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"You can't put the genie back in the bottle": Psychologists' decisions around sharing lived experience of mental health difficulties at work

Section A: What factors are important to psychological professionals' experiences and decision-making around workplace self-disclosure of lived experience of mental health difficulties?

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Section B: The importance of perceptions of "NHS Culture" for clinical psychologists considering a workplace self-disclosure of their lived experience of mental health difficulties

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Summary of the MRP Portfolio

Section A: Presents a critical review of the literature regarding psychological professionals' experiences of workplace self-disclosure, and barriers and facilitators to this. Eight papers published in peer-reviewed journals were critically appraised and reviewed, and common themes identified and discussed; these included motivation for disclosure, stigma and judgement, features of the mental health problem, recipient factors, impact on career and competence, lived experience as an asset, allies, workplace culture, and individual differences. Limitations of the existing literature base, and directions for future research including widening diversity, are discussed.

Section B: Presents a grounded theory study to produce a model of the importance of the perception of "NHS culture" on clinical psychologists' decision-making around workplace self-disclosure of their lived experience of mental health difficulties. The model identifies three key psychological processes contributing to this decision: safety, motivation, and identity. Perceptions of "NHS culture" appeared to interact with these processes, particularly in the domains of "safety" and "motivation". The influence of the "clinical psychologist identity" was also explored and discussed in the context of this decision. Practice implications may include challenging preconceptions of psychologists, integrating teaching around lived experience into clinical training courses, and addressing problem areas of organisational culture within the NHS.

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Section A: Critical literature review

What factors are important to psychological professionals' experiences and decision-making around workplace self-disclosure of lived experience of mental health difficulties?

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Abstract

Despite the high prevalence of mental health difficulties among psychological professionals, and the potential benefits to self-disclosure for professionals, service users, and the community, workplace self-disclosure of such remains rare. It is important to investigate the factors which may be involved in psychological professionals' decision making about whether to self-disclose at work. This paper aims to review and appraise the existing literature to identify factors (barriers and facilitators) important to psychological professionals' choices around workplace self-disclosure of lived experience of mental health difficulties. Electronic searches were conducted using the databases PubMed, Medline, PsycInfo, PsycArticles, ASSIA and Web of Science. Eight papers were identified which met inclusion criteria for the review. Findings in the literature were grouped into themes and critically examined one by one: *Motivation for disclosure, Stigma and judgement, Features of the mental health problem, Recipient and response to disclosure, Impact on career and competence, Lived experience as a professional asset, Allies, Workplace culture,* and *Individual differences.* While the current literature base is limited, there are some commonalities regarding what is helpful and unhelpful across the psychological professionals' sampled. Limitations of the current literature, and implications for future research and practice, are discussed.

Keywords: *self-disclosure; psychological professionals; lived experience; mental health difficulties; literature review*

Introduction

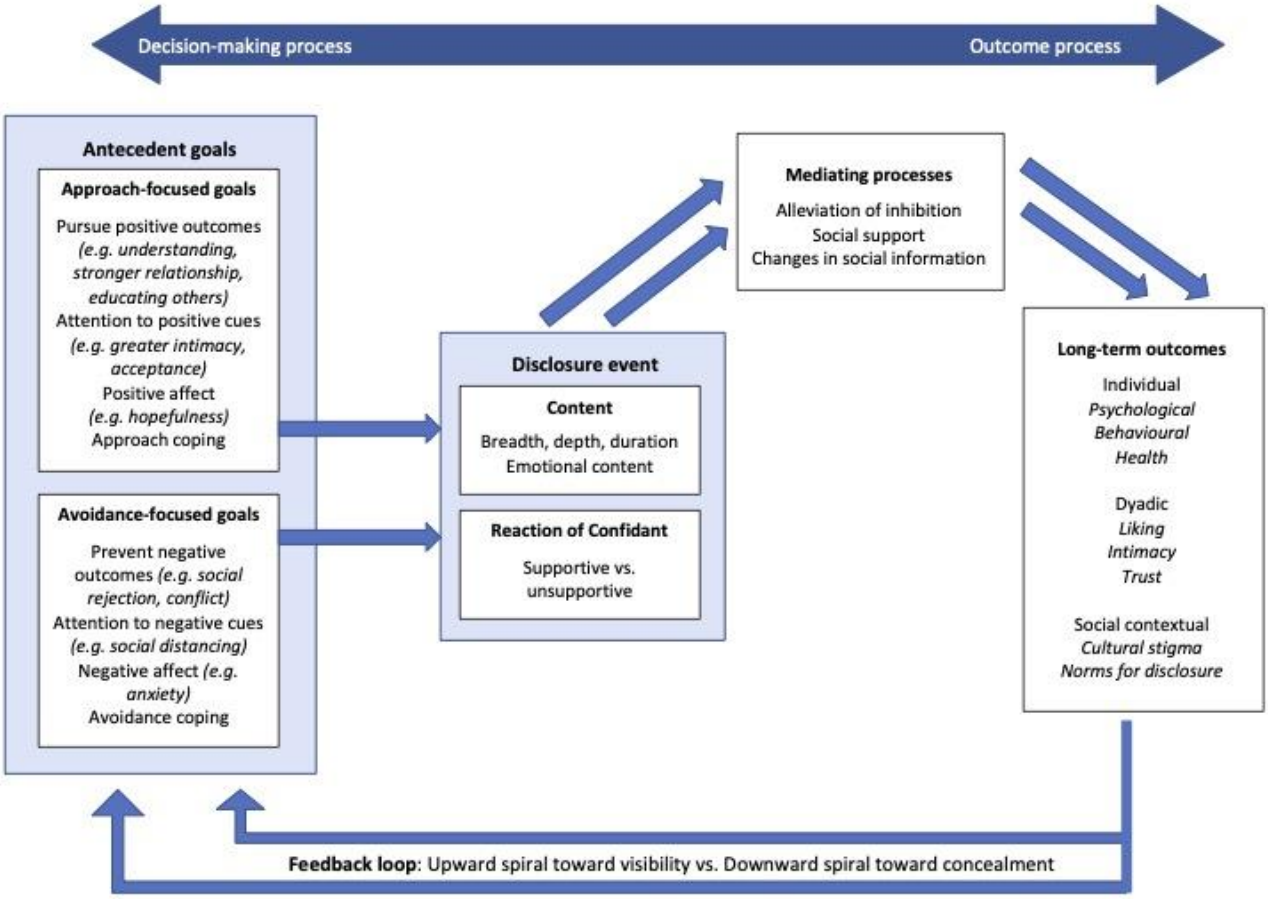
Theoretical background

Self-disclosure is the act of revealing information about oneself in order to develop intimacy in relationships (Reis & Shaver, 1988), and can also function as an exchange to elicit self-disclosure from others (disclosure reciprocity; Berg & Derlega, 1987). Social penetration theory (SPT; Altman & Taylor, 1973; Taylor & Altman, 1975) posits that decisions about self-disclosure are assessed using a cost-benefit analysis, considering the potential risks of disclosure. SPT describes two aspects of self-disclosure: breadth of disclosure relates to the range of subjects an individual self-discloses to another person, and depth relates to the privacy of the content. An individual is more likely to self-disclose items which are not considered "deep", only reaching "depth" of disclosure within intimate relationships (Tolstedt & Stokes, 1984). For most people, information about their mental wellbeing would be considered a sensitive or "deep" subject for self-disclosure (Lee et al. 2020). For the purposes of this review, the term "self-disclosure" should be taken to mean revealing personal information about oneself, including choosing to speak about mental health difficulties.

The Disclosure Processes Model (DPM; Chaudoir & Fisher, 2010; Figure 1) describes the decision-making involved in self-disclosure of a concealable stigmatised identity, and draws on empirical literature on sexuality, trauma, physical and mental health. The DPM considers antecedent goals (motivation to disclose), and divides these into approach-focused goals (pursuing positive outcomes) and avoidance-focused goals (preventing negative outcomes), positing that disclosures with an approach-focused goal may be experienced more positively than disclosures with an avoidance-focused goal. The DPM then considers factors associated with the disclosure event (content of the disclosure, and reaction to the disclosure), and mediating factors including inhibition and social support. A feedback loop is described,

which influences the likelihood of future self-disclosure based on the experience and long-term outcomes of the disclosure.

Figure 1: The Disclosure Processes Model (DPM). Diagram recreated from Chaudoir & Fisher, 2010, p.238



Context and rationale for this review

Among psychological professionals, research has investigated the benefits of a "deep" level of self-disclosure with regard to the lived experience of mental health difficulties (LE of MHD). For the purpose of this review, the term "psychological professionals" refers to the 12 psychological professions identified by Health Education England (n.d.) outlined in Table 1. Despite limited research in this area, psychological professionals are likely to experience high rates of MHD (Bridgeman & Galper, 2010), due to both the emotional demand of the work,

and because those with LE of MHD may be drawn to mental health work (Smith & Moss, 2009).

The potential benefits of self-disclosure of LE of MHD among psychological professionals include: access to personal or professional support, including necessary adjustments; benefits to care provided to clients and the therapeutic relationship (e.g. Pope et al. 1987; Henretty & Levitt, 2010); and the reduction of mental health stigma, and normalisation of MHD within the population and in the community (Corrigan et al., 2013).

Despite this, workplace self-disclosure of MHD across the healthcare professions remains rare (Brooks et al., 2014). For the purpose of this review, workplace self-disclosure should be taken to mean disclosure to colleagues (managers, supervisors, peers, etc.), but does not include self-disclosure within the therapeutic relationship (i.e. to service users). Sadly, it is well documented that mental health (MH) professionals hold the same level of stigmatising views on MH, if not more, than the general population (Harris et al., 2019). For the purpose of the review, "stigma" should be taken to refer to negative or discriminatory attitudes towards someone based on their MHD. "Self-stigma" refers to internalised stigma, shame, and negative attitudes about one's own condition. There may be other factors which contribute to an individual's negative attitudes towards their MHD, including cultural factors, negative/coercive experiences, or impact on health, relationships, and employment. These negative views are not necessarily related to stigma, but are nevertheless important for professionals when considering self-disclosure.

