in conversations and decisions regarding mental health, MHD disclosure, and leave. Staff members were described as powerful, “supervisors inherently have… the upper hand (Jean, trainee)”, some trainees described feeling as though their autonomy had been removed, “I remember really trying to resist… but feeling like… she wouldn’t let me out of the room until I’d agreed to take some time off (Kate, trainee)”, or retained by other staff, “it felt more that she trusted me to know what I needed… and that she was giving me that decision (Kate, trainee)”. Despite this, staff also described wrestling with their dual roles as supervisor and evaluator, “[wanting] to make her like me… But I do… now recognise the need for maintaining a bit of… hierarchy (Joni, supervisor)”. Some had experienced a trainee as feeling relieved to relinquish control, “There was kind of a relief, that... they didn't have to acknowledge anything… (Sandy, tutor)”. Some

mentioned trainees withholding information about their MHDs, possibly to maintain control, "[the problem was] maybe making yourself vulnerable to somebody in authority (Sandy)", "the conversation was less open [after disempowering experience] and I found that that worked better for me (Kate)".

Questioning workplace competence

This category included participants' perspectives on the relationship between workplace competence and personal autonomy to make decisions about mental health leave. The category considered how emotional experiences and resilience influenced this process for different individuals.

Balancing emotional experience

This sub-category addressed the varying attitudes and experiences of emotionality and its expression and appropriateness within the workplace, in relation to competence. Some participants described owning one's own emotional experiences and not being avoidant as a protective factor, "It's the avoidant people who […] are more at risk, I think of getting lost in it (Joni, supervisor)", "It's alright for these cases to impact you but it's a problem, if you… can't tell me about that and… can't reflect on that (Matt, supervisor)". Many felt that being emotional at work was okay if the emotions remained contained in relation to clients, "It's okay to cry. It's okay to be anxious… if they can contain the emotion with the client, then I think that's okay (Sandy, tutor)"; however, one participant described having to take enforced leave shortly after becoming tearful in a supervisory space.

> "I am someone who… cries very easily… that to her came across as a… red flag that I might not be fit to practice […] she was [incorrectly] assuming that's what I would be like on placement and in the therapy room with clients (Kate, trainee)"

Maintaining resilience reserves

This sub-category referred to the assessment of resilience and how this influenced ideas regarding competence and leave taking. Some participants discussed how they determined that they no longer had enough reserves of resilience and reflected on how this impacted on their assessment of competence and remaining at work, "When you talk to people about a stress bucket… felt like I was at the brim and […] there just wouldn't be the resilience there to manage (Jean, trainee)". The decision to take leave also appeared influenced by whether it was deemed possible to restore resilience through other means whilst remaining at work, "I was exhausted… and the reality was that everything at that point was going into work, which meant that I couldn't even attempt to get better (Elaine, trainee)".

Maintaining autonomy and questioning competence

This sub-category referred to personal autonomy regarding MH leave decisions being determined on merit of workplace competence. Generally, participants felt that leave should remain a personal choice unless an individual's workplace functioning was compromised, "I […] see it as a personal decision until and unless it's clear that it's having an impact on someone's ability to work (Jeremy, tutor)". Assessing workplace competence was complex, individual and non-binary, but appeared to include overwhelming emotional, "I felt like a real… sense of foreboding going into work… (Jean, trainee)" and interpersonal experiences, "I felt really disrespected… like she hated me (Trixie, supervisor)", as well as managing risk,

"My mood was like really low, I was a risk to myself (Elaine, trainee)" and other organisational aspects, "She had another patient waiting… and she seemed to have absolutely no awareness of that (Joni, supervisor)". Some participants also spoke about MHDs as separate from FTP, "I wasn't concerned about fitness to practice I thought she was doing great work clinically (Matt, supervisor)", unless they were unable to accept and enact guidance regarding leave when deemed essential, "I think if I'd said to the trainee, you need to go off sick, and they'd said, "No, I don't", that would have been fitness to practice (Sandy, tutor)".

Complex systemic issues

This category referred to the complex and sometimes limiting wider organisational systems and culture within which participants functioned, including the doctoral institutions, NHS placement structures and occasionally the wider mental health services whose ability to make decisions about trainees' welfare superseded that of other structures. These systemic issues appeared to have an impact on the clarity of procedures and communication, affecting participants' ability to navigate conversations around MHDs and trainees' ability to take leave.

Practical course limitations

Participants spoke about the various practical limitations present in the doctorate that made it difficult to discuss MHDs and leave; such as, time pressures, "Completely messes up everything if they have to take time off […] can't really extend the placement and then it clashes with the next placement and teaching block and it's just… (Matt, supervisor)", not wanting to lose their cohort, "I really didn't want to drop down in any way (Elaine, trainee)"; or feeling desperate not to extend training for other reasons, such as degenerative health conditions, "Any suggestion of taking a bit of a break immediately raised the spectre of having to extend training

(Jeremy, tutor)". There also appeared to be variations in service structure that may have interacted with their MH and ability to manage taking leave: "My managers said… these people started therapy then had to end and then reallocate, and we just can't have the same [trainee] back (Matt)".

Unclear procedural communication

This sub-category referred to procedures involved in the management of MHDs and leave-taking and how ambiguity regarding these factors appeared to complicate the process. Some participants suggested that FTP and sickness procedures were not clearly and proactively communicated to trainees or supervisors, "They rely a lot on handbooks… […] it's too long… something this important should probably be highlighted (Joni, supervisor)", "[not knowing about] how my training timeline could be adapted… what's going to happen? (Kate, trainee)", that they were subjectively interpreted depending on staff's variable perceptions, "It was really like what…?! You're doing fitness to practice because of…?? (Matt, supervisor)", and that the term FTP had negative connotations, "Fitness to practice is seen as such a massive disciplinary thing (Joni)" making it harder to discuss.

Disjointed communication across the system

A sense of disconnected communication across the systems seemed to affect stakeholders' abilities to have access to necessary information to base decisions on or to feel united. Some participants described decisions being made in isolation without practical assessment, "[felt pressured to take leave] … and contacted my supervisor and I don't believe that there had been any communication between them (Kate, trainee)" or important information being unknown, "They were saying well actually she's been in hospital on 1 to 1… I didn't even know that

(Matt, supervisor)". Additionally, confusion was highlighted regarding whose responsibility it was to make decisions regarding enforcing leave, "It almost felt like it shouldn't be my decision to say she's not fit to practice, that that should come from the university, but then, how would they know…? (Joni, supervisor)". Finally, in some instances, outside agencies operated in the background and awareness of them was dependent upon the trainee's openness, due to confidentiality, up until the point of hospital admission, "I'd flagged it because… I didn't know if there's any fitness to practice repercussions (Elaine, trainee)".

Navigating access to support and time out

This category referred to trainee and staff abilities to navigate support and time out, and addressed trainee openness, which appeared to play a big role in the navigation of both.

Navigating time out

Navigating time out was an individual and complex process. Trainee openness was seen as allowing collaboration, however, less open trainees sometimes navigated situations alone, "I wasn't aware (Matt, supervisor)" and, in most cases, took leave before workplace competence was compromised, "There was no concerns… related to her performance (Leona, supervisor)". Others seemed unable to acknowledge their MH, making navigation and collaboration difficult, "Her reaction was to be defensive (Joni, supervisor)", "I had to take quite a lot of responsibility for the decision making, and I couldn't really do that in a collaborative way (Sandy, tutor)". In some cases, trainees worked up until crisis point and in one case a trainee's MH team additionally became involved, enforcing a leave-decision that the trainee had already made themselves "I think there was a bit of a belief that I would still go back, which genuinely, I wasn't (Elaine, trainee)". The complexity of the process was highlighted, "That line was

blurry... she was clearly in a real crisis... and yet she was still […] doing… good work with people (Matt, supervisor)".

Navigating support

Some supervisors expressed feeling dependent on trainees being open about their experiences, "You're relying on gut instinct and hope (Joni, supervisor)" and late disclosures provided at the point of crisis often resulted in the trainee immediately going on leave without having accessed support, "The point at which I knew that crossed the threshold into something more was the point at which she went off (Leona, supervisor)". The process of openly acknowledging MHDs through taking leave appeared to enable some individuals to be more open going forwards, "My supervisors were just so kind… really supportive… I think it was… doing it and experiencing it what helped (Skylar, trainee)" and some participants described the importance of proactively setting up supervision as a space where emotional distress is welcome, "I think it's much less likely that a trainee [would inappropriately overshare]… than not saying enough (Leona, supervisor)" to maximise chances of trainee disclosure.

MH in the psychological trenches

This category reflected on how the experiences of binary attitudes, unhelpful narratives, stigma, trainee identity and boundaries within clinical psychology may have impacted participants abilities to openly discuss MH.

Tokenistic MH engagement

Some participants spoke about the culture within doctoral institutions as exhibiting tokenistic MH engagement: "They talk a good game, but the structures don't support it (Leona,

supervisor)". Some spoke about the lack of modelling, "I think it's said a bit tokenistically, but I don't think it's modelled in an experiential way (Skylar, trainee)" and silence in their own cohorts about MHDs, "Logic would dictate that there probably was other people in my cohort with […] mental health issues (Jean, trainee)". Participants discussed compartmentalisation, "You can't be the rescuer... if you also need rescuing (Joni, supervisor)" and how this could be reinforced through almost exclusive non-psychologist experts by experience teaching, ""I hear voices, none of you do. So how can you tell me, what it's like". And I just sat there like, how do you know that none of us hear voices? (Skylar, trainee)". Some suggested an active effort is required by the course to invite openness, "They've got to work a little bit at reassuring you (Jean, trainee)".

Binary attitudes, stigma, and openness

This sub-category referred to the mental separation between trainees and clients that binary attitudes appeared to contribute to and the relationship that some participants felt this appeared to have on stigma, "I felt like I was being told, if you have mental health problems, you're not fit to work (Kate, trainee)" and self-stigma, "Self-stigma was there (Jean, trainee)". It also referred to the impact these aspects may have had on trainees' experiences of being open, "I wouldn't be surprised if there was quite a lot of shame that was stopping her being fully honest about it (Matt, supervisor)"and on their future ability to be open.

> "I felt a sense of hypocrisy… as psychologists we're big proponents of keeping a sense of routine, of occupation and not being stigmatising towards people with mental health problems […] I wish I hadn't been as open with my clinical tutor… because I think that I could have coped, and I could have stayed at work… definitely has put me off from making such open disclosures (Kate, trainee)".

Trainee identity

Participants spoke of many trainees experiencing unhelpfully high standards and levels of perfectionism, as part of trainee clinical psychologist identity, "[feeling like] "I am a failure" … it's in the... essential criteria to be a clinical psychologist (Matt, supervisor)", "We as clinical psychologists are often very perfectionistic and want to be the rescuers and hero's (Kate, trainee)" that was partially reinforced by the system. Due to this, some appeared to struggle to openly acknowledge their MHDs, "It felt in some ways maybe like a failure to have time off… I felt like I wasn't coping as well as my peers. (Skylar, trainee)".

> "There's an idea that you must have it together… to be… doing the job […] that's where we fail trainees… high competition to get into the course and… [being told] multiple times… you're the creme de la crème… it's a really… unhelpful narrative. (Trixie, supervisor)"

Boundaries between personal and professional

Participants frequently wrestled with boundaries when addressing MH in supervision. A common concern was supervision becoming therapy, "It felt like it might be too raw […] crossing a boundary into something too personal… too therapeutic (Jeremy, tutor)", "I always saw supervision… as a place where I couldn't really be that open because it was frowned upon to maybe… look like I was too distressed (Skylar, trainee)". This was often uncomfortable for staff who were simultaneously trying to maintain a bond and evaluate trainees MH whilst attempting not to be intrusive, "I felt like I was being mean [...] I felt I was prizing open a door that was shut for a reason (Joni, supervisor)". This category additionally related to managing interpersonal dynamics, which could sometimes evoke strong feelings, "I had… all these feelings of anger… like I had done something wrong, and I'd let her down and also that… she

just really hated me (Trixie, supervisor)", "There were times I… actually felt quite powerless… and… there were other times where I was almost… too powerful… going back to that idea [drama triangle] of being victimised or persecuting (Jeremy, tutor)".

Learning

This category included reflections about support and future learning, as well as reflecting on change that was facilitated in individuals' approaches to MHDs and taking time off.

Helpful, unhelpful and missing support avenues

Helpful types of support appeared split across practical, "I wouldn't be expected to attend meetings… or to book in any new appointments that week… and also to allow more time for admin as well (Kate, trainee)" and emotional, "My clinical tutor did that sort of reflective space for a couple of sessions and that really… made a massive difference, actually (Jean, trainee)". Some strategies considered unhelpful, included being overly directive and experienced as micro-managing, "What I wanted in support is kind of a safety net of knowing that there's someone there if I need them, but that I don't want smothering me (Kate, trainee)". Some missing supports appeared related to supervisors feeling alone and unprepared to manage a trainee with MHDs "They do supervisory training… but they don't look at... what you do when a trainee's mental health is in question (Joni, supervisor)". Some described feeling unsupported by the universities and still feeling affected years later.

> "I felt really… vulnerable [the trainee was] telling people that I was somebody that was really hard to work with and really demanding and unsupportive… [the university] literally didn't give me a phone call to say, "how are you doing after that?" (Trixie, supervisor)"

Hindsight

This sub-category referred to what participants had learned from their experiences about the future management of MHDs. Many participants appeared to feel that hindsight was often unclear, “Maybe could have contacted the university sooner..? But again… I didn't want her to feel like I didn't think she was coping… (Trixie, supervisor)”, others felt that they had done all they could, particularly when they had tried to create a safe environment but MHDs had still been communicated too late for support, “I talked openly about my mental health, and coached her to be open with me [...] I think I did everything I could (Matt, supervisor)”. Some commented that they would have collaborated more closely with the university staff, to feel less alone with the responsibility and one supervisor instigated the provision of extra support, “I suggested reflective practice, they're now doing that… it's gone down really well (Joni, supervisor)”. A trainee highlighted the wish for universities to utilize their power and be better at addressing “gaslighting” supervisory practices rather than leaving the resolution of such matters unaddressed, or to the trainee, “At a time when my mental health wasn't great (Jean)”. One supervisor felt the experience “Blurred the line even more for me (Matt)” regarding at what stage time off was necessary.