Research has identified several factors associated with healthcare professionals' decisions not to self-disclose at work, including fear of judgement (Corrigan et al., 2013), concerns about confidentiality (Bearse et al. 2013; Edwards & Crisp, 2017), and organisational cultural factors (Rao et al., 2016; Brooks et al., 2014; Carter et al., 2013). More recently, both qualitative and quantitative investigations have focused specifically on

MH professionals' (including psychological professionals') experiences of workplace self-disclosure of LE of MHD. A review is needed to identify and appraise the growing body of literature in this area. This review aims to explore the factors which are important to psychological professionals' choices around workplace self-disclosure of LE of MHD, with a view to identifying practice implications which are facilitative. The NHS has expressed a commitment to staff wellbeing, and this review exploring the experiences of staff with LE of MHD is aligned with the NHS Values of *Respect and Dignity*, *Compassion*, *Improving Lives* and *Everyone Counts*.

Question

What factors are important to psychological professionals' experiences and decision-making around workplace self-disclosure of lived experience of mental health difficulties?

Method

Search strategy

Literature searches were conducted using Web of Science, PubMed, PsycArticles, Applied Social Sciences Index and Abstracts, Medline (from EBSCO) and PsycInfo, to identify literature from a range of relevant professional fields (medicine, nursing, psychology and social sciences). Preliminary searches were conducted using a combination of search terms from the known literature, and the search with the most relevant results pool was used. The search terms used were: ("psychologist*" OR "psycholog* profession*" OR "psychotherapist*" OR "CBT therapist*" OR "systemic therapist*" OR "family therapist*" OR "cognitive behavio* therapist*" OR "counsellor*" OR "child* wellbeing practitioner*" OR "education* mental health practitioner*" OR "prosumer*" OR "wounded healer") AND ("mental health" OR "mental illness") AND ("lived experience" OR "self stigma") AND

("self disclosure" OR "self-disclosure"). The named therapeutic roles included in the search are based on the 12 psychological professions as described by Health Education England (n.d.; see Table 1), with broader terms such as "psychotherapist" and "counsellor" capturing a range of therapeutic models and approaches. Searches including the term "workplace" were attempted, but were found to exclude some relevant studies, so this search term was excluded from the final search and the results manually screened for "workplace" self-disclosures. Search terms were applied to all literature available from these electronic databases up to the 25th August 2022. Due to the relative paucity of literature in this area, "forward" searching (searching for articles which have cited an identified paper) and "backward" searching (screening the reference list of an identified paper) were also used to identify further articles for screening. All papers identified were screened according to the inclusion criteria for this review (Table 1). Initially, titles and abstracts were screened for relevance, followed by full text screening to assess congruence with inclusion criteria. A summary of the screening process and results can be seen in Figure 2.

Table 1: Inclusion and exclusion criteria for review

Inclusion criteria	**Exclusion criteria**
The paper is published in a peer-reviewed journal in English. A majority of participants/respondents identified themselves as psychological professionals, based on the 12 psychological professions identified by Health Education England (n.d.) i.e. clinical psychologists, educational psychologists, counselling psychologists, forensic psychologists, child wellbeing practitioners, education mental health practitioners, and psychotherapists (including specific therapeutic approaches e.g. CBT therapist, systemic therapist, etc.). The paper describes professionals' considerations around self-disclosure of LE of MHD at work (either qualitatively or quantitatively). The paper need not be an empirical study, so long as it meets the other inclusion criteria described above. This may include first-person accounts written by psychological professionals.	The paper does not comprise original research, i.e. review paper.

Research focusing solely on the experiences of other mental health professionals (e.g. mental health nurses, psychiatrists, social workers, occupational therapists) was excluded on the basis that their professions may have qualitatively different experiences of self-disclosure than psychological professionals, or may face different barriers to self-disclosure, due to the nature of their job roles.

Research involving peer support workers or experts-by-experience was excluded from the review on the basis that their experiences may differ from psychological professionals', as self-disclosure of LE of MHD is an explicit element of their job role.

First-person accounts were not excluded from this review, as doing so would risk the exclusion of voices of professionals with LE of MHD.

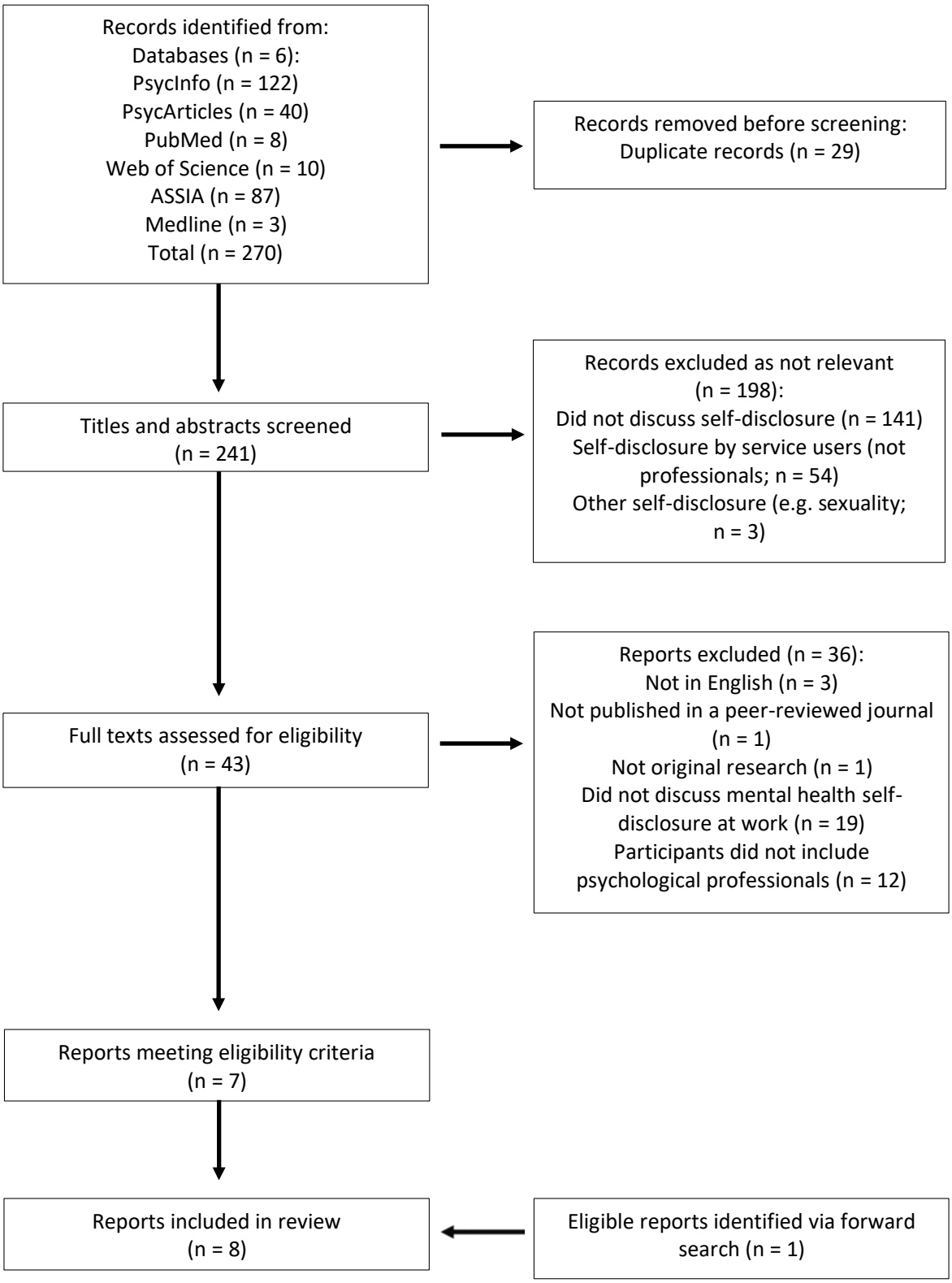
Quality appraisal tools

Seven of the eight studies were quality assessed using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). The MMAT is a universal tool which can be used to critically appraise mixed methods, qualitative, randomised control trials, and quantitative descriptive studies, so was deemed appropriate for this review which includes studies from a range of methodological approaches. Each section of the MMAT provides options for either mixed methods, qualitative or quantitative studies. For this review, the "quantitative descriptive" section was used to appraise quantitative studies. The authors recommend that an overall quality score is not provided, rather that a more detailed appraisal is included for each study (Table 3), and discourage the exclusion of papers which are assessed to be "poor" quality (Hong et al., 2018).

The MMAT can only be used to assess empirical studies. One paper included in this review (Vierthaler & Elliott, 2022) was not an empirical study and therefore could not be appraised using the MMAT. Instead, the JBI Critical Appraisal Checklist for text and opinion papers (CACTO; MacArthur et al., 2015) was used to assess the quality of this paper.

Results

Figure 2: PRISMA diagram showing search and identification strategy



Overview of included studies and their quality

Table 2: Descriptive characteristics of included papers

Authors	Year published	Methodology	Participants' professional roles	Participant demographics	Study aims	Factors explored as important to decision-making around self-disclosure
Turner, Moses & Neal	2022	Qualitative: Grounded theory	12 trainee clinical psychologists with lived experience of mental health difficulties	75% female, 25% male. Mean age 30 years (range 26-37). Ethnicity data not collected or reported. UK.	To explore trainees' experiences of mental health self-disclosure during training	Motivation to disclose; Enablers/facilitators to self-disclosure (trusting relationships, feeling safe, having an in-road); Barriers to self-disclosure (impact on training, voicing the unspoken, internalising stigma); Features of the disclosure; Responses to disclosure; Impact of disclosure
Grice, Alcock & Scior	2018	Quantitative (Factor analysis, ANOVA, multilevel linear model analysis)	348 trainee clinical psychologists (both with and without lived experience of mental health difficulties)	Not collected or reported to preserve anonymity. UK.	To examine prevalence of mental health difficulties in this population and explore factors related to anticipated self-disclosure of these difficulties	Anticipated stigma; type of mental health problem (specific phobia vs major depression vs schizophrenia); recipient of disclosure; maladaptive and adaptive perfectionism; temporal proximity (whether the problem was past or current)
Joseph, Barnes, Harris & Boyd	2022	Mixed methods: Descriptive statistics and questionnaire analysis	35 trainee mental health professionals; majority psychologists (18), also including social workers, doctors, nurses and counsellors	66% female, 24% male. 85.7% 'Caucasian', 2.9% (1 participant) Asian American, 2.9% African American, 5.7% 'Other' ethnicity. USA.	To explore common reasons for trainee self-disclosure, and the challenges and needs of mental health trainees with lived experience of mental health concerns	'Outness' of recipient of disclosure; motivation for disclosure (seeking accommodations; seeking advice/supervision; help-seeking (i.e. seeking recommendations for support); being reprimanded (either for something related to mental health problem, or unrelated reprimand is impacting on mental health problem))
Elliott & Ragsdale	2020	Qualitative: Flexible coding	12 practicing psychotherapists with LE of MHD	75% female. Age range 36-63 years. No ethnicity data collected or reported. USA.	To explore mental health professionals' experiences of mental health self-disclosure at work	Stigma in the workplace (direct and indirect); recipient of disclosure; job performance (lived experience as both an asset and a liability)
Tay, Alcock & Scior	2018	Quantitative (chi-square, ANOVA, t-tests)	678 clinical psychologists (both with and without lived experience of mental health difficulties)	82.2% female. 91.6% white. 84.2% in the 30-50 year age range. UK.	To assess the prevalence of mental health difficulties among clinical psychologists, and stigma-related concerns relating to self-disclosure	Recipient of disclosure; type of mental health difficulty; level of self-stigma; being judged negatively; negative impact on career; negative impact on self-image; shame
Boyd, Zeiss, Reddy & Skinner	2016	Mixed methods: Descriptive statistics and thematic analysis	77 mental health professionals with LE of MHD; 50% psychologists, also including nurses, social workers, and psychiatrists	Not collected or reported to preserve anonymity. USA.	To examine prevalence of mental health difficulties in this population, and explore professional achievements, accommodations, and experiences of disclosure and stigma	Lived experience as a professional asset; caution about disclosure; self-care to remain work-ready; pride and strength

King, Fortune, Byrne & Brophy	2021	Qualitative: Comparative case study	33 mental health professionals including psychologists and psychotherapists (10), social workers, nurses, occupational therapists, psychiatrists, peer support workers and non-clinical staff	79% female, 15% male and 6% non-binary. No other demographics reported. Australia.	To explore what makes it possible for mental health professionals to share their lived experience in the workplace	Perceived organisational support; perceived supervisor support; individual differences; identity management (avoiding prejudice and discrimination); sharing knowledge gained from lived experience; team culture; consequences of disclosure
Vierthaler & Elliott	2022	1st person narrative account	Psychologist with LE of MHD	Both authors female. No other demographics reported. USA.	To highlight challenges faced by prosumers	Stigma and discrimination among colleagues; lived experience as an asset; negative impact on career; shame and internalised stigma; disclosure as 'freeing'; family history, experiences and messages; 'battle buddies' (sharing with other people with lived experience); workplace environment

Participants

Table 2 provides a summary of the participants for each paper. A total of 1,195 professionals were sampled across the seven empirical studies; 1,026 across the two quantitative studies and a further 169 across the mixed methods and qualitative studies. All studies included in this review sampled at least a subset of psychological professionals within their overall sample. Four studies used samples which were comprised entirely of psychological professionals (trainee clinical psychologists, Grice et al. 2018, Turner et al., 2022; clinical psychologists, Tay et al., 2018; and psychotherapists, Elliott & Ragsdale, 2020). Three studies sampled psychological professionals as part of a larger sample of mental health professionals (Joseph et al., 2022; Boyd et al., 2016; King et al., 2021), and it is unfortunately not possible to parse the responses of the psychological professionals from those of their MH colleagues in these cases. The eighth paper, Vierthaler and Elliott (2022), presents a narrative account of the experiences of a psychologist with LE of MHD, and of her friend and colleague, also a psychologist.

Due to the sensitive nature of the subject matter, some papers do not report demographic data to preserve participant anonymity (Boyd et al., 2016; Grice et al., 2018); and those that do, do not report ethnicity (Elliott & Ragsdale, 2020; King et al., 2021; Turner et al., 2022). Only two papers described ethnicity data, with most participants identified as white (Tay et al., 2018, 91.6%; Joseph et al., 2022, 85.7%). Similarly, the majority of respondents for whom gender identities are reported are female (see Table 2).

Methodology

Two papers present quantitative investigations into factors influencing workplace self-disclosure behaviour among psychologists (Grice et al., 2018; Tay et al., 2018). Two further papers employ mixed methods, using both descriptive statistics and qualitative analyses (questionnaire analysis, Joseph et al., 2022; and thematic analysis, Boyd et al.,

2016). Three studies gather and examine qualitative data from interviews with professionals, analysing via flexible coding (Elliott & Ragsdale, 2020); grounded theory (Turner et al., 2022); and comparative case study (King et al., 2021). The eighth paper is not an empirical study, but presents a first-person narrative account, written by a psychologist with LE of MHD, and her psychologist friend (Vierthaler & Elliott, 2022). The account is included in this review as it meets the criteria for inclusion and presents potentially rich experiential knowledge of the subject. It is not known how many of the other authors included have LE of MHD.

Limitations

As with much research in the field, a major limitation of all the included studies is the relative homogeneity of participant samples, with the majority of participants for whom demographic data are reported described as female and white. While this may be largely representative of the psychological professions (Longwill, 2015), the experiences of ethnically minoritised psychological professionals may not be adequately represented by the papers included in this review.

Similarly, research in this area is subject to sampling bias, as participants are only those who feel willing and able to disclose sensitive information about their own experiences. Some studies included in this review have attempted to mitigate this bias by collecting data completely anonymously (Grice et al., 2018; Boyd et al., 2016), but these still may not represent the experiences of those colleagues who, for whatever reason, may not have felt able to contribute.

As usual with qualitative data, reported results and interpretations are not considered to be representative of the whole population, but illustrative of the experiences of those sampled. However, there appears to be at least some congruence between qualitative reports across the studies – see Results.

Quality assessment

Table 3 shows the quality appraisal using the MMAT and the CACTO for the studies included in this review. Generally, all eight papers were found to be of relatively high quality, although all are subject to the limitations described above.

Table 3: Quality assessment of included papers

MMAT	Question	Turner et al. ____	Grice et al. 2018	Joseph et al. 2022	Elliott & Ragsdale, 2020	Tay et al. 2018	Boyd et al. 2016	King et al. 2021	Vierthaler & Elliott, 2022	Comments
Screening questions	S1. Are there clear research questions?	Y	Y	Y	Y	Y	Y	Y	-	All empirical papers set out research questions/aims clearly.
	S2. Do the collected data allow to address the research questions?	Y	Y	Y	Y	Y	Y	Y		
1. Qualitative	**1.1 Is the qualitative approach appropriate to answer the research question?**	Y	-	Y	Y	-	Y	Y	-	
	1.2 Are the qualitative data collection methods adequate to address the research question?	Y		Y	Y		Y	Y		
	1.3 Are the findings adequately derived from the data?	Y		Y	Y		Y	Y		
	1.4 Is the interpretation of results sufficiently substantiated by the data?	Y		Y	Y		Y	Y		
	1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y		Y	Y		Y	Y		
4. Descriptive quantitative	4.1. Is the sampling strategy relevant to address the research question?	-	Y	-	-	Y	-	-	-	Risk of non-response bias is increased due to the sensitive nature of the data. It is also difficult to tell whether the sample is representative of the target population for this reason. *Tay et al. 2018: Participants were recruited via the BPS of which an increasing number of psychologists are not members, so this method may not sufficiently represent the target population.*
	4.2. Is the sample representative of the target population?		CT			CT				
	4.3. Are the measurements appropriate?		Y			Y				
	4.4. Is the risk of nonresponse bias low?		N			N				
	4.5. Is the statistical analysis appropriate to answer the research question?		Y			Y				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	-	-	N	-	-	N	-	-	In both studies, no explicit rationale is explained for the use of a mixed methods design. *Boyd et al. 2016: Used a convenience sample which is reported not to be representative, rather 'illustrative'.*
	5.2. Are the different components of the study effectively integrated to answer the research question?			Y			Y			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?			Y			Y			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?			N/A			Y			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?			Y			N			
CACTO	1. Is the source of the opinion clearly identified?	-	-	-	-	-	-	-	Y	
	2. Does the source of the opinion have standing in the field of expertise?								Y	
	3. Are the interests of the relevant population the central focus of the opinion?								Y	
	4. Is the stated position the result of an analytical process, and is there logic in the opinion expressed?								Y	An experiential process
	5. Is there reference to the extant literature?								Y	
	6. Is any incongruence with the literature/sources logically defended?								N/A	

Y = Yes; N = No; CT = Can't tell; N/A = Not applicable.

Findings

Synthesis of data

Review of the literature identified commonalities in psychological professionals' reported experiences of decision-making around workplace self-disclosure. Main areas were listed for each study, which were then grouped into nine themes for the purpose of this narrative review (see Table 4). This approach follows guidance from Mays et al. (2005) on conducting narrative reviews using qualitative, quantitative and mixed-methods literature within the healthcare field. Each of these themes will now be considered in turn.