Change in attitudes towards managing MHDs

This sub-category referred to changes in attitude that occurred through the experience and how this impacted on the management of MHDs. Some trainees experienced a positive resolution, which appeared to make them more comfortable with acknowledging their MHDs and seeking input from supervisors, “I'd be more open about things like that now… it wouldn't be a decision I'd make in isolation (Skylar, trainee)”, whereas negative experiences seemed to have the opposite effect, “the way my clinical tutor handled it… has definitely put me off from making

such open disclosures (Kate)". Some participants noted becoming more invested in self-care and wondered whether this would be helpful in managing MHDs in future "I feel like I wouldn't have got to the point of having time off […] because I wouldn't have been in the same situations (Skylar, trainee)". One supervisor described wanting to incorporate an element of hierarchy into her style to help manage future difficult supervisory situations, "Quite informal and friendly is how I tried to be... I think it backfired a little bit… because [when I had to] be more on the side of supervisor... she took it as quite an attack (Joni)".

Discussion

This study created a novel theory conceptualising the navigation of communication regarding MHDs within the UK CP doctorate. Following a summary of the study's findings, methodological considerations and clinical implications will be discussed. Future research ideas are also considered.

Consistent with Tay and colleagues (2018) findings of qualified CPs, many trainees did not readily disclose MHDs, making it difficult to collaboratively discuss, implement adaptations, or navigate the leave decision-making process. Staff described feeling reliant on open trainee communication, and much of the findings focused on how roles and systems interacted to inhibit or encourage such communication. Findings appeared to support previous literature suggesting stigma may be a factor in some professionals withholding information about MHDs and not seeking workplace adaptations (Dearing et al., 2005; Harris et al., 2016). It is possible that this process was further exacerbated by the evaluative nature inherent within the doctorate (Rønnestad & Skovholt, 2003). Moreover, aspects of some trainees' identities may make them vulnerable to judgement, as some trainees felt shame when not able to execute their high self-

expectations. This echoed previous studies suggesting that 'maladaptive perfectionism' (which researchers reported to be common amongst trainees) and shame could prevent trainee and qualified CPs from disclosing about MHDs (Grice et al., 2018; Tay et al., 2018).

In line with Spence et al. (2014), this study also found that CP culture may implicitly discourage disclosure. Spence et al. (2014) suggested that the implementation of the scientist-practitioner model (Division of Clinical Psychology, 2010) encouraged practitioners to adopt an expert role, which was perceived to have a potentially limiting effect on the self-disclosure of difficulties, potentially corroborating this study's findings on binary MH attitudes, stigma, and limited modelling by other psychologists. Spence and colleagues also found that all participants had minimised their self-disclosures whilst on training.

The importance of modelling MHDs was flagged in prior literature and was suggested to be vital in overcoming stigma (Boyd et al., 2016b). However, the importance of personal experiences and dispositions relating to openness should not be overlooked. For example, many trainees self-reported openness from the off-set and many staff reported trainees who were not open, regardless of the level of staff encouragement, such as disclosing about their own MHDs. The withholding of sensitive information could be interpreted as a method used by some trainees to maintain control over situations that may feel threatening. Support for this idea can be found in the work of Singh-Pillay and Cartwright (2019, p. 83) who found that trainee non-disclosure could be understood as part of a "subversive power dynamic in service of self-preservation and protection of the vulnerable trainee self". Their findings suggested that feeling powerless may trigger a submissive and self-protective relational style to re-address the power imbalance.

The findings of this study indicated that trainees' personal autonomy regarding leave should be respected unless their workplace functioning is impaired, and that, in accordance with British Psychological Society guidance (BPS, 2020), FTP procedures should be used as a last resort if voluntary leave is declined at this stage. However, the precise point at which this occurs remains debated, which adds to the difficulty of making these decisions. The current study indicates that FTP or MH procedures were not transparent or clearly communicated to many participants. In a respondent validation interview, a participant acknowledged that laying procedures out in a set way might help individuals feel more contained, but they would be reluctant to do so due to the individuality of each situation. It is possible that some ambiguity around procedures has trickled down from governing bodies such as the Health and Care Professions Council (HCPC, 2019) whose policies loosely inform about the types of information they might investigate, "untreated, unacknowledged or unmanaged […] mental health conditions" but do not shed light on specific processes. It is possible that the mystery surrounding such processes and the individual interpretations they allow, at a time of intense scrutiny and reliance upon a professional whom one may not necessarily trust, may make the process of openly acknowledging MHDs difficult.

Limitations

The study utilised self-selection and participants may have had a unique interest or experience. All trainee participants described a degree of openness in their narratives, whereas staff participants primarily discussed a lack of openness in their trainees and frequently described being open with them about their own MHDs. The study was unable to recruit trainees or staff who had been less open at the time, perhaps reflecting their less open approaches to MH. Nevertheless, valuable information was gained to understand why some practitioners may feel less open.

The study had a small sample size due to difficulty recruiting participants and may not have reached data saturation. However, this study sought data sufficiency (Dey, 1999), which holds that in qualitative research, data suggests categories rather than saturates them and exhaustive coding is seldom used. Towards the end of the interview stage, little new data surfaced for the key categories, meeting Dey's (1999) criterion for sufficiency. The study also lacked cultural representation as all participants were Caucasian and identified as European. The study was therefore unable to incorporate learning from multi-cultural perspectives about MH and training; more research is required.

Implications

Many participants portrayed CP training as lacking personal discourse about MHDs and propagating binary or tokenistic attitudes. A cultural shift may therefore be indicated to enable a more open and less stigmatising way of relating to MHDs. Many solutions may be organisational in nature, examples might include regularly incorporating psychologists with lived experience into the curriculum, actively normalising disclosures (BPS, 2020) and maintaining a focus on self-care, such as mandatory leave between placement changeovers. Additionally, it might be worth considering programmes like that of Harris and colleagues (2019), who found that a two-year programme of educational and contact interventions aimed at stigma and mental health providers (including psychologists) reduced workplace stigma and increased professionals' willingness to share their own lived experience.

Although FTP and sickness procedures are complex processes, it may be helpful to actively address them early in the training process and demystify them where possible. It may be helpful to distinguish between MHDs and FTP procedures, through providing examples (BPS, 2020, p. 29). Similarly, providing examples of what extended academic timelines could look

like might make the process feel more containing. This study suggests that workplace competence may include being able to balance emotional experiences, resilience, and practical features. It also suggested that decisions should not be made in isolation or without grounding in practical assessment. Assuming there is a power imbalance, it may be advantageous to promote transparent and collaborative thinking and decision making (Singh-Pillay & Cartwright, 2019) along with interpersonal qualities such as empathy, which might strengthen the supervisory working alliance and increase the likelihood of disclosure (Ladany & Inman, 2012). Although challenging to assess, it may also be worthwhile reconsidering how supervisory situations are managed when trainees report feeling unduly dismantled in placements, since this can reduce disclosure and harm their MH and confidence, particularly as new practitioners (Brown et al., 2020).

Various elements of support were noted as lacking, particularly for supervisors who often reported feeling alone and lacking an appropriate space where they could discuss and work through their experiences, which sometimes weighed heavily. It may be beneficial for decision making to be held more jointly between universities and supervisors and to make additional support available, such as supervisor reflective practise groups, additional support during and after such a process, or the provision of robust training, including how to manage and navigate situations where supervisees may be experiencing MHDs.

Future research

This research relied on small numbers across three distinct roles to build an initial theory. Future research might focus on gathering more in-depth data, particularly within doctoral training institutions, as this research suggested that they functioned like a container within which the other processes took place. It would be interesting to hear from trainees who were

able to access support that enabled them to manage whilst at work, to understand what factors may have enabled a different experience. Recruiting trainees and staff who were reluctant to be open about their MH may be challenging but important in understanding the processes involved in reluctance as well as the journey towards openness. Finally, it may be beneficial to invest in research, developing programmes such as Harris and colleagues' (2019), tailored for doctoral programmes, or new supervisory training to better manage trainee MH experiences.

Conclusion

This study sought to better understand how CP trainees, supervisors, and course staff navigate disclosures regarding MHDs and the need for support and time off. Using grounded theory, a novel model was developed that begins to provide insight into the complex interplay between personal and systemic issues that influence the navigation of time off. It distinguishes multiple categories of influence upon the communication and navigation of MHDs. This encompassed both CP culture and challenging practical realities that appeared to impact the ability to openly discuss and manage experiences of MHDs. Managing such situations was complex and dynamic, and responses varied across individuals depending on the relationship, level of openness and collaboration as well as the needs of the specific scenario. Findings suggest implications for the clarification of MH procedures and destigmatisation of MH within doctoral programmes. Additional research was indicated to better understand closed communication styles regarding MHDs and how to encourage openness.

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Section C: Appendices

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Appendix A: Critical Appraisal Tables

Table of Articles Appraised Using the Joanna Briggs Institute – qualitative checklist (Lockwood et al., 2020)

	1. Is there congruity between the stated philosophical perspective and the research methodology?	2. Is there congruity between the research methodology and the research question or objectives?	3. Is there congruity between the research methodology and the methods used to collect data?	4. Is there congruity between the research methodology and the representation and analysis of data?	5. Is there congruity between the research methodology and the interpretation of results?	6. Is there a statement locating the researcher culturally or theoretically?	7. Is the influence of the researcher on the research, and vice-versa, addressed?	8. Are participants, and their voices, adequately represented?	9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?
Spence et al., (2014)	Yes	Yes	Yes	Yes	Yes	Somewhat, I would have liked to know what the researchers biases were.	Somewhat, acknowledged impact on study and use of journaling etc but nothing about how dealt with specific events that arose	Yes	Yes	Yes
Ladany et al., (1997)	Unclear	Yes	Yes	Yes	Yes	Yes	Somewhat, infers impact on study and on researcher, not said how addressed specific events that arose. But had lots of auditing and reviewing by entire team	Not many direct quotes	No	Yes

	1. Is there congruity between the stated philosophical perspective and the research methodology?	2. Is there congruity between the research methodology and the research question or objectives?	3. Is there congruity between the research methodology and the methods used to collect data?	4. Is there congruity between the research methodology and the representation and analysis of data?	5. Is there congruity between the research methodology and the interpretation of results?	6. Is there a statement locating the researcher culturally or theoretically?	7. Is the influence of the researcher on the research, and vice-versa, addressed?	8. Are participants, and their voices, adequately represented?	9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?
Singh-Pillay & Cartwright (2018)	Yes / unclear?	Yes	Yes	Yes	Yes	Yes would have liked to know more about specific biases and theoretical orientation.	Yes	Mostly, would have liked to see a few more quotes.	Talked about informed consent No statement of ethical approval	Yes
Singh-Pillay & Cartwright (2021)	Yes / unclear? Feel like they both fit but not clearly stated?	Yes	Yes	Yes	Yes	Yes No to theoretical orientation – what does this even mean??	Yes	Yes	Maintaining confidentiality and anonymity discussed. No statement of ethical approval	Yes
Sweeney & Creaner (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mostly, could have had a few more quotes	Yes	Yes
Gray et al., (2010)	No philosophical perspective stated.	Yes	Yes	Yes	Yes	Yes	Yes	No, longer direct quotes would have been nice	No mention of confidentiality or anonymity and no statement of ethical approval.	Yes

Table of Articles Appraised Using the Joanna Briggs – analytical cross sectional study checklist (Moola et al., 2020)

	1. Were the criteria for inclusion in the sample clearly defined?	2. Were the study subjects and the setting described in detail?	3. Was the exposure measured in a valid and reliable way?	4. Were objective, standard criteria used for measurement of the condition?	5. Were confounding factors identified?	6. Were strategies to deal with confounding factors stated?	7. Were the outcomes measured in a valid and reliable way?	8. Was appropriate statistical analysis used?
Schweitzer & Witham (2018)	Unsure, had to be practicum and supervised and recruited from clinpsy programs, but no mention of any exclusion criteria	Mostly. Did not report race.	Used online survey, so all would be accessed same way again – reliable. SSQ only measures satisfaction with supervision, which is a limited ax of supervision outcome and was also not designed to measure this – designed to measure client satisfaction with therapy. But it is widely used in research, and satisfaction is associated with disclosure. All measures showed good internal consistency	N/a	Very vague? I don't think so. Think checked with pairwise analyses and didn't find difference, but didn't say anything about what they were checking, what differences they were looking for?	No	Yes the tools were reliable and mostly valid – see exposure question. Self report so could be under or over reported but no interrater bias…	Yes
Pakdaman et al., (2014)	Yes I think so. APA accred clin or couns psy doctoral programmes in practicum between date and date.	Mostly. Did not report age.	Wai-s adapted from clinician measure. CTRDQ is imaginary vignettes. CTRDQ has no reliability reported	Not a condition as such but measures as being on courses… Is this an N/A?	No	No	Wai-s adapted from clinician measure. CTRDQ is imaginary vignettes.	Yes

1. Were the criteria for inclusion in the sample clearly defined?	2. Were the study subjects and the setting described in detail?	3. Was the exposure measured in a valid and reliable way?	4. Were objective, standard criteria used for measurement of the condition?	5. Were confounding factors identified?	6. Were strategies to deal with confounding factors stated?	7. Were the outcomes measured in a valid and reliable way?	8. Was appropriate statistical analysis used?
No exclusion mentioned		But has some form of validity – but don't know what.				CTRDQ has no reliability reported But has some form of validity – but don't know what. All self-report to could be under or overreported	

Table of Articles Appraised Using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018)

	5.1 Is there an adequate rationale for using a mixed method design to address the research question?	**5.2. Are the different components of the study effectively integrated to answer the research question?**	**5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
Hess et al. (2008)	Yes – to categorise participants into "good" and "problematic" supervisory groups before examining qualitative differences between them.	Yes – stats divided the groups, and the rest was answered qualitatively.	Yes	N/A	Yes Small sample – although appropriate for CQR. Purposively sampled and self-selected. May not be representative of whole population. Outcome measures – used SSQ – adapted from clinician measure. Rich data from interviews and judges employed to increase objectivity, as well as seeking feedback from participants.
Mehr et al. (2010)	Yes – to qualitatively develop categories for content and reasons of ND and then to examine the relationships between the content and reasons. And to examine relationships between trainee anxiety SWA and willingness to disclose and ND.	Yes – tables and qualitative findings and stats interwoven throughout.	Yes	N/A	Yes Used a large sample, although purposively and self-selectedly sampled. May not be representative of whole population. Unequal male to female ratio.

			Self-report survey appropriate when investigating phenomena with unidentified variables. Outcome measure – WAI/S-Short adapted from clinician scale. Confounding variables tested for. Power analysis carried out.

Appendix B: University Ethical Approval

This has been removed from the electronic copy.