Table 4: Matrix of main areas explored by each paper, grouped into themes for review

Theme	Turner et al., 2022	Grice et al., 2018	Joseph et al., 2022	Elliott & Ragsdale, 2020	Tay et al., 2018	Boyd et al., 2016	King et al., 2021	Vierthaler & Elliott, 2022
Motivation for disclosure	Motivation to disclose	-	Motivation for disclosure (seeking accommodations; seeking advice/supervision; help-seeking; being reprimanded (either for something related to MH problem, or unrelated reprimand is impacting on MH problem)	-	-	Self-care to remain work-ready; Pride and strength	-	-
Stigma and judgement	Barriers to self-disclosure (internalising stigma)	Anticipated stigma	-	Stigma in the workplace (direct and indirect)	Level of self-stigma; being judged negatively; impact on self-image; shame	Caution about disclosure	Identity management (avoiding prejudice and discrimination)	Stigma and discrimination among colleagues; shame and internalised stigma; disclosure as 'freeing'
Features of MH problem	-	Type of MH problem (specific phobia vs major depression vs schizophrenia); temporal proximity	-	Depression not stigmatised, but self-injury is.	Type of MH difficulty	-	-	-
Recipient and response to disclosure	Enablers of self-disclosure (trusting relationships, feeling safe);	Recipient of disclosure	'Outness' of recipient of disclosure	Recipient of disclosure	Recipient of disclosure	-	Response to disclosure – once bitten, twice shy	-

	barriers (voicing the unspoken); features of the disclosure; responses to disclosure							
Impact on career and competence	Barriers (impact on training)	-	-	Job performance (LE as a liability)	Negative impact on career	Worry about applying for jobs in the future	-	Negative impact on career
LE as a professional asset	-	-	-	Job performance (LE as an asset)	-	LE as a professional asset	Sharing knowledge gained from lived experience	Lived experience as an asset
Allies	-	-	-	-	-	-	Perceived supervisor support	Battle buddies
Workplace culture	-	-	-	'Archaic' hierarchy as a barrier; Not a close-knit team	-	-	Perceived organisational support; Team culture, hierarchy	Workplace environment
Individual differences	'You shouldn't have these kinds of difficulties' – perception of what a psychological professional 'should' be	Maladaptive and adaptive perfectionism	-	-	-	-	Individual differences	-

Theme 1: Motivation for disclosure

Three papers included in this review explored psychological professionals' motivation to disclose as a factor in their decision making and experiences around workplace self-disclosure of LE of MHD (Turner et al, 2022; Joseph et al, 2022; Boyd et al, 2016).

Design

Two studies (Joseph et al., 2022; Boyd et al., 2016) used a mixed methods approach to investigate prevalence (quantitative) and experiences (qualitative). The data important for this review are derived from their qualitative analyses. Joseph et al. (2022) used questionnaire analysis to explore the challenges faced by trainees with LE of MHD, and common reasons for self-disclosure. Boyd et al. (2016) used thematic analysis of interviews with professionals to explore experiences of self-disclosure and stigma.

Turner et al. (2022) interviewed trainee clinical psychologists with LE of MHD and used grounded theory methodology to explore self-disclosure experiences.

Findings

Investigation of psychological professionals' motivation to self-disclose LE of MHD includes consideration of the necessity of disclosure, for example when a psychological professional requires time off work or other accommodations, or is obliged to report due to a sense of professional duty (Turner et al., 2022). Obligatory disclosures are reported to be experienced more negatively than disclosures over which professionals have more control and agency (Turner et al., 2022).

Equally, psychological professionals may choose to disclose for other reasons, including to demonstrate pride and strength (Boyd et al., 2016), to allow colleagues to see "that side" of them and know them better (Turner et al., 2022), or to share experiential knowledge (see Theme 6: LE as a professional asset). All three studies identified that

workplace self-disclosure is used by some psychological professionals to support destigmatisation of MH problems (Joseph et al., 2022; Turner et al., 2022; Boyd et al., 2016).

Critical evaluation

Two of these studies examined the experiences of trainees (Joseph et al., 2022; Turner et al., 2022). While the training experience may present different challenges from those faced by qualified psychological professionals (see Discussion), trainees work clinically part-time and therefore may report comparable experiences in the workplace. Two papers (Joseph et al., 2022; Boyd et al., 2016) sampled psychological professionals as a majority of a larger sample, meaning that their findings may not solely represent the views of psychological professionals, but mental health professionals more broadly.

All three studies were assessed to be relatively high quality (Table 3), however they are subject to the limitations of the literature described above, particularly the lack of heterogeneity of sample and sampling bias. In addition, it's possible that a sampling bias has led to a disproportionate number of professionals who report self-disclosure because their MH has been sufficiently poor as to necessitate a disclosure at work; and therefore may not be representative of professionals who have never needed to disclose at work.

Summary

Psychological professionals report that their motivation to disclose (e.g. professional obligation, personal authenticity, or activism) is an important consideration in their decisions around workplace self-disclosure. As two of the studies sampled psychological professionals as a majority subset of a broader sample of mental health professionals, these findings may be more representative of this broader group than psychological professionals in particular.

Theme 2: Stigma and judgement as a barrier to disclosure

Seven papers included in this review considered the impact of stigma and judgement on psychological professionals' decision-making around workplace self-disclosure of LE of MHD (Turner et al., 2022; Grice et al., 2018; Elliott & Ragsdale, 2020; Tay et al., 2018; Boyd et al., 2016; King et al., 2021; Vierthaler & Elliott, 2022).

Design

Three studies used qualitative analyses of interview data to explore psychological professionals' experiences of stigma and judgement in relation to their LE of MHD (Turner et al., 2022; Elliott & Ragsdale, 2020; King et al., 2021). Vierthaler and Elliott (2022) use a narrative account to describe challenges faced by a psychologist when navigating a MH episode and the decision to self-disclose at work. Boyd et al. (2016) conducted a mixed-methods investigation, but the data important for this theme are derived from their thematic analysis of interview data.

Two studies (Grice et al., 2018; Tay et al., 2018) used quantitative data to describe psychological professionals' reports of stigma and judgement, and the impact of stigma on professionals' decisions to self-disclose. Tay et al. (2018) conducted ANOVAs and *t*-tests to examine the effect of differing levels of stigma on disclosure rates, whereas Grice et al. (2018) employed a multilevel linear model to investigate the impact of anticipated stigma on likelihood of (hypothetical) disclosure.

Findings

Self-stigma and shame. Three articles explored the importance of shame and self-stigma in psychological professionals' decisions about workplace self-disclosure (Turner et al., 2022; Tay et al., 2018; Vierthaler & Elliott, 2022). All three studies suggested a high level of self-stigma and shame may pose a barrier to disclosure in the workplace. For example, Turner et al. (2022) report that psychological professionals feel "embarrassed", "weak", "anxious" and

worried about affecting their colleagues' perceptions of them (p.738). Psychological professionals who experience high levels of self-stigma are less likely to disclose at work than their peers (Tay et al., 2018), and nearly half of psychological professionals who have never disclosed cite "shame" as a barrier (ibid.). Vierthaler notes that, had she not chosen to disclose, this would have exacerbated feelings of internalised stigma and shame (Vierthaler & Elliott, 2022).

Stigma and discrimination among colleagues. Six articles consider the impact of stigma and workplace discrimination among MH colleagues. The decision to conceal LE is discussed as a form of workplace identity management (King et al., 2021), with the goal of avoiding discrimination. Vierthaler and Elliott (2022) describe balancing the "weight of [MH] symptoms with the weight of the attached stigma" (p.47), and report stigmatising comments from both colleagues and treating clinicians. Psychology trainees who anticipated greater levels of stigma among their colleagues were less likely to self-disclose at work (Grice et al., 2018), and a majority (71.7%) of psychologists cited "being judged negatively" as an important factor in their decision not to disclose at work (Tay et al., 2018). Elliott and Ragsdale (2020) report psychological professionals' experiences of direct and indirect stigma and discrimination, including threats to "call the board on me" (p.681) following a disclosure to a colleague. Psychological professionals who choose not to disclose report being "scared to death of being outed" (ibid., p.682) and cite fear of stigma and discrimination as reasons for the concealment of their LE (Elliott & Ragsdale, 2020; Boyd et al., 2016).

Critical evaluation

All six empirical studies were assessed to be of relatively high quality, although all are subject to the limitations described above. Vierthaler and Elliott (2022) presented a first-person narrative account, which was assessed using the JBI CACTO to be of relatively high quality, but is representative only of the authors' opinions and experiences, and cannot be

considered generalisable more widely. However, the experiences described are comparable to many of the experiences reported in empirical qualitative studies of the same phenomena (Turner et al., 2022; Elliott & Ragsdale, 2020; King et al., 2021).

As above, two papers (Boyd et al., 2016; King et al., 2021) sampled psychological professionals as a majority of a broader sample of mental health professionals, which may make their conclusions more applicable to this broader group rather than psychological professionals in particular.

Summary

Stigma and discrimination, both internal and among MH colleagues, present barriers to workplace self-disclosure of LE of MHD. This has been demonstrated through both qualitative examination of psychological professionals' reported experiences, and (quantitative) exploration of the impact of stigma on disclosure rates.

Theme 3: Features of the mental health problem

Three studies explore the importance of the features of the MH problem to be disclosed in psychological professionals' decisions about workplace self-disclosure (Grice et al., 2018; Tay et al., 2018; Elliott & Ragsdale, 2020).

Design

Two of these studies (Grice et al., 2018; Tay et al., 2018) employed quantitative analyses to investigate the impact of MH problem variables on disclosure rates. Grice et al. (2018) conducted two-way ANOVAs to investigate the impact of MH problem "type" on levels of anticipated stigma and disclosure behaviour. Tay et al. (2018) conducted chi-square analyses to explore the effect of the problem "type" on professionals' willingness to self-disclose.

The third study (Elliott & Ragsdale, 2020) used flexible coding to analyse interviews with psychotherapists with LE of MHD.

Findings

"Features" of the MH problem include the diagnosis, social acceptability, and temporal proximity (i.e. current or historical). Grice et al. (2018) found that psychological professionals were significantly more likely to disclose a current MH problem than a historical one.

Qualitative reporting (Elliott & Ragsdale, 2020) indicates that psychological professionals are mindful of the "acceptability" of a diagnosis when choosing whether to self-disclose, with personality disorders and deliberate self-injury among the least acceptable. Similarly, quantitative studies (Grice et al., 2018; Tay et al., 2018) explored levels of stigma and disclosure among different types of MH problem. Tay et al. (2018) identify bipolar disorder, psychosis and addiction as "heavily stigmatised disorders" and depression, anxiety and eating disorders as "less stigmatised disorders", and hypothesised that psychological professionals would be less likely to disclose "heavily stigmatised" disorders. Grice et al. (2018) used examples of MH diagnoses to represent "less stigmatised" (specific phobia), "moderately stigmatised" (depression) and "highly stigmatised" (schizophrenia) difficulties, to measure anticipated stigma and disclosure. As predicted, participants reported higher levels of anticipated stigma for more highly stigmatised difficulties, and this was associated with a decreased likelihood of anticipated disclosure (Grice et al., 2018). However, Tay et al. (2018) found no difference between actual disclosure rates for psychologists disclosing heavily stigmatised disorders and less stigmatised disorders.

Critical evaluation

All three studies were assessed to be of relatively high quality (Table 3), while subject to the limitations of the literature described above. In addition, Grice et al. (2018) asked

participants to "anticipate" their responses to hypothetical disclosure scenarios, which may not represent actual disclosure behaviour. This is observed in the discrepancy in findings on disclosure rates between Grice et al. (2018) and Tay et al. (2018). Both quantitative studies included participants with and without LE of MHD, meaning it was occasionally difficult to parse the responses of professionals with LE from those without.

Summary

The "acceptability" of the MH problem, and the temporal proximity to it, appear to be important factors in psychological professionals' decision making around workplace self-disclosure of LE of MHD.

Theme 4: Recipient and response to disclosure

Six papers (Turner et al., 2022; Grice et al., 2018; Joseph et al., 2022; Elliott & Ragsdale, 2020; Tay et al., 2018; King et al., 2021) explored the importance of the recipient of and responses to disclosure on psychological professionals' decisions around workplace self-disclosure.

Design

Three papers (Turner et al., 2022; Elliott & Ragsdale, 2020; King et al., 2021) used qualitative analyses of interview data to explore the importance of the recipient of (Turner et al., 2022; Elliott & Ragsdale, 2020) and responses to (Turner et al., 2022; King et al., 2021) self-disclosures in the workplace.

Joseph et al. (2022) used mixed methodology to analyse survey data from mental health professionals (including psychological professionals) with LE of MHD. Their chi-square analysis is most useful here, in elucidating the link between recipient type and disclosure behaviour. Two further papers (Grice et al., 2018; Tay et al., 2018) also employed

statistical analysis to describe the effect of recipient type (e.g. family, peers, employers) on self-disclosure behaviour.

Findings

Recipient of disclosure. The relationship between discloser and recipient is an important factor in psychological professionals' decisions about self-disclosure, and individuals can be selective in choosing to whom they disclose (Turner et al., 2022; Elliott & Ragsdale, 2020). Trust and safety are cited as facilitative for disclosure within working relationships (Turner et al., 2022; Elliott & Ragsdale, 2020), as well as the "outness" of the recipient (i.e. people report being more likely to disclose to a colleague who they already know to have LE of MHD; Joseph et al., 2022).

Two quantitative studies (Tay et al., 2018; Grice et al., 2018) examined the impact of a variable recipient group on likelihood of hypothetical disclosure, with psychological professionals more likely to disclose to peers than superiors (supervisors, managers; Grice et al., 2018; Tay et al., 2018). Of all potential recipients (family, friends, work peers and employers), psychologists reported the most negative experiences when disclosing to employers (Tay et al., 2018).

Response to disclosure. Turner et al. (2022) explored psychological professionals' experiences of disclosure and the significance of the recipient's response in future decision making. Participants describe facilitative (listening, exploring) versus unhelpful responses ("jumping to fix", lack of curiosity). King et al. (2021) identified that professionals were less willing to self-disclose in the future if they had previously had a negative disclosure experience at work – "once bitten, twice shy" (p.6).

Critical evaluation

All six studies were of relatively high quality (Table 3). As above, these studies are subject to common limitations, including homogeneity of sample, and sampling bias. Grice

and colleagues' (2018) findings may not represent actual disclosure experiences or behaviour, due to the use of hypothetical disclosure situations.

The findings from Joseph et al. (2022) and King et al. (2021) may be representative of the views of mental health professionals more widely (rather than psychological professionals in particular), as psychological professionals were sampled as majority of a broader participant pool.

Summary

Qualitative studies describe both facilitative and restrictive features of the recipient on the decision to self-disclose. Namely, the psychological professionals sampled reported that they may be more likely to self-disclose within a trusting and safe relationship, and to a recipient who is also "out". The response to the disclosure is also important, with interview data used to describe both facilitative and unhelpful responses (Turner et al., 2022). Quantitative investigations found that psychological professionals were more likely to disclose to workplace peers than superiors.

Theme 5: Impact on career and competence

Five papers outline psychological professionals' considerations about the impact of their self-disclosure on their career, and judgements about their professional competence (Turner et al., 2022; Elliott & Ragsdale, 2020; Tay et al., 2018; Vierthaler & Elliott, 2022; Boyd et al., 2016).

Design

Boyd et al. (2016) used mixed methodology to describe and analyse survey data. Their thematic analysis of open-ended survey responses is most helpful here, to describe professionals' concerns around the impact of a disclosure on their career and competence. Other qualitative reports (Turner et al., 2022; Elliott & Ragsdale, 2020) analysed interview

data to explore this. Vierthaler and Elliott (2022) presented a first-person narrative account which included exploration of Vierthaler's considerations and experiences of the impact of her MH difficulties and disclosure on her career, and the careers of other "out" psychologists.

Tay et al. (2018) used descriptive statistics to summarise data from clinical psychologists with LE of MHD reporting the reasons they have chosen not to self-disclose at work.

Findings

Tay et al. (2018) reported that 67.4% of psychologists who had not disclosed their LE of MHD to anyone cited a potential negative impact on their career as a reason not to disclose. Concerns about judgement of clinical competence were widespread, with psychological professionals worrying about the potential consequences of a disclosure (Turner et al., 2022). While many psychological professionals report their LE as a professional asset (Theme 6), some acknowledge that it can also cause complications in their clinical work, including being triggered by clients' stories, and empathising "too much" with clients and "falling into the well of despair with [them]" (Elliott & Ragsdale, 2020, p.683). This understandably is an important consideration when contemplating self-disclosure to colleagues, with concerns around colleagues' perception of fitness to practice cited as a significant barrier to self-disclosure (ibid.).

Concerns around career progression and future job applications are also important (Boyd et al., 2016; Vierthaler & Elliott, 2022). Vierthaler describes a colleague telling her she was "dangerous… you should not be practicing" (Vierthaler & Elliott, 2022, p.47), and notes that other psychological professionals who have publicly "come out" have done so later in their careers, when they have already achieved progression and respect, and the disclosure may pose less of a risk to their careers (Vierthaler & Elliott, 2022).

Critical evaluation

The four empirical papers (Boyd et al., 2016; Tay et al., 2018; Turner et al., 2022; Elliott & Ragsdale, 2020) were all assessed to be relatively high quality, as was Vierthaler and Elliott's (2022) narrative account. As above, Vierthaler and Elliott's (2022) paper cannot be used to represent the views of psychological professionals more widely, although this is also the case with all the qualitative investigations reviewed. Additionally, Boyd and colleagues (2016) sampled psychological professionals as a subset of a broader group of mental health professionals, so again these findings may represent mental health professionals more broadly. However, the presence of comparable views and experiences across these qualitative investigations may add weight to their findings.

Summary

Psychological professionals report feeling worried about how their MH problems will affect their career and how their competence is viewed, and for many, this presents a barrier to self-disclosure at work.

Theme 6: Lived experience as a professional asset

Four papers explored psychological professionals' perceptions of their LE as a professional asset, and the importance of this in deciding whether to self-disclose their LE at work (Elliott & Ragsdale, 2020; Boyd et al., 2016; King et al., 2021; Vierthaler & Elliott, 2022).

Design

All four papers which discuss LE as a professional asset used qualitative approaches to do so. Two (Elliott & Ragsdale, 2020; King et al., 2021) analysed interview data with professionals, whereas Boyd et al. (2016) used thematic analysis to evaluate survey

responses. Vierthaler and Elliott's (2022) narrative account also describes LE as a professional asset.

Findings

Psychological professionals sampled perceived their LE to be an asset to their professional work in several ways, including providing hope (Elliott & Ragsdale, 2020), evidence of recovery (Boyd et al., 2016), compassion and understanding (Boyd et al., 2016), authenticity and "fullness of self" (King et al., 2021), and to normalise MH difficulties (King et al., 2021). While these assets benefit direct work with clients, psychological professionals also report using self-disclosure to educate and challenge stigma among colleagues, and to advocate for the service user position (Elliott & Ragsdale, 2020). Positioning LE as a professional asset may facilitate psychological professionals' self-disclosure, although it is unlikely to counteract psychological professionals' legitimate concerns about perceptions of competence (Theme 5).