Appendix C: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

"Navigating mental health difficulties, extra support and time off:
Trainee clinical psychologists and their placement supervisors and training providers"

I would like to invite you to take part in my research study. It is important to understand what taking part would involve for you and to understand the purpose of the study before making a decision.

Please read this information sheet carefully and take your time to consider if this research is right for you.

My name is Stephanie Heckert (S.Heckert1112@canterbury.ac.uk), and I am a trainee clinical psychologist at Canterbury and Christ Church University. This research is part of the work towards achieving my Doctorate in Clinical Psychology, and a paper will be submitted for publication in a peer reviewed journal upon completion. This study is being supervised by Dr Sue Holttum (Senior lecturer at Salomons institute for applied psychology) and Dr Kat Alcock (Principle clinical tutor at UCL).

What is the purpose of the study?

The study aims to gain insight into the factors that determine at what point a trainee clinical psychologist asks for / is offered extra support by their supervisor or training provider and how they determine when this support is no longer sufficient to enable the trainee to manage at work, resulting in a period of leave from work / training, due to mental health difficulties. It will attempt to explore some of the difficulties and ambiguities surrounding this decision-making process, as well as what can make this process easier.

The study will incorporate the views of trainees (or newly qualified clinical psychologists about their experience whilst on training), placement supervisors and course staff who have managed a trainee experiencing the aforementioned. There are no known studies of this nature to date.

What would participating in this research involve?

If you express your interest, you will receive a brief screening questionnaire that will gather basic demographic data about you (such as whether you are a trainee or a qualified psychologist).

There will be a single, audio-recorded interview, lasting between 1 – 1.5 hours. This can be via telephone or an online video platform such as Skype. This can be negotiated and will depend on what seems most appropriate.

This conversation will involve talking to me about your personal experiences and reflections upon these decision-making processes.

You may be contacted at a later date to ask your views on the findings of this research. If this should happen, you may decline without giving a reason, should you wish to.

What are the possible benefits of taking part?

Some of the possible benefits of taking part include having your experiences listened to and forming part of this research. It may include feeling that you are contributing to the narrative surrounding this topic and that the information you provide may contribute towards improving things for others in similar situations in the future.

It is my hope that this research will improve the understanding of this process from the combined view of trainees, supervisors and training providers and that it will aid in opening an ongoing dialogue of how it can be improved and clarified.

The aim of this is to influence the transparency and clarity surrounding such situations and to improve the support available for trainees and guidance for supervisors.

What are the possible disadvantages of taking part?

Talking about your personal experiences may bring up some memories of a challenging or possibly upsetting situation for you. If you think that talking about this could be too upsetting, you may want to carefully consider whether or not to take part. If the interview seems as though it is challenging for you, I may check in with you, to ensure that you feel up to continuing. You will not have to answer any questions that you do not wish to and you can pause or end the interview at any point, without needing to provide any explanation. Information would be provided about where to seek support after our conversation, should you feel that this would be helpful.

Who can take part?

The research study is open to:

- UK based clinical psychology trainees or newly qualified (two years post qualification) clinical psychologists

- Who wish to reflect back on past experiences of mental health difficulties whilst on training that resulted in a period of leave (any length) from placement / training.
- Or who wish to reflect back upon past experiences of mental health difficulties whilst on training that were able to be managed without a period of leave with support within the context of the supervisory relationship.
- Placement supervisors who have supervised a trainee and been involved in such a process with their trainee within the last 3 years and where this is no longer an on-going issue.
- Training provider staff who have supervised a trainee and been involved in such a process with their trainee within the last 3 years and where this is no longer an on-going issue.

Who might not be able to take part?

The research study is not interviewing:

- Any present or past trainees from the Salomons' course as the researcher is based there.
- Any placement supervisors who wish to share their relevant experiences of a current or past Salomons' trainee.
- Any training provider staff working at Salomons.
- Trainees or newly qualified Clinical Psychologists who are currently experiencing mental health difficulties to such an extent that a period of leave is likely or imminent.
- Supervisors who are managing a trainee who is actively in the midst of experiencing mental health difficulties to such an extent that a period of leave is likely or imminent.

Do I have to take part in the study?

No. This study is completely voluntary. If after reading this information you decide that you would like to participate, you will be given a form to sign, which will indicate that you have read this information, been given time to reflect upon it and ask any questions that you might have. Signing the form will then signal your written consent to take part. If you change your mind before or during the interview, you have the right to cancel the interview and withdraw your information. There is a two-week window after you have given your interview, during which you may still change your mind and request that your data be destroyed and not included in the research. You do not have to provide a reason for any of these decisions.

Will my details be kept confidential?

Any information that you provide will be kept strictly confidential. Any identifiable information about you will be kept securely and separately from your audio-recording and analysis. The names of individuals, course centres or placements will not be asked for.

Due to the large quantity of transcribing and time constraints on this research, it may be necessary to utilise an approved transcription service. In this instance, the transcriber would sign a confidentiality agreement. All recordings will be routinely encrypted.

The interview transcripts will be carefully anonymised, removing any identifiable names, places and organisations. This will happen before anyone else within the research team will be able to look at the transcripts. Any verbatim excerpts to be quoted in the study will be cautiously selected, to ensure that other people will not be able to identify you.

Your data will be stored electronically and will be password protected.

Your personal details, consent forms and audio-recordings will be destroyed after the study is completed. Your anonymised transcript will be stored for up to ten years after completion of the study to aid any further research.

When might confidentiality be breached?

This study is in line with the Health and Care Professionals Council and the British Psychological Society as these organisations govern the ethics of our profession. Due to this, these regulations will be followed regarding confidentiality:

- Your right to confidentiality may be breached if you disclose information that leads to significant concern about your own safety or the safety of another person. In such rare cases a third party may be informed without your formal consent.

- Before a third party is informed, this situation will be discussed with the researcher's project supervisor to discuss any concerns, unless such a delay would involve significant risk.

- I would seek to discuss it with you first, where possible.

Has the study been reviewed?

This study has been reviewed and approved by the Salomons Ethics Panel.

What happens next?

Take some time to think about whether you want to participate in this research and feel free to discuss it with people close to you. Alternatively, you can contact me if you have any questions (S.Heckert1112@canterbury.ac.uk). If you would like to participate, you will be asked to sign a consent form or to record your verbal consent prior to beginning the interview. If you record consent via audio, it will be separated from the main interview.

Thank you very much for showing an interest in my study.

Principle Investigator:

Stephanie Heckert (S.Heckert1112@canterbury.ac.uk)

Concerns and complaints
If you have any concerns about how this study is being conducted, please contact:

Principal Supervisor:

Dr Sue Holttum (Sue.Holttum@Canterbury.ac.uk)
Senior Lecturer,
Salomons Institute for Applied Psychology,
Canterbury Christ Church University,
1 Meadow Road,
Tunbridge Wells,
Kent
TN1 2YG

If your complaint is not resolved, you may contact Dr Fergal Jones, Research Director, Salomons Clinical Psychology Programme, who is independent of the study: fergal.jones@canterbury.ac.uk

Appendix D: Informed Consent Form

PARTICIPANT CONSENT FORM

"Navigating mental health difficulties, extra support and time off:
Trainee clinical psychologists and their supervisors and training providers"

☐ I confirm that I have read and understand the information sheet for this study. I have had the opportunity to reflect on the information, ask questions and have had these answered satisfactorily.

☐ I understand that participation in this study is entirely voluntary and understand that I do not need to enter into the study and that I can leave the study without giving any explanation before or during the interview. I can also have my data withdrawn from the study and destroyed for up to two weeks following the interview.

☐ I consent to the audio recording of my interview.

☐ I agree for my consent to be audio-recorded in the case that I am not able to return the form in time, ahead of a Skype or telephone interview.

☐ I have been told how my information will be handled: how it will be stored and kept anonymous, how it will be used and who will have access to it.

☐ I understand that if I share information that leads to enough concern about the safety of myself or that of another, it may be deemed necessary to inform an appropriate third party without formal consent. Prior to this occurrence the researcher's project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

☐ I agree that anonymous quotes from my interview may be used in research reports and publications, where all data used will be treated as anonymous and confidential.

☐ I agree to be contacted for my comments on the findings of the study. I am aware I can decline my involvement with this.

☐ I agree to take part in the above study.

Participant signature_____ Date_____

Name of participant_____

Signature of principal investigator_____ Date_____

Name of principal investigator: Stephanie Heckert, Trainee Clinical Psychologist

Appendix E: Debrief Sheet

Debrief Sheet

Thank you for giving your time to take part in this research project.

If after participation in this research project you are experiencing any distress or discomfort, you may wish to contact immediate sources of support such as your family, friends, GP or a therapist. If you are a trainee clinical psychologist, your course tutor, manager or personal advisor may be able to support you or help you access support, such as therapy.

Psychological therapies
To find your nearest local psychological therapies service, you can search on the NHS choices webpage:
https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10008

Alternatively, you could seek support from student counselling programmes or employee assistance programmes. Your course tutors or managers may be able to help signpost you to the help that is available to you within your organisation.

NHS Choices
If you're worried about an urgent medical concern, call 111 and speak to an adviser.
Website: https://www.nhs.uk/pages/home.aspx
Helpline: 0113 825 0000

Samaritans
A 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress. Freephone: 08457 90 90 90 Website: www.samaritans.org

ACAS (Advisory, Conciliation and Arbitration Service)
Provides free and impartial information and advice to employers and employees on all aspects of workplace relations and employment law.
http://www.acas.org.uk/index.aspx?articleid=1864

They also provide a Helpline on 0300 123 1100 for free and impartial advice. The ACAS helpline phone service is available Monday - Friday 8am-6pm.

Citizens Advice
Provide free, confidential and impartial advice, including on employment problems. To find details of your local Citizens Advice:
https://www.citizensadvice.org.uk/about-us/how-we-provide-advice/advice/

If you are a member of a **workers' union**, you can contact them for advice in relation to work related issues. Examples of unions include:

Unison (https://www.unison.org.uk) and Unite (http://www.unitetheunion.org).

Thank you again for your participation and support.

Appendix F: Requesting Permission to Advertise Within Training Institutes

Dear [redacted],

I hope my email finds you well. My name is [redacted] and I'm a trainee at Salomons institute for applied psychology (Canterbury Christ Church university). I'm writing to ask whether you would be willing to offer trainees and clinical supervisors at [redacted] the opportunity to take part in my doctoral research project. All participation will take place online, in line with COVID-19 regulations.

My project seeks to interview trainees and supervisors of trainees who encountered a situation where the trainee experienced mental health difficulties whilst on training. The project aims to develop insight into the processes involved in understanding and negotiating when it is time to discuss such difficulties and how the decision to take time off is navigated between trainee and supervisor. It is my hope that this research will support the increasing discourse around the subject of trainee mental health and will aid in the development of processes to support both trainees and supervisors.

This project is being supervised by Dr Sue Holttum (Salomons) and Dr Kat Alcock (UCL), both of whom have previously supervised projects relating to the mental health of those in psychological professions.

This project has received ethical approval from Salomons.

I have attached the participant information sheet for your perusal, should you be interested to find out more about this project.

Kind regards,

[redacted]

Appendix G: Recruitment Emails at Training Institutions

Dear Trainee Clinical Psychologists at [redacted],

My name is [redacted] and I am a second-year trainee clinical psychologist at Salomons institute for applied psychology (Canterbury Christ Church university). I am emailing to ask if you would consider taking part in my doctoral research project. My project seeks to interview trainees and supervisors of trainees (not dyads) who encountered a situation where the trainee experienced mental health difficulties whilst on training. The project aims to develop insight into the processes involved in understanding and negotiating when it is time to discuss such difficulties and how the decision to take time off is navigated between trainee and supervisor. It is my hope that this research will support the increasing discourse around the subject of trainee mental health and will aid in the development of processes to support both trainees and supervisors.

This project is being supervised by Dr Sue Holttum (Salomons) and Dr Kat Alcock (UCL), both of whom have previously supervised projects relating to the mental health of those in psychological professions. This project has received ethical approval from Salomons.

I have attached the participant information sheet with further details on the study.

Please do contact me at [redacted] if you are interested in taking part and/or have any questions or concerns.

Thank you for your time.

Kind regards,

[redacted]

Dear Clinical Supervisors at [redacted],

My name is [redacted] and I am a second-year trainee clinical psychologist at Salomons institute for applied psychology (Canterbury Christ Church university). I am emailing to ask if you would consider taking part in my doctoral research project. My project seeks to interview trainees and supervisors of trainees (not dyads) who encountered a situation where the trainee experienced mental health difficulties whilst on training. The project aims to develop insight into the processes involved in understanding and negotiating when it is time to discuss such difficulties and how the decision to take time off is navigated between trainee and supervisor. It is my hope that this research will support the increasing discourse around the subject of trainee mental health and will aid in the development of processes to support both trainees and supervisors.

This project is being supervised by Dr Sue Holttum (Salomons) and Dr Kat Alcock (UCL), both of whom have previously supervised projects relating to the mental health of those in psychological professions. This project has received ethical approval from Salomons.

I have attached the participant information sheet with further details on the study.

Please do contact me at [redacted] if you are interested in taking part and/or have any questions or concerns.

Thank you for your time.

Kind regards,

[redacted]

Appendix H: Recruitment Advertisement on Facebook / Twitter

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

"Navigating mental health difficulties, extra support and time off:
Trainee clinical psychologists experiencing mental health difficulties, and their supervisors"

I would like to invite you to take part in my research study. My name is [redacted] ([redacted]), and I am a trainee clinical psychologist at Canterbury and Christ Church University. This study is being supervised by Dr Sue Holttum (Senior lecturer at Salomons institute for applied psychology) and Dr Kat Alcock (Principal clinical tutor at UCL).

What is the purpose of the study?

The study aims to gain insight into the factors that determine at what point a trainee clinical psychologist asks for / is offered extra support by their clinical supervisor and how they determine when this support is no longer sufficient to enable the trainee to manage at work, resulting in a period of leave from work / training, due to mental health difficulties. It will attempt to explore some of the difficulties and ambiguities surrounding this decision-making process, as well as what can make this process easier.

It is my hope that this research will improve the understanding of this process from the combined view of trainees and clinical supervisors and that it will aid in opening an ongoing dialogue of how it can be improved and clarified. The aim of this is to influence the transparency and clarity surrounding such situations and to improve the support available for trainees and guidance for clinical supervisors.

I am **currently only recruiting trainee and newly qualified clinical psychologists**. I will be recruiting clinical supervisors at a later stage.

Who can take part?