Critical evaluation

The three qualitative investigations (Elliott & Ragsdale, 2020; King et al., 2021; thematic analysis in Boyd et al., 2016) were assessed to be of relatively high quality, as was Vierthaler and Elliott's (2022) account. All four papers remain subject to the limitations described above, and in addition all use qualitative data and are therefore difficult to generalise to the professional population more widely. While LE is described as a professional asset, the papers do not make an explicit link between the perception of LE as an asset and an increased likelihood to self-disclose, although many of the participants reported that it was an important factor in their decision-making. To the author's knowledge, no quantitative investigations have taken place which evaluate the effect of the perception of LE as a professional asset on workplace self-disclosure rates.

As above, two studies (Boyd et al., 2016; King et al., 2021) sampled psychological professionals within a larger sample of mental health professionals, so these findings may be more representative of this wider group than specifically applicable to psychological professionals.

Summary

Many of the psychological professionals sampled perceive their LE to be an asset, both to their direct clinical work, and to team knowledge and understanding. While the area is relatively well-described qualitatively, there is a lack of inferential analysis in this area to link the perception of LE as an asset to increased self-disclosure rates.

Theme 7: Allies

Two papers discuss the importance of workplace allies in psychological professionals' choices and experiences of self-disclosure of LE of MHD (King et al., 2021; Vierthaler & Elliott, 2022).

Design

Both papers used qualitative approaches to discuss the importance of allies for psychological professionals thinking about self-disclosure at work. King et al. (2021) interviewed professionals to elucidate a theme around supervisory support. Vierthaler and Elliott's (2022) narrative account advocates for the importance of allies, both in and out of the workplace.

Findings

Vierthaler and Elliott (2022) refer to "battle buddies", a term borrowed from the US military to describe a reciprocal relationship where two people look out for each other's wellbeing. Vierthaler explains that it can be helpful for a "battle buddy" to be someone who also has LE of MH difficulties, reflecting Joseph and colleagues' (2022) finding that

professionals are more likely to self-disclose to "out" colleagues (see Theme 4, above). Supportive supervisors can also help to provide a safe environment in which to self-disclose (King et al., 2021).

Critical evaluation

This is an under-examined theme within the literature, with only brief coverage in two qualitative papers. As Vierthaler and Elliott's (2022) paper only represents the authors' own views, King et al. (2021) presented the only empirical data on the importance of allies for professionals with LE of MHD. As above, this kind of qualitative analysis does not lend itself to generalisation across the population, so this area would benefit from further investigation. Again, King and colleagues' (2021) sample included psychological professionals as well as mental health colleagues, so it is not possible to determine whether these findings are applicable to psychological professionals specifically. The two studies included here were assessed to be of relatively high quality (Table 3).

Summary

Initial investigations suggest that allies may play an important role in mental health professionals' choices about workplace self-disclosure of LE of MHD. Allies with their own LE of MHD may be particularly facilitative. Further research would be beneficial.

Theme 8: Workplace culture

While all nine papers could be said to describe some element of workplace culture, three discuss "culture" directly (Elliott & Ragsdale, 2020; King et al., 2021; Vierthaler & Elliott, 2022).

Design

All three papers which discuss "culture" use a qualitative method to do so. Two papers (Elliott & Ragsdale, 2020; King et al., 2021) gathered interview data from

professionals with LE of MH difficulties, and Vierthaler and Elliott (2022) provide a first-person account of the influence of workplace culture on Vierthaler's self-disclosure.

Findings

Vierthaler and Elliott (2022) advocate for work environments with recovery-orientated beliefs and expectations, to promote and empower psychological professionals with LE of MHD. Similarly, King et al. (2021) identified that "organisational support" is important for professionals when considering whether to self-disclose their LE.

Team "hierarchy" may influence psychological professionals' willingness and safety to self-disclose (Elliott & Ragsdale, 2020). Described as "archaic" (ibid., p.682), hierarchical teams may affect power differentials among colleagues, which could place a professional in a safer, or less safe, position depending on their position in the hierarchy. Greater power may place professionals in a "safer" position – with "less to lose" (King et al., 2021, p.4) – but this is not necessarily associated with more willingness to disclose (Elliott & Ragsdale, 2020). Indeed, professionals in high-ranking positions may feel *more* concerned about the impact of their disclosure on their career, position and competence (Elliott & Ragsdale, 2020), and consequently conceal their LE of MHD. Some professionals who describe their workplace as having a "flat structure" report finding this facilitative in fostering a safe environment in which to self-disclose, and that a supportive team culture was beneficial for staff wellbeing and retention (King et al., 2021).

Interpersonal relationships and sense of "closeness" within a team may also be important for psychological professionals when deciding whether to self-disclose their LE. One psychological professional described that there was "not a lot of interaction, not a lot of closeness" (Elliott & Ragsdale, 2020, p.682) within the team, and this had presented a barrier to their self-disclosure.

Critical evaluation

Again, while all three papers were assessed to be of relatively high quality (Table 3), all have used qualitative methodology, making findings difficult to apply across the population. To the author's knowledge, there has been no investigation into the potential influence of "workplace culture" variables on psychological professionals' choices around workplace self-disclosure. Further research would be beneficial in this area, with particular awareness of the limitations of the existing literature.

Summary

Workplace culture, including team hierarchy and interpersonal closeness, is an important consideration for professionals thinking about workplace self-disclosure. Investigations suggest that a "flat" structure may be more facilitative for self-disclosure than a hierarchical structure (Elliott & Ragsdale, 2020; King et al., 2021). The area is under-examined and could benefit from further investigation.

Theme 9: Individual differences

Of course, individual differences between psychological professionals also play an important role. Three papers (King et al., 2021; Turner et al., 2022; Grice et al., 2018) explored the importance of individual differences in choices around workplace self-disclosure.

Design

Two studies analysed interview data to qualitatively examine the importance of individual characteristics on self-disclosure choices (King et al., 2021; Turner et al., 2022), and the third (Grice et al., 2018) employed a multilevel linear model analysis to investigate the interaction between reported perfectionism ("adaptive" and "maladaptive") and hypothetical disclosure decisions.

Findings

Grice and colleagues (2018) examined the relationship between perfectionism and self-disclosure of LE of MH difficulties. Perfectionism (particularly maladaptive perfectionism) was found to be associated with a decreased likelihood of self-disclosure (Grice et al., 2018), to conceal information which may be judged negatively. King et al. (2021) used the term habitus to describe a professional's "way of being in the workplace" (p.4), with some individuals adopting a more "real and raw" (p.4) habitus and linking this with their workplace self-disclosure.

King et al. (2021) also identified the importance for some participants of "professional imperatives around self-disclosure" (p.4). Interviews suggested this may include "trying to blank slate" (King et al., 2021, p.4), or putting on "a professional façade" (p.6). One respondent remarked "you should not have these sorts of problems if you are a [psychological professional]… you feel a bit embarrassed" (Turner et al., 2022, p.738).

Critical evaluation

All three studies were assessed to be of relatively high quality (Table 3), although all remain subject to the limitations of the literature described above. As above, Grice et al. (2018) employed a hypothetical scenario paradigm to elicit self-disclosure decisions, which may not be representative of trainees' actual disclosure behaviours.

Only two categories of individual differences, perfectionism and habitus, are explored in the literature in relation to psychological professionals' workplace self-disclosure. The importance of other individual characteristics, including demographic variables (age, gender identity, ethnicity), could be investigated by further research in this area. The sensitive nature of the subject matter often necessitates that demographic data are omitted to preserve participant anonymity, but this significantly limits the capacity to investigate individual differences meaningfully.

Summary

Individual differences have been shown, in a limited way, to play an important role in psychological professionals' self-disclosure decisions. Maladaptive perfectionism may be associated with a lower likelihood of self-disclosure. "Habitus", or a professional's way of being in the workplace, is also an important factor. Those with a more "real and raw" habitus may be more open to self-disclosure than their colleagues who adopt a "professional façade" at work.

Discussion

The reviewed literature describes many ways in which psychological professionals report feeling unable to self-disclose their LE of MHD. Barriers appear to include stigma and discrimination at work; low social acceptability of the MHD; unhelpful responses to the disclosure; fear about judgements of competence and career progression; workplace culture, including hierarchy; and individual differences such as perfectionism and a professional's "way of being" at work.

There are also findings across the literature of facilitative practices which may encourage and support psychological professionals to self-disclose at work, including higher social acceptability of the MHD; supporting the destigmatisation of MHD in the profession and the community; the "outness" of the recipient; helpful, curious responses to the disclosure; being later in one's career, after career goals have been achieved; LE as a professional asset; allies in the workplace, including other professionals with LE or supportive supervisors; a "flat" workplace structure; and a professional's "real" habitus at work.

Some of the literature included in this review suggests a movement of psychological professionals with LE of MHD away from shame and towards acceptance, pride and

activism. There appears to be a greater presence in the psychological professions of "out" clinicians, and recent years have seen the development of professional networks for clinicians with LE of MHD (e.g. in2gr8mentalhealth.com), with the aim of helping to normalise MH problems for psychological professionals and combat stigma. The visibility of these professionals may facilitate more open sharing, as evidenced by findings that professionals are more likely to disclose to an "out" colleague (Joseph et al., 2022). This finding may be consistent with SPT (Altman & Taylor, 1973), and particularly with the idea of disclosure reciprocity (Derlega & Berg, 1987). The facilitative effect of having an "out" colleague may be partly due to the reciprocal nature of self-disclosure; in other words, feeling willing and able to disclose to a colleague because they have disclosed to you first. However as yet, the activism of "out" professionals is unlikely to outweigh the existing stigma and shame associated with MHD within the profession, in a cost-benefit analysis of risk. Across the literature, negative attitudes towards MHD (including stigma and self-stigma) are reported widely (seven of nine studies included here), whereas activism and the identification of LE as an asset appears less frequently (four of nine studies) and is less robustly described. It would be beneficial for further investigations to explore this phenomenon, in order to identify facilitative practices for psychological professionals with LE of MHD.