- UK based clinical psychology trainees **or** newly qualified (two years post qualification) clinical psychologists
- Who wish to reflect on **past** experiences of mental health difficulties whilst on training that resulted in a period of leave (any length) from work or training.
- Or who wish to reflect on **past** experiences of mental health difficulties whilst on training that were able to be managed without a period of leave with support within the context of the supervisory relationship.

Who might not be able to take part?

- Any present or past trainees from the Salomon's course as the researcher is based there.
- Trainees or newly qualified clinical psychologists who are currently in the midst of experiencing such difficulties. The study focusses exclusively on past experiences to minimise the potential for participant distress.

What happens next?

Take some time to think about whether you want to participate in this research and feel free to discuss it with people close to you. Alternatively, you can contact me if you have any questions or concerns.

Thank you very much for showing an interest in my study.

Appendix I: Demographic Form

Initial screening Form

1. What is your age? _____

2. What is your gender? _____

3. With which racial or ethnic category do you identify?

White (European) ○ White (other) ○ Black African ○ Black Caribbean ○

Black British ○ Asian○ Asian British ○ Other ethnic group_____

4. Are you responding to this study from the perspective of the trainee or from the supervisor?

_____

_____

5. When do / did you qualify (Year)?

_____

6. If you feel comfortable to do so, please share a little bit about what type of mental health difficulties you experienced while on training, or helped a trainee to manage?

_____

_____

7. Did you / the trainee require temporarily taking some time off in relation to this difficulty?

_____

_____

8. How many occasions have you had where you were thinking seriously about your / a trainee's mental health and possible need for support or time out?

_____

9. Which client groups were you working with at the time when the mental health issue arose?

_____

10. Which therapeutic orientation were you working within at the time?

_____

Appendix J: Interview Schedules

Trainee interview schedule

How do trainees determine when to ask for extra support at work due to mental health difficulties?

1. Can you tell me about what happened whilst you were experiencing mental health difficulties at work, whilst you were a trainee?

a. Can you tell me about how you came to understand that your struggles might warrant some extra help.

b. What happened at this time, can you tell me about a specific event or situation that highlighted something to you about this, can you talk me through it? [what emotions did you have? What did you do? What did you notice? Was anything different? How did you come to that view?]

c. Can you tell me about your experience of discussing this with your supervisor? With your training provider? Who raised the issue? What happened? What was the outcome of this discussion?

How do trainees determine when their difficulties are interfering too much with their practice and the support is no longer enough?

2. Can you tell me about the time when you first wondered whether your difficulties might be affecting your practice too much, whilst you were a trainee?

d. What prompted this line of thinking? [what happened at this time, either in relation to your placement, academic work, mental health difficulties or anything else that may have been happening for you?]

e. When did you know or feel that you had tried everything possible to manage the situation whilst at work?

f. Can you tell me about your experience of discussing the idea of 'time-off' with your supervisor? [How did you feel about it? What was your reasoning? Did you have any wider thoughts around this topic, i.e. not necessarily relating to the placement itself? Who brought up the idea? Was there anything that made talking about this easy or difficult?]

g. How did you experience your supervisor's understanding of what was going on for you at this time?

h. Looking back at this experience with hindsight, what might you do the

same and what might you do differently? [was there anything in particular that you learned in relation to understanding the line between when to ask for help and when to step back?]

What are the factors that helped or hindered this process?

3. Can you tell me about what factors have helped or hindered your ability to ask for extra support or to discuss potentially taking some time off, whilst you were a trainee?

Possible prompts to follow up on or enquire after if they were not mentioned:

i. How did your relationship with your supervisor affect this process?

h. How did you experience your work / or training environment in relation to what we have been speaking about?

j. To what extent, if any, did previous experiences (your own or those of others) of similar situations impact upon your approach to this situation?

k. How did you experience the level of support that you were offered throughout this process? [looking back, what might you like to remain the same and what might you like to be done differently?

l. Did you experience any self-stigma or stigma from others during this time? If so, how did this impact the process for you, if at all?

m. Is there anything else that you feel is important to share?

Supervisor interview schedule

How do supervisors determine when their trainees need extra support at work due to mental health difficulties?

1. Have you got a specific trainee in mind that you'd like to talk about? Can you tell me about what happened whilst your trainee was experiencing mental health difficulties at work?

a. Can you tell me about how you came to understand that your trainee

might be having mental health difficulties that might be affecting their work?

b. Can you tell me about how you came to understand that your trainee

might warrant some extra help at work?

c. What happened at this time, can you tell me about a specific event or

situation that highlighted something to you about this, can you talk me through it? [what emotions did you have? What did your trainee do? What did you do? What did you notice? Was anything different about how the trainee seemed to you? How did you come to that view?]

d. Can you tell me about your experience of discussing this with your

trainee? With their training provider? Who raised the issue? What happened? What was the outcome of this discussion?

How do supervisors determine when their trainees' difficulties are interfering too much with their practice and the support being offered is no longer enough?

2. Can you tell me about the time when you first wondered whether your trainee's difficulties might be affecting their practice too much, perhaps even with extra support?

Supervisor interview schedule

How do supervisors determine when their trainees need extra support at work due to mental health difficulties?

1. Have you got a specific trainee in mind that you'd like to talk about? Can you tell me about what happened whilst your trainee was experiencing mental health difficulties at work?

a. Can you tell me about how you came to understand that your trainee

might be having mental health difficulties that might be affecting their work?

b. Can you tell me about how you came to understand that your trainee

might warrant some extra help at work?

c. What happened at this time, can you tell me about a specific event or

situation that highlighted something to you about this, can you talk me through it? [what emotions did you have? What did your trainee do? What did you do? What did you notice? Was anything different about how the trainee seemed to you? How did you come to that view?]

d. Can you tell me about your experience of discussing this with your

trainee? With their training provider? Who raised the issue? What happened? What was the outcome of this discussion?

How do supervisors determine when their trainees' difficulties are interfering too much with their practice and the support being offered is no longer enough?

2. Can you tell me about the time when you first wondered whether your trainee's difficulties might be affecting their practice too much, perhaps even with extra support?

Were there things that your trainee did that were helpful or less helpful in dealing with this situation?]

l. To what extent, if any, did previous experiences (your own or those of others) of similar situations impact upon your approach to this situation?

m. How did you view the level of support that you felt in a position to offer the trainee throughout this process? [was there anything that was perhaps lacking from the system, that could have better supported you or the trainee?]

n. To what extent, if any, do you think that stigma around mental health, or the trainee's self-stigma, might have affected the process or your interactions with the trainee at the time?

o. Is there anything else that you feel is important to share?

Course staff interview schedule

How do course staff determine when their trainees need extra support at work due to mental health difficulties?

1. Have you got a specific trainee in mind that you'd like to talk about? Can you tell me about what happened whilst your trainee was experiencing mental health difficulties at work?

a. Can you tell me about how you came to understand that your trainee

might be having mental health difficulties that might be affecting their work?

b. Can you tell me about how you came to understand that your trainee

might warrant some extra help with work?

c. What happened at this time, can you tell me about a specific event or

situation that highlighted something to you about this, can you talk me through it? [what emotions did you have? What did your trainee do? What did you do? What did you notice? Was anything different about how the trainee seemed to you? How did you come to that view?]

d. Can you tell me about your experience of discussing this with your

trainee? With their clinical supervisor? Who raised the issue? What happened? What was the outcome of this discussion?

How do course staff determine when their trainee's difficulties are interfering too much with their practice and the support being offered is no longer enough?

2. Can you tell me about the time when you first wondered whether your trainee's difficulties might be affecting their practice too much, perhaps even with extra support?

j. What prompted this line of thinking? [what happened at this time, either in relation to their work, conversations that you were having or their mental health difficulties? What was it about this that signified to you that your trainee's difficulties were impacting too much upon their work? Was anything different about this?]

k. When did you know or feel that you had tried everything possible to manage the situation whilst the trainee was still at work? [what options had been available and what were the limitations of these?]

l. Can you tell me about your experience of discussing the idea of 'time-off' with your trainee? [How did you feel about it? What was your reasoning at the time? Did you have any wider thoughts around this topic, i.e. not necessarily relating to the placement itself? Who brought up the idea? Was there anything that made talking about this easy or difficult?]

m. How did you experience your trainee's understanding of what was going on for them at this time?

n. Looking back at this experience with hindsight, what might you do the same and what might you do differently? [was there anything in particular that you learned in relation to understanding the line between needing extra help and when perhaps the trainee should step back? Was there anything that you learnt about how best to manage such a situation?]

What are the factors that helped or hindered this process?

3. Can you tell me about what has helped or hindered your ability to offer a trainee extra support or to discuss potentially taking some time off, due to their mental health?

Possible prompts to follow up on or enquire after if they were not mentioned:

j. How did your relationship with your trainee affect this process?

k. How did you experience your trainee's attitude in relation to what we have been speaking about? [How did you trainee's attitude or actions affect this process? Were there things that your trainee did that were helpful or less helpful in dealing with this situation?]

l. To what extent, if any, did previous experiences (your own or those of others) of similar situations impact upon your approach to this situation?

m. How did you view the level of support that you felt in a position to offer the trainee throughout this process? [was there anything that was perhaps lacking from the system, that could have better supported you or the trainee?]

n. To what extent, if any, do you think that stigma around mental health, or the trainee's self-stigma, might have affected the process or your interactions with the trainee at the time?

o. Is there anything else that you feel is important to share?

Appendix K: Examples of Open Coding (6 pages)

This has been removed from the electronic copy.

Appendix L: Abridged Axial and Selective Codes

Category	Sub-category	Codes
Trainee and staff histories and stressful life events	COVID-19	Struggling to observe a significant change from norm. Struggling with being remote / long distances. Wanting to see trainees unmasked face. Trainee struggling with alterations to practice caused by COVID. COVID confusing the boundary landscape. Stripping closeness from normally supportive environment. Being easier to hide difficulties behind a screen. Interfering with getting to know someone. Worsening feelings of judgement due to distanced relationships. Difficulty accessing loved ones in another country
	Life events	Breaking up with long-term partner Difficult living arrangements Working in unfamiliar and complex settings Feeling inexperienced Experiencing physical difficulties Moving away from support system Being bereaved Being pregnant Being burgled Coinciding MHDs triggered by current life events Overwhelming caring responsibilities Feeling pressure from life combining with course
Personal attitudes towards MHDs, power and autonomy	Own experiences shaping management of MHDs	Measuring trainees stress by own standards Experiencing past experiences as shaping future provision of support Drawing on own experience of being 'all over the place' Wanting to prevent negative experiences of MH disclosure for others Wanting to embody compassionate leadership Sharing own experiences of MH on training Experiencing blunt, invalidating, and shaming SVn Locating attitude towards supervising within own context of lived experience and training. Trying to transfer own experiences of acceptance and compassion about MH onto trainee Comparing to past experience of own mental health as trainee Being aware of how long could safely work from past experiences.
	Level of trust within trainee and staff relationship	Trusting trainee's self-awareness. Making things as easy and proactive as possible. Highlighting trust supervisors need to have that trainee is okay. Losing sight of trainee feelings amidst bureaucracy. Avoiding seeking support due to distance between SVR and trainee. Approaching SVr resulting in feeling less contained than before. Focussing on policy over emotional needs. Communicating bluntly as off-putting. Feeling frustrated due to lack of responsibility Becoming entitled and disrespectful. Having the basics of a good supervisory relationship would have been enough.

		Reliant on supervisors willingness to feel heard. Feeling supported by supervisors. Losing trust.
	Navigating power differentials	Making joint decisions. Feeling relieved that expectations were removed. Being passive and appreciating someone else resolving the situation. Wrestling with balancing understanding supervisory role with managerial. Needing to balance protecting with enforcing. Alternating between feeling powerless and powerful and persecutory. Discussion becoming more polarised. Needing to take responsibility in non-collaborative way. Allowing trainee to maintain sense of agency. Removing trainee's agency. Turning away from open disclosures. Changing how and when to disclose. Hiding extent of struggle and coping privately.
Questioning workplace competence	Balancing emotional experience	Assuming tearfulness to mean uncontained emotion on placement Crying in supervision but unable to own that. Defining issue as not being able to reflect on difficulty. Being aware and open about difficulties without being 'in it' as indicator still well enough. Being able to sit next to own experiences as necessary for positively leveraging intersecting personal and client issues in therapy. Avoidant people at greater risk of getting 'lost in it'. Needing not to feel overwhelmed by own stuff to be able to make space for clients. "It's okay to cry and be anxious... as long as you can still do what's required".
	Maintaining resilience reserves	Feeling at the brim, about to overflow. Being tipped over without resilience to manage it. Being unwilling to risk making a mistake. Having reserves of resilience as fundamental in decision making process. Comparing to previous occasions when had been able to regroup and felt resilient. Simple support strategies enough to top up resilience when not too low. Questioning ability to tolerate difficulty with clients. Noting point of "I can't do this any longer" as line - not much buffer. Assessing readiness in terms of being able to manage and tolerate own emotions and experiences.
	Maintaining autonomy and questioning competence	Viewing taking time off as personal decision until and unless impacts on ability to work. work competency like elevator - takes decision making up a level. DR feeling that if she went into work it would be FtP equating it to a pilot not being able to fly. If trainee had refused time off would have invoked FtP. FtP / enforced leave as route if trainee did not agree to go on leave. Refusing to take any personal responsibility - external blaming. Feeling disrespected and hated.

		Leaving choice up to trainee about leave so long as they were still functioning and competent. Competency versus self-care in taking a break. if unable to think about herself, then having to think about SUs well-being instead. Unable to contain own stuff in work context. Emotional leaking. Being a risk to self as needing to step back. Not enjoying VS dreading work. Feeling 'I can't face going to work'.
Complex Systemic issues	Practical course limitations	Noting lip service of annual leave. Managing MH easier once qualified because you can take time off. Less pressure outside training world - easier to take time off. Training feeling like being bashed around. Clashing components of course don't allow for flexibility. Struggling to meet minimum criteria after time off. No space to deal with any life stressors, course as all encompassing. Placements not being matched well to their trainees. Unfair pairing of trainee to placement. Losing study days to avoid extending training. Increasing time pressure. Finishing old placement and starting new placement simultaneously.
	Unclear procedural communication	More guidance around FTP in trainees as being helpful. Possible procedures not spoken about. Not wanting to be clear about level of concern as felt difficult and defensive in SVn but leading to blindsiding trainee in MPR. Needing clearer lines of communication. More clarity around MH and Leave procedures needed. Wishing the course were upfront / clearer about how leave of absence / adjusted timelines work. Knowing the procedure making 2nd LoA feel 'okay'. Feeling contained after understanding the leave procedure. Course holding information or procedures implicitly / unclearly. Procedures relying on overly long, inaccessible handbooks. Unknowing of ability to extend training. Feeling unaware of uni sickness procedures. Confusion about responsibility.
	Disjointed communication across the system	5 - way staff communication. Finding it hard to make a decision without all the information. Feeling pushed into a harsher position perhaps due to uni 'going too far', being enmeshed. Feeling annoyed / confused about lack of communication at uni. Trainee reaching out to generic first year tutor and no follow up happening. Sharing concerns with tutor and learning he had not been informed of communication with other tutor. Lack of communication impacting ability to recognise patterns i.e. complacency early on. Thinking could improve on hearing SVrs collective voices about what support they need. Courses as divorced from supervisors. Acknowledging difference in opinions about how much should be communicated between UTs and SVrs. Relief about lack of communication.

		No communication with SVrs about what happened after going off. Not communicating with CT soon enough due to feeling like going behind her back. One way street between course and SRs. Not aware of why this trainee went off or how that conversation with manager went.
Navigating access to support and time out	Navigating time out	Hearing suddenly at crisis point. Being aware of tendency to 'put on a brave face' and not be open about struggles. Speaking to tutor and then going off sick. No time between seeking support and going off sick. Telling trainee to take two days off as leave. Telling trainee to take leave as not in right place to be in. MH team not happy to have me in work any longer. MH team invoking MHA ax. Feeling forced to take time off. No performance related or fitness to practice concerns before going off sick. Needing to take responsibility for decision-making in non-collaborative way. Preferring to be collaborative but relationship not allowing for that. Wanting to finish on time blocking conversations about leave Good clinical practice as not necessarily linked to good state of MH.
	Navigating support	Trainee 'private person' didn't want people to know their details. Some trainees finding it much easier to be open. Lack of openness limiting ability to access support options. Leave changing ability to acknowledge and openly discuss problem. Being open to trainees struggles as personally found rigid distinctions between personal and clinical material unhelpful. Finding it unhelpful to say supervision shouldn't go into therapy. Changing relationship to self as mediating ability to access support. Being vulnerable in front of others as aiding openness and experiencing safety when talking about experiences.
MH in the psychological trenches	Tokenistic MH engagement	Experiencing conflictual message about MHD as confusing. Lacking positive model about MH from course. Not acknowledging dual role. Experiencing no teaching from dual role psychologists. Needing to be brave to bring it up in RPG as not spoken about in other areas of course life. Imagining it might not feel weird if MH was openly addressed. Reducing engagement with MH to one lecture in first year. Feeling MH not widely considered by courses. Being given reflective practice as a space for MH. Questioning blindness / failure to attend to experience. Managing experience in less tokenistic manner. Addressing trigger warnings tokenistically. topical tick box exercise. Modelling psychological struggle theoretically not experientially. Modelling of openness (tutors, SVS) impacting own openness.
	Binary attitudes, stigma and openness	Equating the combat against mental health stigma with combatting racism.

		Destigmatisation requiring a step further than avoiding overt comments. Commenting on power the course could have to effect positive change regarding MH stigma. Removing us vs them. Unhelpful us vs them narrative. Confusing position from course on MHD and therapy. Clashing identities, sitting with dual roles in face of binary assumptions and perceived stigma. Dividing expert and professional roles. Propagating us VS them during teaching. Locating stigma with the unspoken. Feeling topic is not spoken about enough. assuming people in room wouldn't score highly on ACES. Assuming logically there must have been others in cohort with MHDs Silence in cohort about MHDs. Struggling with experts by experience and the implicit assumption that psychologists 'are well'.
	Trainee identity: is imperfect acceptable?	Trainee perception of needing to 'have it all together'. Unhelpful narratives of competition and "creme de la creme" in clin psychology. Unhelpful building of ego instead of realising we're all "just people that feel all sorts of things at different times". Keeping barrier up as allowing self to retain rescuer image. Not wanting to be seen as a patient. Not wanting to be worse than other psychologists. Trainees as carrying MH discourses with them. Self-stigma prevalent in profession. Believing that a good psychologist must be a 'certain way'. Feeling like MHD / time off means 'not coping as well as others' - perhaps due to hidden nature of MHDs in cohort. Taking time for own MHDs equated to failing self and others. Wounded healers. Psychologists' identity 'messed up themselves". Equating identity as trainee to needing to be perfectionistic. Trainee identity as perfectionistic and self-critical.
	Boundaries between personal and professional	Finding the line between clinical material and personal therapy. Feeling invasive, mean, forcing open a locked door. Being very open about own life in supervision. Disclosing own therapy within supervision. Being too distressed = inappropriate. Understanding supervision as a place where there were limits on how much distress one could show. Feeling allowed to speak about certain personal experiences (being a carer) rather than others (being abused) in supervision. Feeling confused or unsure about where the boundaries between appropriate supervision and personal therapy lie. Holding B&W view of supervision, of personal vs professional and of who controls and decides this narrative between trainee and SV. SV responsibility that personal material stays related to the client and is not therapy.
Learning	Helpful, unhelpful and missing support avenues	Being badmouthed by trainee to others and unable to defend herself. SVr feeling left alone to clean up mess. SVr receiving no communication from university to check if she was okay or to support her.

		Wishing uni had managed cohort dynamics differently. Creating additional tasks / load as going off sick. SRy training not covering what to do if trainee has MHDs. Reduction / managing of responsibilities. Trying to normalise trainees experience and reframe own negative experience as having healing elements. Attempting to validate to protect against feelings of shame. Embodying compassionate leadership. Adjustments negotiated with SVr after time off / such as using SVr laptop to sometimes work from home. Sharing own experience to highlight it hasn't damaged career.
	Hindsight	Reflecting confusion about what she could have done for the trainee. Wondering if extra time with trainee would have affected her ability to take responsibility for some of her own difficulties. Setting up open lines of communication with CT from beginning to ensure transparency. acknowledging that she maybe worked too close until admission to hospital. Wondering if she had gone off earlier, if could have avoided dropping down a year. in hindsight seeking guidance from course much earlier. Questioning whether doing things differently would have actually helped. Seeking out the placement that the trainee needed developmentally. Not holding the line potentially reinforced issue and created more issues later. Wanting course to manage poor supervisory practices Implementing reflective practice group for supervisors.
	Change in attitudes towards managing MHDs	Turning away from open disclosures. Developing ability to challenge unhelpful statements during lectures about sensitive topics since sick leave. Having time off changed view of what material could be brought to supervision. Locating increase in openness in time / process / experience. After being initially led by CT, change occurred in process and navigating MHD together. Breaking the belief that avoidance was a workable solution as the change crux. communicating on the same page about progress following acknowledgement of MHDs. Disjuncture feeling better after leave when trainee was able to acknowledge their feelings and urges to avoid. Thinking self-stigma lessened after time off. Being able to accept what she needed and realising it wasn't that bad. humour and compassion allowing trainee to lean into experience without shame or guilt.

Appendix M: Individual Participant Diagrams

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Appendix N: Abridged Memo Excerpts