These findings must be held lightly in the context of the limitations of the reviewed literature. As discussed throughout, participant samples may not be adequately representative of psychological professionals more broadly. The inclusion of trainee clinical psychologists (Grice et al., 2018; Turner et al., 2022) and of other MH professionals (Joseph et al. 2022; Boyd et al., 2016; King et al., 2021) may mean that the above findings are not purely representative of psychological professionals with LE of MHD. In addition, all the papers included in this review are subject to self-selection bias. All participants were willing, at least anonymously, to talk about their MH experiences, or to express an opinion on professionals

with LE. Only two papers sampled psychological professionals both with and without LE (and therefore potentially captured views of psychological professionals with LE who were unwilling to disclose this; Grice et al., 2018; Tay et al., 2018). However, due to this expanded participant selection, Grice et al. (2018) asked participants to answer hypothetical questions, which may not represent real decision-making behaviour (Bell et al., 2011).

Similarly, the very nature of this research may exclude people for whom self-disclosure is not felt to be safe. This may be especially relevant for colleagues of the Global Majority who may already feel discriminated against and under-represented in the profession. This issue is compounded by the lack of representation within the literature. As outlined previously (see Table 2), some papers do not report demographic data, and those that do are majority white. While this may be representative of psychological professions in general (Longwill, 2015), the experiences of Black or ethnically minoritised psychological professionals with LE of MHD may not be adequately represented by the papers included in this review.

The Disclosure Processes Model

Many of the barriers and facilitators identified in this review can be understood within the framework of the DPM (Chaudoir & Fisher, 2010; See Introduction and Figure 1). The DPM theorises that individuals pursuing an avoidance-focused goal may be more likely to attend to negative social responses, and to interpret neutral stimuli as negative, than those who pursue approach-focused goals. Within this framework, obligatory disclosures may be considered an avoidance-focused motivation (to avoid negative outcomes of non-disclosure), which may account for psychological professionals' broadly more negative experiences of these types of disclosures. Similarly, other areas of the literature identified in this review may represent avoidance-focused antecedent goals within the DPM, including the avoidance of stigma and judgement, and lower social acceptability of the presenting MH problem.

Areas reported to be facilitative for self-disclosure in the workplace may represent approach-focused antecedent goals within the DPM framework. The framing of LE as a professional asset is one example (e.g. to educate others, promote understanding, provide hope), which in turn may be associated with more positive disclosure experiences. Disclosure to an "out" colleague may also represent an approach-focused goal.

The DPM's feedback loop is evident in some of the literature reviewed. Across several themes, psychological professionals identified that a poor disclosure experience would make them less likely to disclose in the future. Conversely, while the current literature does not examine the impact of positioning LE as a professional asset on disclosure behaviours, the DPM framework suggests that this sort of disclosure could contribute to an "upward spiral toward visibility" (p.238). Further research could examine the importance of positioning LE as an asset in facilitating workplace self-disclosure.

As discussed above, the role of allies is under-investigated in the literature and would benefit from further exploration. Allies may have a role in activating the mediating factor "social support" within the DPM, and therefore their contribution could be preliminarily understood in terms of providing necessary social support to facilitate self-diclsosure.

There are also areas of the literature which are not so well-explained by the DPM. Psychological professionals are obligated to reduce or cease practicing if their health could affect job performance or put clients at risk (e.g. HCPC, 2016). This can cause anxiety for psychological professionals with LE of MHD when deciding whether to self-disclose at work. This impact of self-disclosure on career and competence relates to a code of ethics specific to caring professions, and therefore is not described by the DPM. However, broadly the components are recognisable: the potential negative consequences of such a disclosure may represent an avoidance-focused antecedent goal, and the response to the disclosure and

potential long-term outcomes may contribute to a feedback loop "downward… toward concealment" (p.238).

Similarly, workplace cultural factors are not so well-described, as they relate to cultural and team processes which are not considered by the DPM. This area could benefit from further investigation, to produce a model of self-disclosure processes within the context of a workplace or team culture.

Individual differences among psychological professionals also naturally play a role in decisions around workplace self-disclosure, but are not considered within the remit of the DPM and may be better explained by other theoretical frameworks (for example, self-concealment as a mediator between perfectionism and psychological distress; Kawamura & Frost, 2004).

Research directions

Despite the acceleration in published studies in recent years, this area lends itself to further study due to the relative paucity of literature. Many of the areas reviewed could benefit from further exploration. It may be particularly helpful to conduct further investigations into the role of LE as a professional asset, and the benefits to both team working and clinical practice this may afford. Additionally, areas which are especially underexamined in the literature, and are not well-explained by the DPM, are the importance of "workplace culture" and the presence of workplace allies. As above, future study could examine psychological professionals' experiences of workplace culture and its impact on their decision making around self-disclosure of LE of MHD. In future research, it would be particularly helpful to consider how best to represent the voices of minoritised professionals.

Practice implications

Given the limitations of the existing literature, there is not strong enough evidence to provide recommendations for practice for all psychological professionals, although the

facilitators identified in this review may contribute to mental health workplaces which support and encourage professionals to share their LE of MHD, should they wish to.

Conclusion

The extant literature highlights important factors in psychological professionals' decision making around self-disclosure of LE of MHD at work. While the current literature is limited in its representativeness of the population, there appear to be some factors in common among at least some psychological professionals sampled. These could be considered in the development of facilitative and supportive workplace environments to encourage authenticity of self at work. There remains a dearth of literature in this area. Further research is encouraged, especially regarding the experience of LE of MHD as a professional asset, and the importance of workplace culture on clinicians' choices around self-disclosure.

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Section B: Empirical paper

The importance of perceptions of "NHS Culture" for clinical psychologists considering a workplace self-disclosure of their lived experience of mental health difficulties

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For submission to the Journal of Clinical Psychology

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

Salomons Institute for Applied Psychology

Canterbury Christ Church University

Abstract

The prevalence of mental health difficulties among clinical psychologists is high, but workplace self-disclosure of these remains rare. There may be benefits to psychologists' workplace self-disclosure of mental health difficulties, including personal benefits, benefits to service users, and collective benefits to society (e.g. reducing stigma). This project set out to investigate the experiences of nine clinical psychologists with lived experience of mental health difficulties within the NHS, to produce a theory of the interactions between their perceptions of "NHS culture" and their decision-making around self-disclosure. A grounded theory is presented, describing the core category "weighing the decision – to disclose or not to disclose?". Perceptions of "NHS culture", and the psychological processes involved in the decision (safety, motivation, identity), are described. NHS culture appeared to interact with the decision-making process, particularly in the domains of "safety" and "motivation". Participants described some influence of the "clinical psychologist identity" on their personal and professional identities and decisions. Participants also expressed some hope for the future. Practice implications, limitations of the study, and research directions are discussed.

Keywords: *clinical psychologists; lived experience; self-disclosure; organisational culture; NHS*

Introduction

Despite limited research with the population, psychologists are likely to experience higher rates of mental health difficulties (MHD) than the general public (including suicide and suicidal ideation; Bridgeman & Galper, 2010), due to both the emotional demand of the work, and because those with experience of MHD are likely to be drawn to mental health work (Smith & Moss, 2009). Evidence suggests that over 60% of UK clinical psychologists may have personal experience of MHD (Tay et al., 2018), which is a considerably higher proportion than current estimates for the UK population (43%; Mental Health Foundation, 2016).

Self-disclosure among psychologists

Despite the high prevalence of MHD among psychologists, talking about MHD at work remains rare (Tay et al., 2018). Within the literature, the benefits of psychologists' self-disclosure appear to be three-fold. Firstly, the personal benefit, including accessing support and reasonable occupational adjustments. Second, the potential benefit to clients: many psychologists reported concealing their own emotional distress from supervisors and continuing to work with clients, with over a third reporting their distress had had a negative impact on their clinical work (Pope et al., 1987). Additionally, self-disclosure within the therapeutic relationship can be beneficial to its success, with therapists who self-disclose perceived as warmer (Henretty & Levitt, 2010) and more trustworthy (Lundeen & Schuldt, 1989). The third consideration is at a societal level, with self-disclosure having a positive impact on both internalised and external mental health stigma, and normalisation of MHD in the community (Corrigan et al., 2013).