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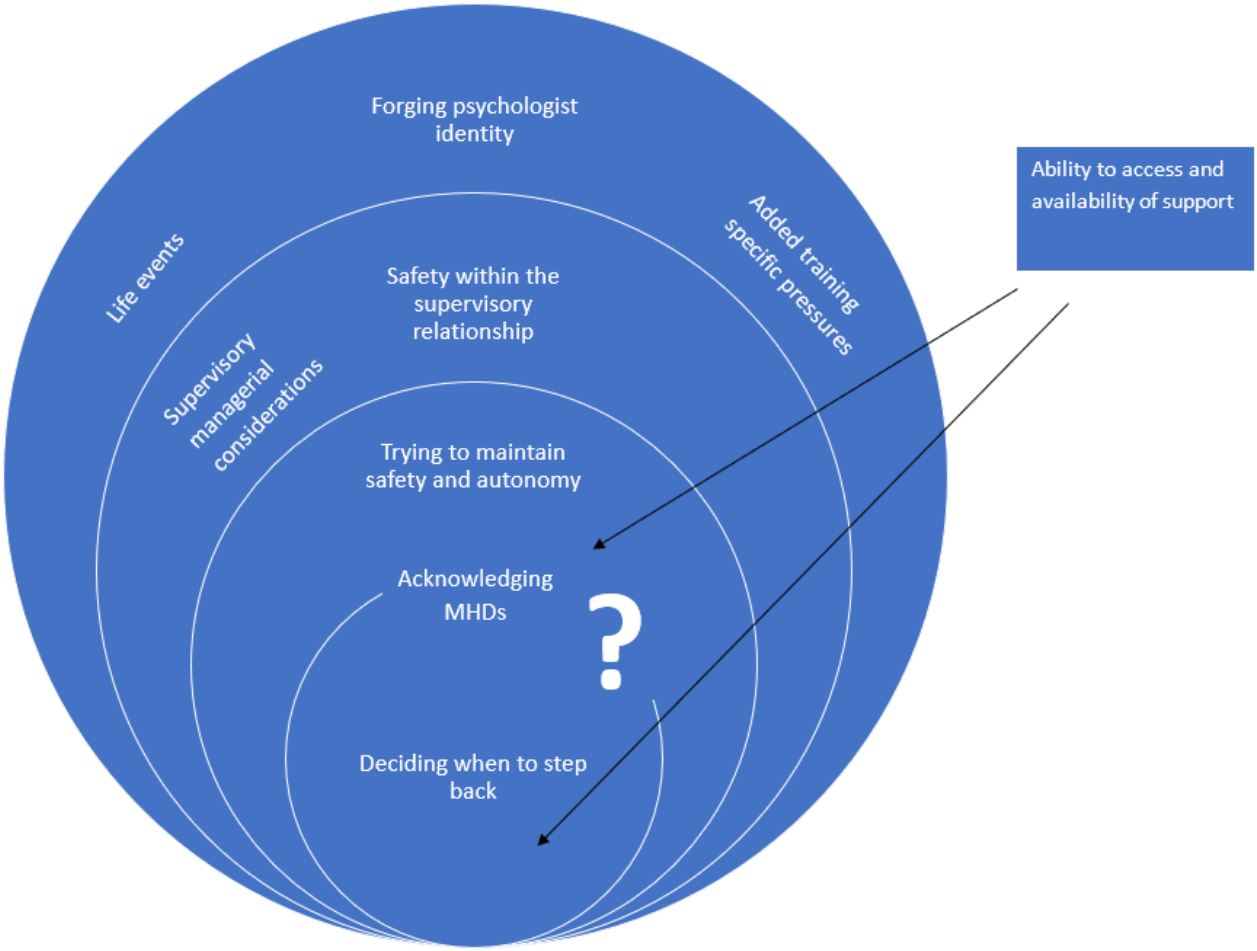
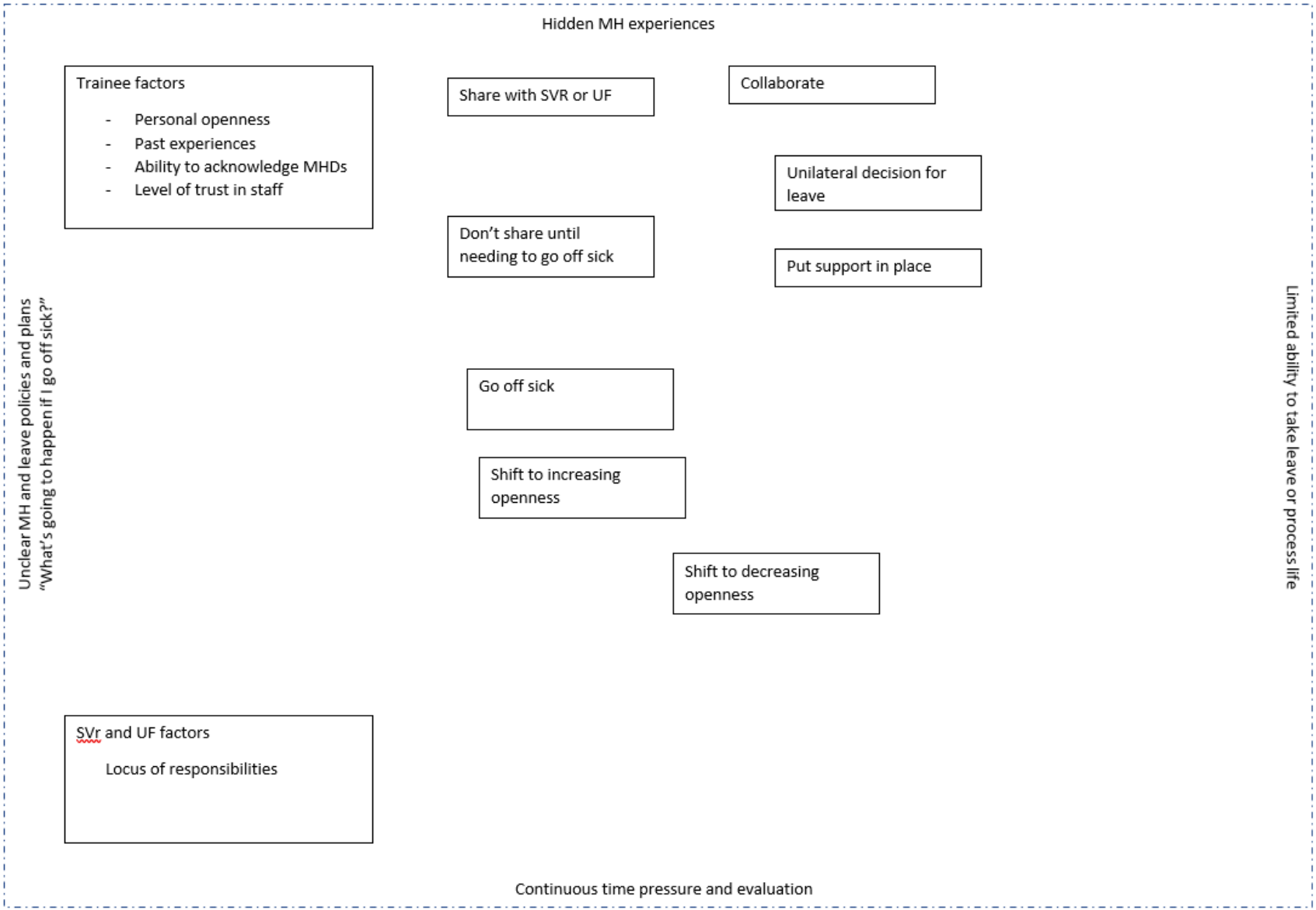
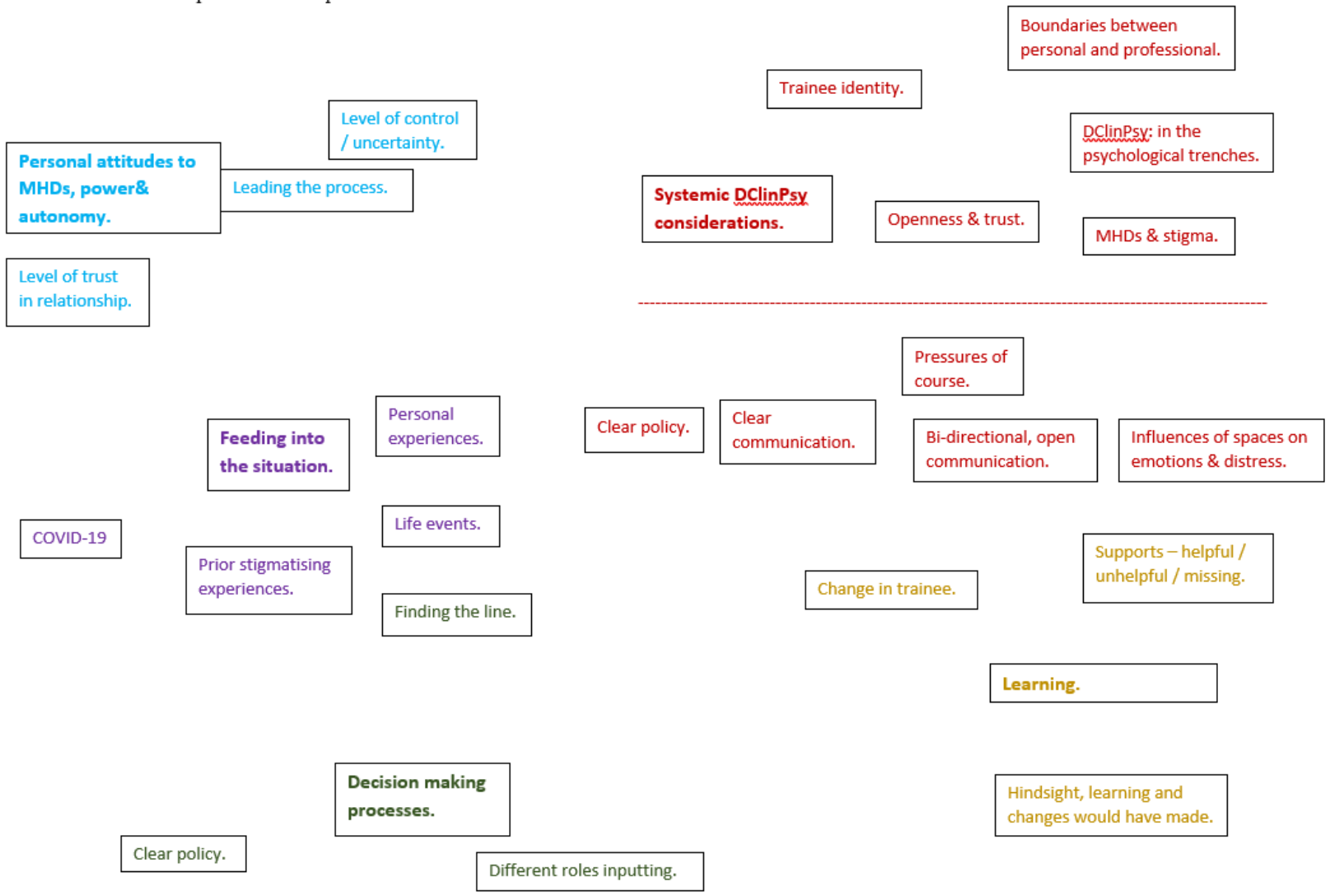
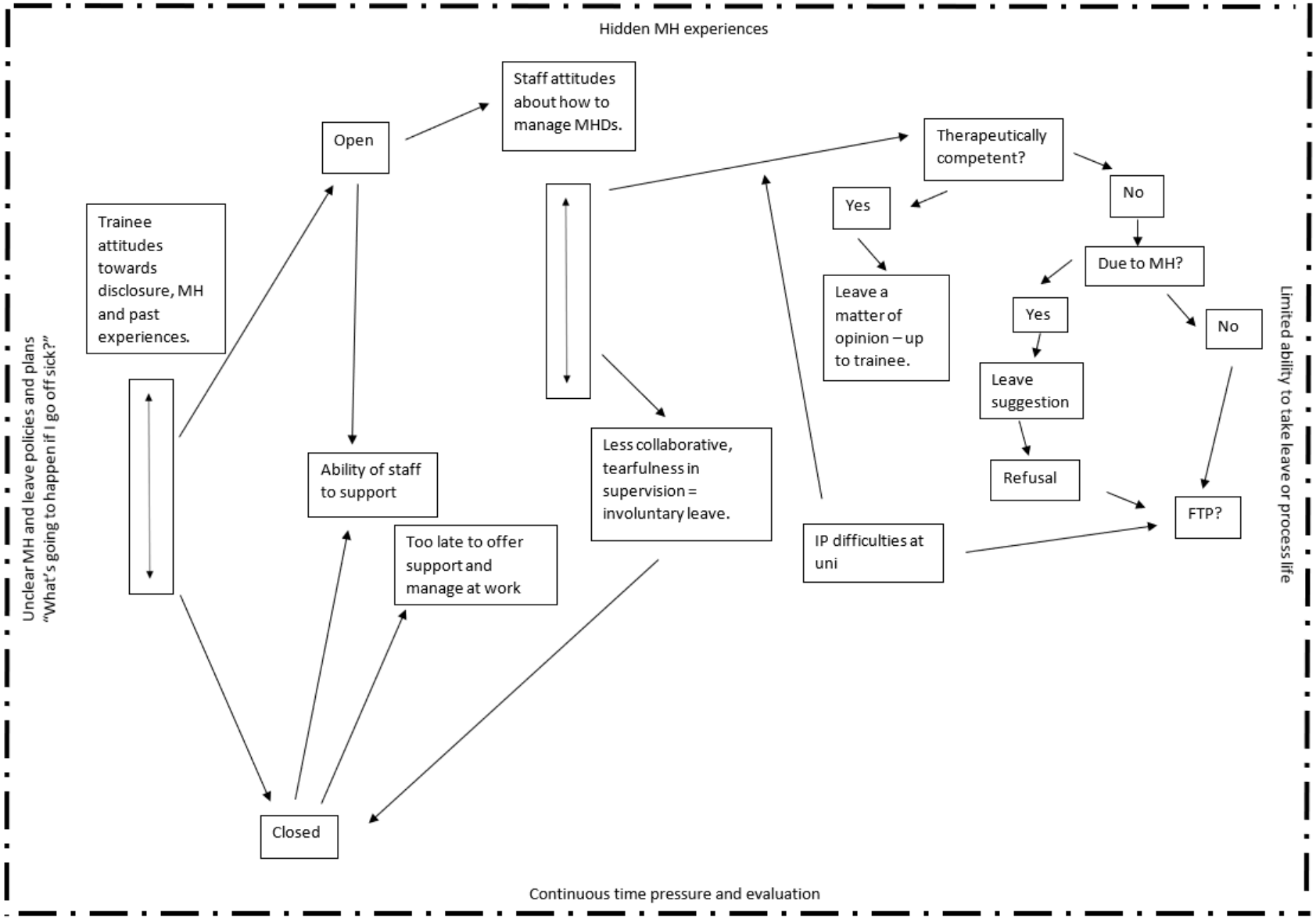
Appendix O: Evolution of Theory Model

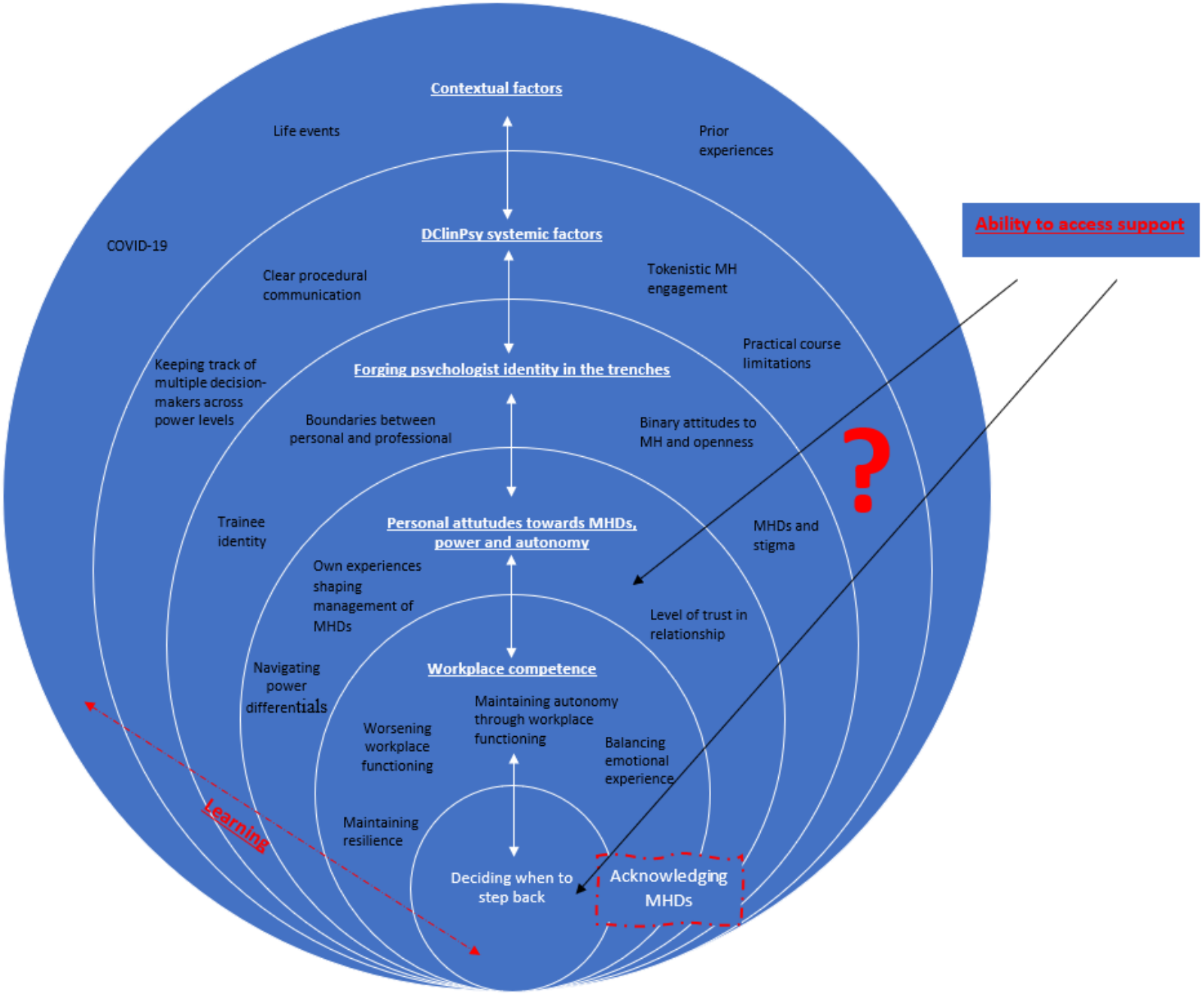


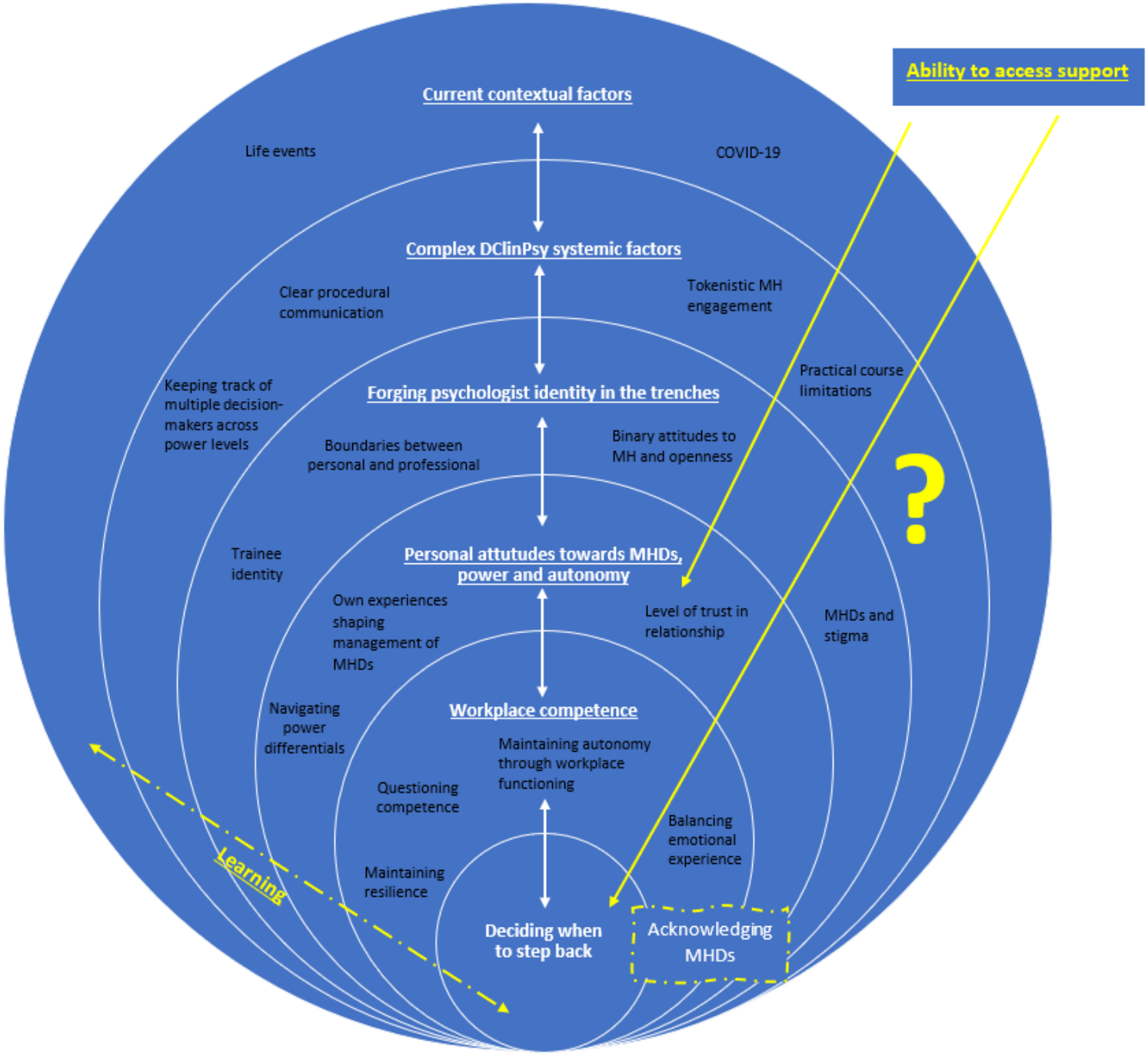

Hidden MH experiences
Trainee factors
- Personal openness
- Past experiences
- Ability to acknowledge MHDs
- Level of trust in staff
Share with SVR or UF
Collaborate
Unilateral decision for leave
Don't share until needing to go off sick
Put support in place
Go off sick
Shift to increasing openness
Shift to decreasing openness
SVr and UF factors
Locus of responsibilities
Unclear MH and leave policies and plans
"What's going to happen if I go off sick?"
Limited ability to take leave or process life
Continuous time pressure and evaluation

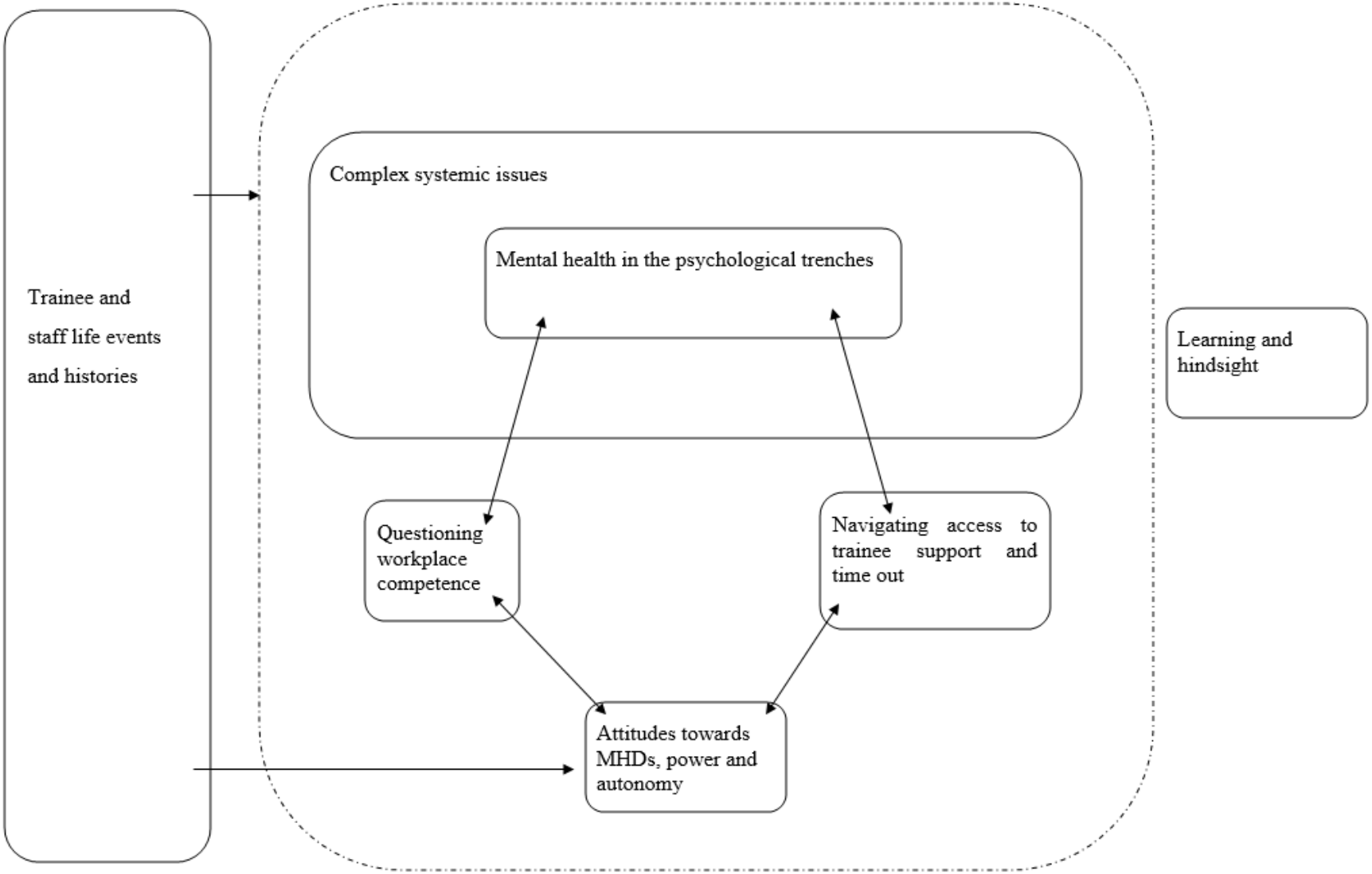
1. How is it determined when the difficulties are interfering too much with practice and the support is no longer enough?
2. What are the factors that help or hinder this process?

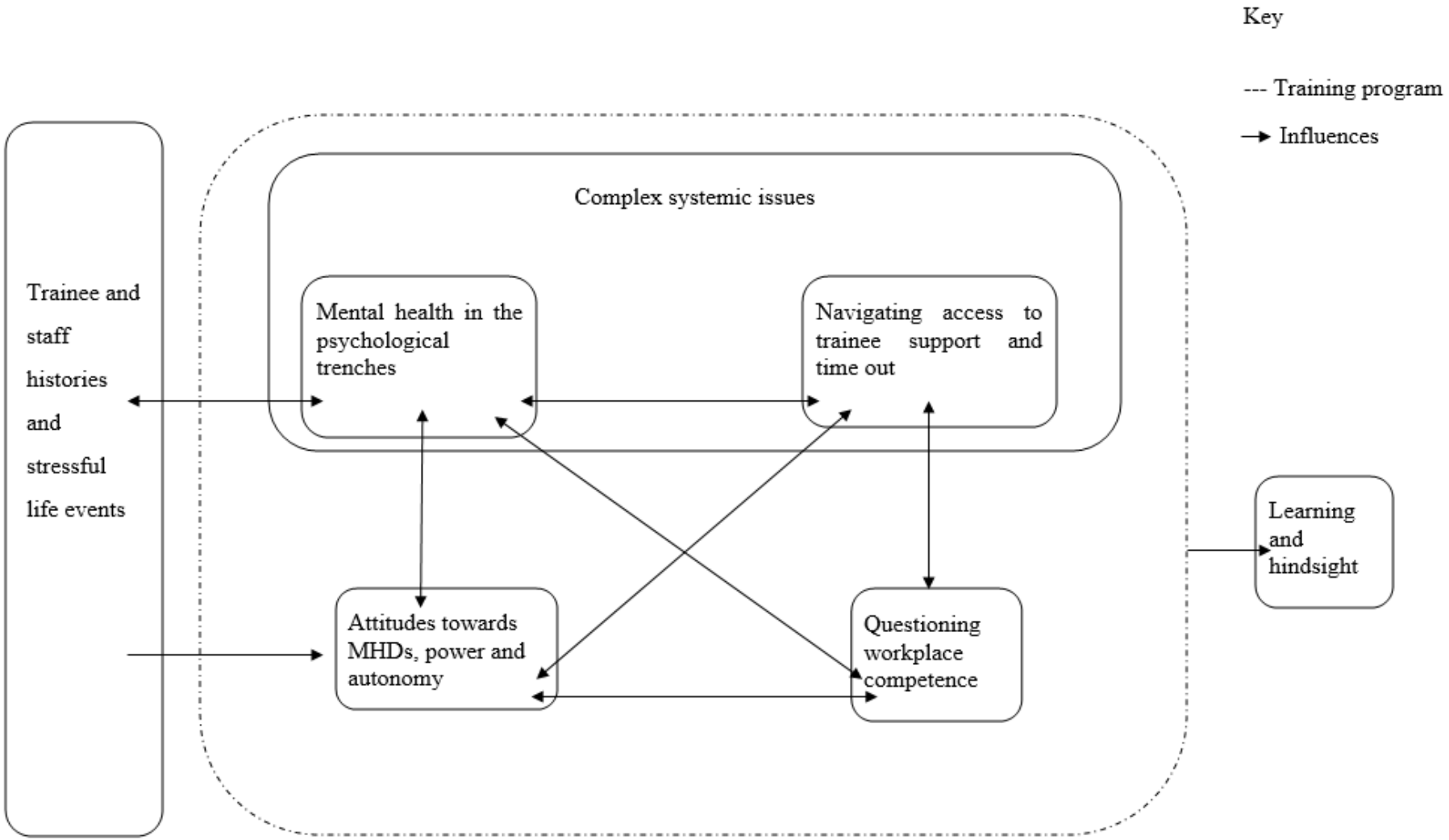


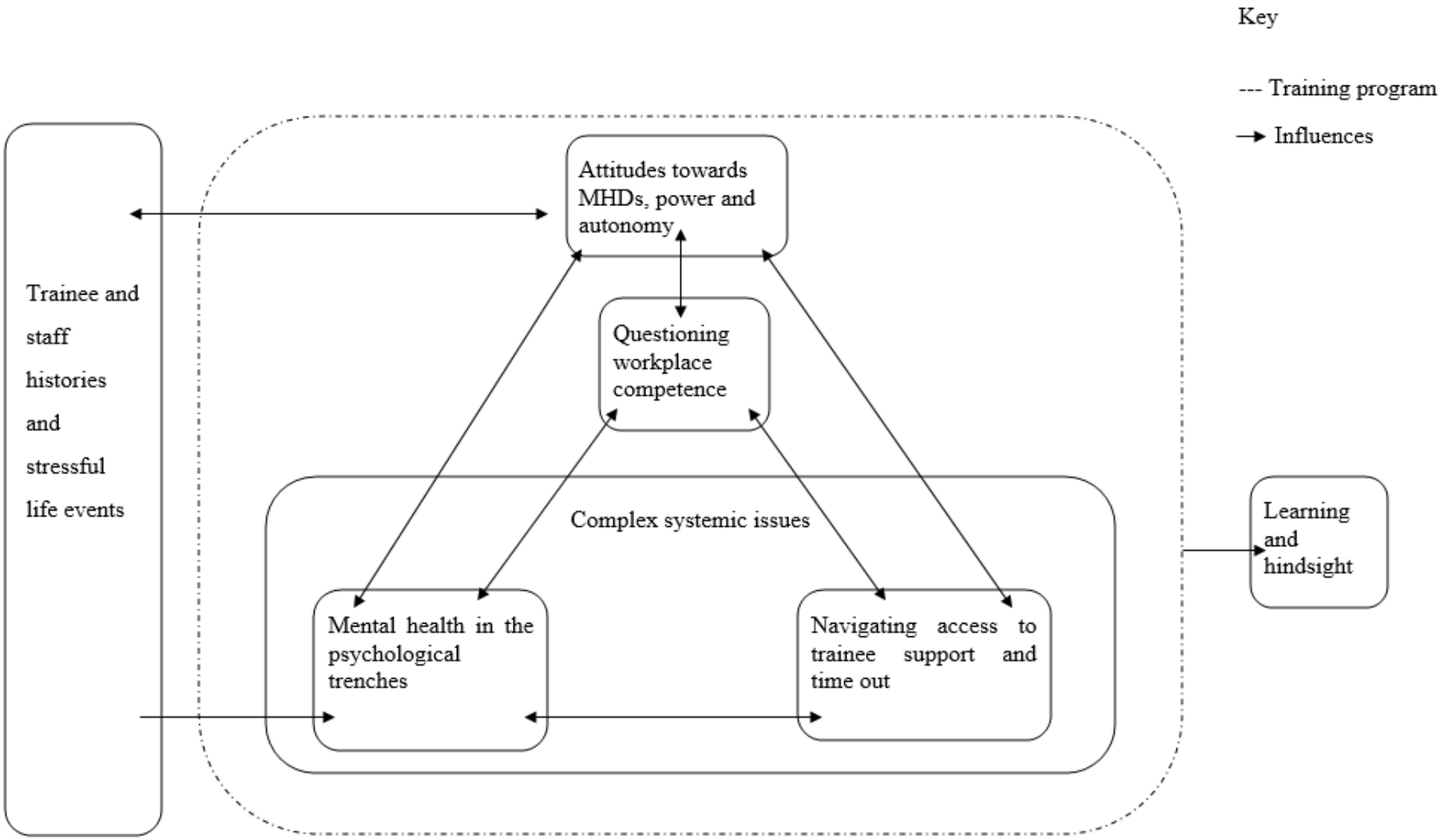

Hidden MH experiences
Unclear MH and leave policies and plans
"What's going to happen if I go off sick?"
Limited ability to take leave or process life
Continuous time pressure and evaluation
Trainee attitudes towards disclosure, MH and past experiences.
Open
Staff attitudes about how to manage MHDs.
Ability of staff to support
Too late to offer support and manage at work
Closed
Less collaborative, tearfulness in supervision = involuntary leave.
Therapeutically competent?
Yes
No
Leave a matter of opinion – up to trainee.
Due to MH?
Yes
No
Leave suggestion
Refusal
FTP?
IP difficulties at uni


Contextual factors
Life events
Prior experiences
COVID-19
DClinPsy systemic factors
Clear procedural communication
Tokenistic MH engagement
Forging psychologist identity in the trenches
Keeping track of multiple decision-makers across power levels
Practical course limitations
Boundaries between personal and professional
Binary attitudes to MH and openness
Personal attutudes towards MHDs, power and autonomy
Trainee identity
MHDs and stigma
Own experiences shaping management of MHDs
Level of trust in relationship
Workplace competence
Navigating power differentials
Maintaining autonomy through workplace functioning
Worsening workplace functioning
Balancing emotional experience
Maintaining resilience
Deciding when to step back
Acknowledging MHDs
Learning
Ability to access support
?


Ability to access support
Current contextual factors
Life events
COVID-19
Complex DClinPsy systemic factors
Clear procedural communication
Tokenistic MH engagement
Forging psychologist identity in the trenches
Keeping track of multiple decision-makers across power levels
Practical course limitations
Boundaries between personal and professional
Binary attitudes to MH and openness
?
Trainee identity
Personal attutudes towards MHDs, power and autonomy
Own experiences shaping management of MHDs
Level of trust in relationship
MHDs and stigma
Navigating power differentials
Workplace competence
Maintaining autonomy through workplace functioning
Questioning competence
Balancing emotional experience
Learning
Maintaining resilience
Deciding when to step back
Acknowledging MHDs


Trainee and staff life events and histories
Complex systemic issues
Mental health in the psychological trenches
Questioning workplace competence
Navigating access to trainee support and time out
Attitudes towards MHDs, power and autonomy
Learning and hindsight


Key
--- Training program
→ Influences
Trainee and staff histories and stressful life events
Complex systemic issues
Mental health in the psychological trenches
Navigating access to trainee support and time out
Attitudes towards MHDs, power and autonomy
Questioning workplace competence
Learning and hindsight

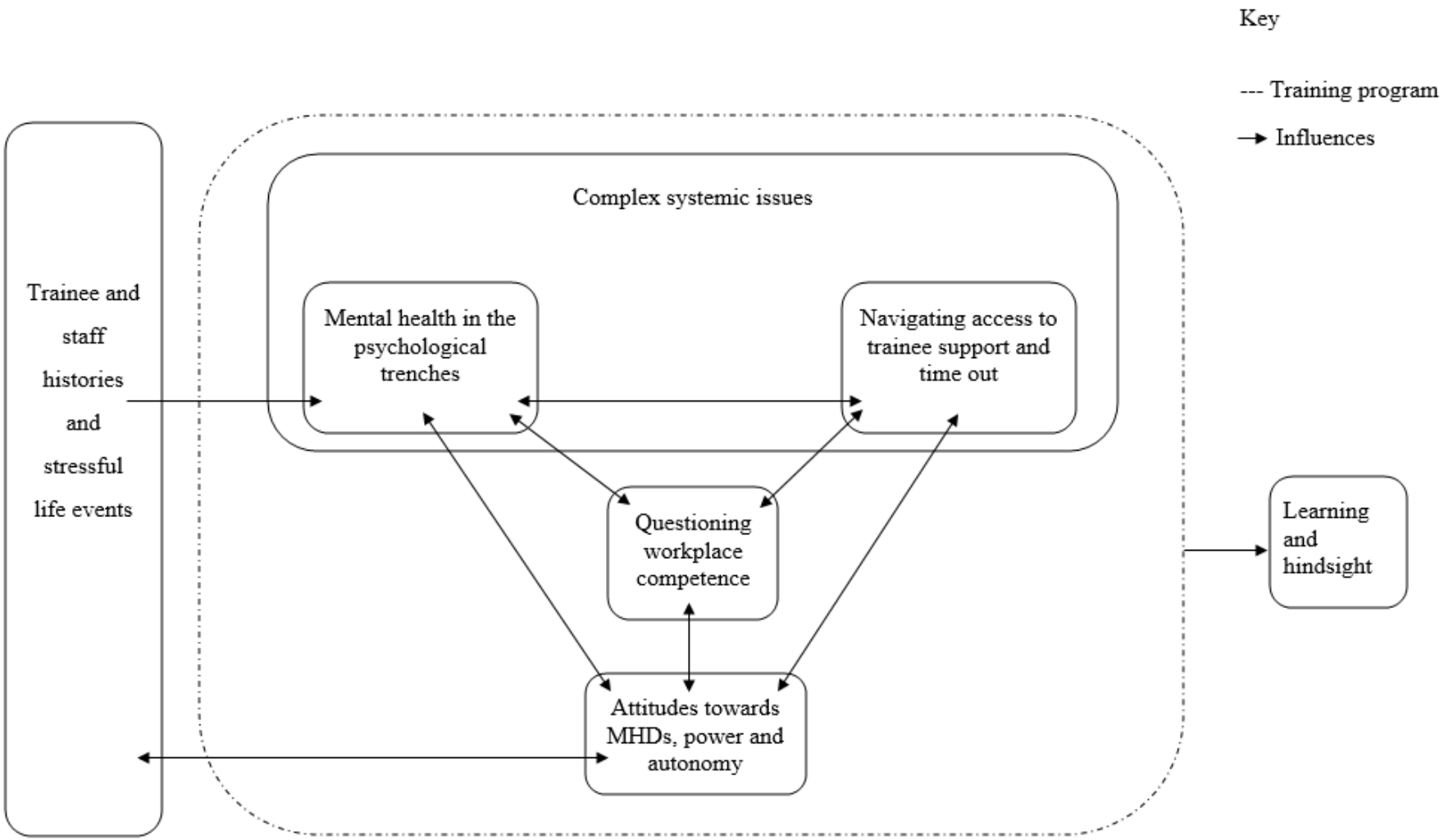

Key
--- Training program
→ Influences
Trainee and staff histories and stressful life events
Attitudes towards MHDs, power and autonomy
Questioning workplace competence
Complex systemic issues
Mental health in the psychological trenches
Navigating access to trainee support and time out
Learning and hindsight

Appendix P: Positioning Statement

This study was undertaken by a female trainee clinical psychologist, in her mid-thirties. Her interest in this topic resulted from observing challenging experiences relating to this topic throughout her career, first as an assistant psychologist and later as a trainee. She was aware of her own identification with the role of trainee at this time, as well as her passion regarding the treatment of practitioners with lived experience of MHDs. These personal experiences and beliefs will likely have influenced the outcome of the research in some ways, however the researcher endeavoured to be aware of her biases and assumptions entering this process and engaged in bracketing interviews to reduce the impact of these assumptions on the research process. She also regularly reflected on these issues throughout the research process, kept a diary and maintained a stance that was actively seeking, open and curious about ideas that might not fit these initial assumptions.

The researcher felt very aware of potential mental health stigma that trainees might have experienced that might make openly discussing this topic delicate as well as the potential judgements that supervisors and university facilitators (hereafter 'staff' when referred to collectively) may have feared from the researcher as they were aware that she would have identified at some level with the people that they were discussing. Bearing these possibilities in mind the researcher paid particular care to creating a non-judgemental, validating, and empathetic space for participants. Although not all bias may have been possible to remove, being a trainee may have also allowed the researcher in some ways to obtain a deeper understanding of the data and how it might affect trainees with MHDs.

Appendix Q: The Emergent Model



Appendix R: Abridged Notes from a Respondent Validation Interview

- Clarifying the category labels – "Clear communication" as confusing – as the point of the category is that the communication is not clear. Amend sub-category name to reflect that.

"I was thinking that, again, the label keeping track of multiple decision makers doesn't quite capture what you're describing, which to me sounds more like disjunction between multiple decision makers or problems in communication between multiple decision makers."

- Similar issue with another label being unclear – change name to reflect the disjointed communication between the system.

"But you're trying to figure out what's affecting that kind of point of decision making. And I guess, if there's no communication, there is no point of community, there is no point of decision making as a, it's like you've described, sometimes decisions just taken out of people's hands, because communication hasn't occurred."

"When you're writing your discussion. It's maybe something to think about in in your discussion."

"In terms of recommendations, so that's why I was thinking, to use this information. We need we need to think about communicating more clearly, don't we? And you could use your different categories, or themes to inform your recommendations around communication."

Incorporate suggestions into the discussion where possible, reflecting on the impacts made of communication and how these can be addressed / supported.

Appendix S: Author Guidelines for Prospective Journal

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Appendix T: End of Study Notification Letter

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Appendix U: End of Study Summary Report for Participants and Ethics Committee

Dear [participant],

Thank you for taking part in my study regarding the navigation of mental health difficulties, extra support, and time off during clinical psychology training. Your contributions were invaluable to the completion of this project. I am writing to provide you a summary of the outcome. The full document will be sent to you once my project has been fully approved, pending VIVA and any amendments, as agreed. Please feel free to provide me with any feedback if you so wish.

Background

The experience of mental health difficulties has been reported to be often undisclosed within the field of clinical psychology, by both qualified and trainee practitioners. The reasons for this are varied and complex but have been indicated to include the fear of being stigmatised and seen as less competent, resulting in a culture of silence, which has been suggested to reinforce itself and prevent some individuals from being open with their supervisors, accessing workplace adaptations and support. This can have implications both for the individual practitioner as well as their clients, in some instances. Clinical psychology training can be a competitive and academically, practically, and emotionally demanding experience that takes place in a time-pressured environment, which has the potential to exacerbate mental health difficulties. The competitive and evaluative nature of training may also make the disclosure of difficulties harder. This project sought to create a novel theory to understand how the navigation of conversations, extra support and time off are managed within the scope of clinical training, between trainees, supervisors and course trainers.

Method

The research used grounded theory methodology, which enables the building of theory from gathered data. Ten participants were interviewed, four trainees, four supervisors and two

university staff. Grounded theory analysis was used to code interview transcripts and then group these codes into categories and finally, into higher level categories. This process happened at the same time as future interviews, allowing for strategic sampling of future participants and the tailoring of interview questions. Using constant comparison, the categories were continually compared across the data, which made the findings more likely to be reflective of most participants. The final theory was discussed with a sub-set of participants to gain their feedback, which informed the final model.

Outcomes

Findings led to a model (see below), which suggested different elements of influence, upon the process and across the three roles. There were seven main categories, containing sub-categories within them (see table for all categories). The model intended to convey the complex and interrelated processes involved in the decision making and navigation of disclosure about mental health difficulties accessing / implementing support and time out. The dotted line outlines the backdrop of the doctorate and the individual and systemic processes that it contained.

A model of disclosure and management of MHDs within the UK DClinPsy

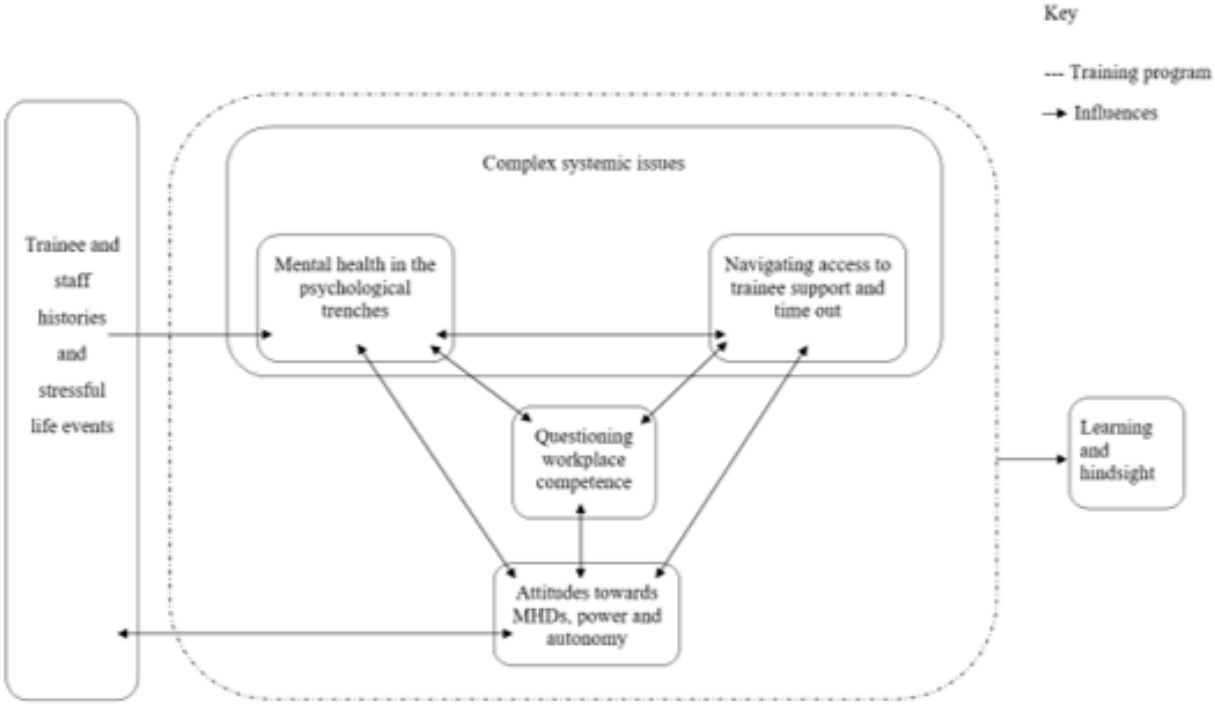

Table of categories and sub-categories

Category	Sub-categories
Trainee and staff histories and stressful life events	COVID-19
	Life events
Personal attitudes towards MHDs, power and autonomy	Own experiences shaping management of MHDs
	Level of trust within trainee and staff relationship
	Navigating power differentials
Questioning workplace competence	Balancing emotional experience
	Maintaining resilience reserves
	Maintaining autonomy and questioning competence
Complex Systemic issues	Practical course limitations
	Unclear procedural communication
	Disjointed communication across the system
Navigating access to support and time out	Navigating time out

Category	Sub-categories
	Navigating support
MH in the psychological trenches	Tokenistic MH engagement
	Binary attitudes, stigma and openness
	Trainee identity: is imperfect acceptable?
	Boundaries between personal and professional
Learning	Helpful, unhelpful and missing support avenues
	Hindsight
	Change in attitudes towards managing MHDs

Conclusions

The findings of this study have highlighted the complexity and individuality of this process, along with systemic and organisational issues that may make this process more difficult to navigate. In line with previous research, stigma was noted to be part of the system within which trainees operate (along with binary narratives, lack of modelling and tokenistic engagement regarding mental health) and appeared to influence their ability to be open. Personal experiences and attitudes appeared to influence participants approaches to disclosure and navigation of mental health issues and disclosure of difficulties risked negative outcomes

in some cases, whereas non-disclosure often led to non-collaborative decisions being made about trainees with limited ability to implement workplace adaptations. Unclarity regarding mental health procedures appeared to further complicate this process, increasing trainee anxiety and allowing for varied individual interpretations of fitness to practice procedures, dependant, upon the individual's personal attitude towards the management of mental health difficulties and the limits of personal autonomy in such cases. Consistent with existing literature; the findings suggested that the culture within clinical psychology may implicitly discourage the disclosure of mental health difficulties. Practical implications may involve a cultural shift and could begin with the modelling of mental health difficulties by psychologist lecturers, redressing binary attitudes towards mental health, actively inviting and normalising disclosures and focusing on self-care. Proactively clarifying and communicating relevant mental health procedures and investing in robust and tailored supervisor training may also be beneficial.

Thank you again for your participation in my project, I could not have completed it without your generous time and experiences. Please feel free to contact me if you have any questions or comments.

Stephanie Heckert

Trainee Clinical Psychologist

Salomons Institute for Applied Psychology

Canterbury Christ Church University, UK

NHS email: Stephanie.Heckert2@nhs.net