A recent review of the literature investigating workplace self-disclosure of MHD highlighted possible barriers to disclosure (see Section A), including stigma and judgement, feared responses to disclosure, impact on career and competence, and workplace culture. The

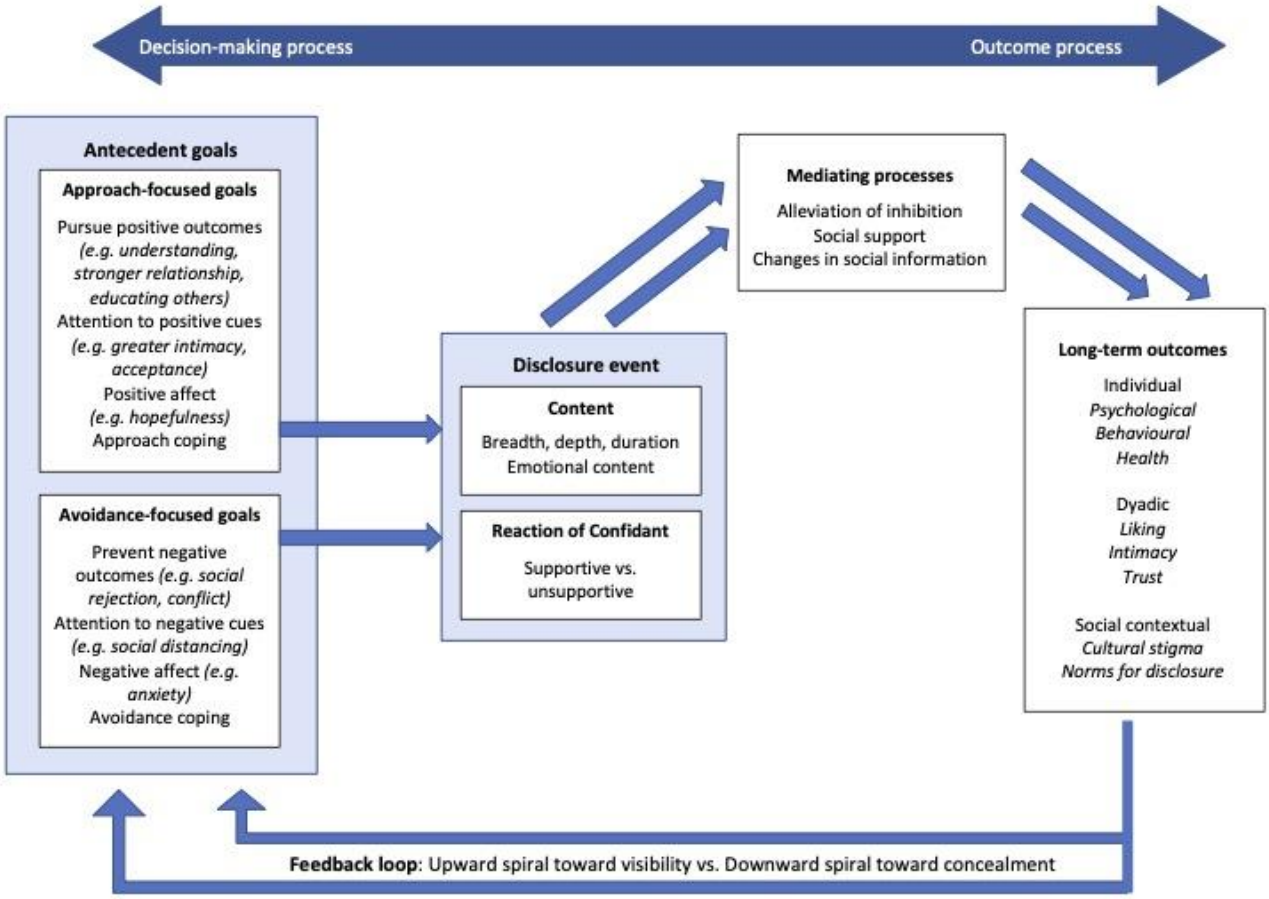
influence of workplace cultural factors on psychologists' self-disclosure decisions was considered to be under-examined in the literature (Section A), and not well-described by existing theories of self-disclosure. To date, investigations into the experience of this workplace culture and its importance in self-disclosure have not been published. The current study will seek to elucidate the perceived themes of this workplace culture which may interact with other social processes to inform psychologists' decision-making around self-disclosure at work.

What is self-disclosure?

While there is no established definition of "self-disclosure", it has been described as the act of revealing personal or private information about oneself (American Psychological Association, 2023), and can be used to develop intimacy in relationships (Reis & Shaver, 1988) or to elicit disclosures from others (disclosure reciprocity; Berg & Derlega, 1987). According to Social Penetration Theory (SPT; Altman & Taylor, 1973), a decision to self-disclose is based on a cost-benefit analysis, taking into account the motivations and potential consequences of such a disclosure. Within SPT, there are two aspects of self-disclosure: breadth and depth. One is more likely to self-disclose items which are not considered "deep", only reaching "depth" of disclosure within intimate relationships (Tolstedt & Stokes, 1984). For most people, information about their mental wellbeing would be considered a sensitive or "deep" subject for self-disclosure (Lee et al. 2020), although there is a growing movement of activists within clinical psychology who argue that, in order to normalise difficulties and reduce stigma, mental health should not be considered a "deep" self-disclosure, and those who wish to should be able to speak about it openly (e.g. Boyd et al., 2016). For the purposes of the current study, the term "self-disclosure" is taken to mean revealing personal information about oneself, including choosing to speak openly about MHD.

Based on their work with concealable stigmatised identities, Chaudoir and Fisher (2010) introduced the Disclosure Processes Model (DPM) to describe the decision-making process involved in a self-disclosure, taking into account motivations, recipient reactions, social context and long-term outcomes (Figure 1; also see Section A).

Figure 1: The Disclosure Processes Model (DPM): Diagram recreated from Chaudoir & Fisher, 2010, p.238



While this model is helpful for understanding disclosure processes, it fails to describe the importance of environment (or culture) for self-disclosure, as discussed in Section A (pp.38-39); workplace, or organisational, culture may play an important role in decisions around self-disclosure (e.g. Elliott & Ragsdale, 2020; King et al., 2021).

Organisational culture

The idea that organisations have distinct "cultures" has long been referenced – Eldridge and Crombie (1974) liken an organisation's culture to an individual's personality, rendering each organisation distinct from others. Allaire and Firsirotu (1984) take an anthropological stance (a culture is something an organisation *is*, rather than something it *has*) and posit that a culture is composed of "cultural properties". Meek (1988) also advocated this anthropological understanding: culture "*cannot be discovered or manipulated, it can only be described or interpreted"* (p.464) and *"[is] not a concrete entity, rather [is an] abstract concept that [is] to be used to interpret behaviour"* (p.465). Stokes (1994) takes this constructivist stance one step further, and describes the "organisation-in-the-mind" (p.121), positing that the concept of the "organisation" exists within the mind of each individual member, and that these understandings do not necessarily share the same properties. However, the culture of the organisation can be described due to the presence of a "collective organisation-in-the-mind" which is shared by all members of the organisation (ibid.). Following these descriptions, this investigation will take an interpretative constructivist stance to analyse the concept of organisational "culture" and its relationship with self-disclosure.

NHS Culture

For many years, studies have described elements of organisational culture within the UK's National Health Service (NHS; e.g. Lyth, 1988; Harrison et al., 1992; Mannion et al., 2009; Konteh et al., 2011; Goodwin, 2019) especially in the wake of serious and widely-publicised failings by NHS trusts. While difficulties have long been identified, there appears to have been a cultural shift in recent decades towards competition, hierarchy and bureaucracy (Mannion et al., 2009), and studies have identified differing priorities for cultural change between NHS management and patient representatives (Konteh et al., 2011).

In recent years, the NHS Staff Survey has highlighted deep-seated problems throughout the NHS, including bullying and harassment (The Kings Fund, n.d.-a). It also highlights workforce pressures, such as difficulties with retention and recruitment of staff, and estimates a significant impact on wellbeing, with almost 45% of respondents experiencing ill-health due to work-related stress (NHS Survey Coordination Centre, 2023). Only 57% of staff say they would recommend the NHS as an employer, and 32% say they often think about leaving the NHS (ibid.); these percentages have both fallen over the past 4 years.

Recent years (including the COVID-19 pandemic) have seen an increase in social objectification of NHS staff, exemplified by the "NHS Heroes" rhetoric from the UK Government and media (e.g. NHS Heroes, 2022; Cox, 2020). Evidence suggests that even NHS managers believe that all NHS staff share core "altruistic" values which drive their work (as opposed to pay or job satisfaction; Merali, 2003). Meanwhile, public satisfaction with the NHS has fallen to its lowest since records began (Morris et al., 2023). The challenging working climate in the NHS, its apparent impact on staff wellbeing, and wider societal pressures in 2023 present an important opportunity to investigate the impact of this culture on NHS staff.

NHS Values

In seeking to elucidate the relationship between "NHS culture" and disclosure behaviour, this project will contribute to a greater understanding of the ways in which NHS culture is supportive, and the areas in which this could be developed. This aligns with NHS values (Department of Health and Social Care, 2021), both in relation to staff wellbeing (*Respect and Dignity*, *Compassion*, *Improving lives*, *Everyone counts)* and quality of clinical care (*Commitment to quality of care* and *Working together for patients).*

Aims and research questions

While many studies discuss the importance of "organisational culture" in clinicians' decision-making about workplace self-disclosure, to date no studies have been published which examine experiences of this culture in relation to self-disclosure. This project therefore aimed to develop a theoretical framework to describe the ways in which the perceived cultural properties of "NHS culture" interact with other social processes to influence clinical psychologists' decision-making around workplace self-disclosure of lived experience (LE) of MHD. Grounded theory (GT) methodology was used to address the following research questions:

a. What are NHS-based clinical psychologists' experiences around workplace self-disclosure of lived experience of mental health difficulties?
b. What are NHS-based clinical psychologists' perceptions of "NHS culture" in relation to self-disclosure?
c. How does the perception of "NHS culture" interact with other psychological and social processes (e.g. professional identity, stigma, power/relationships) when clinical psychologists are making decisions around self-disclosure?
d. Which properties of "NHS culture" are perceived as facilitative or restrictive for clinical psychologists when considering self-disclosure of lived experience of mental health difficulties?

Method

Design

The idea for this project was formed and designed in collaboration with experts-by-experience (psychologists with LE of MHD). Given the research questions related to an individual's understanding of 'culture', and its impact on their experiences, and given Meek's

(1988) anthropological understanding of 'organisational culture', an interpretative constructivist stance appeared appropriate. The study was granted approval by the HRA (Appendix A).

Methodology

Due to the potentially rich, nuanced and heterogenous nature of the subject, GT methodology was used to gather and analyse semi-structured interview data. An interpretative constructivist approach was used, as described by Urquhart (2013), following Charmaz's (2006) social constructivist approach to GT. This approach is most representative of the author's own epistemological stance, that reality is socially constructed and experience is influenced by one's own interpretations of meaning. GT does not claim to elucidate an objective reality, rather one possible explanation for a social phenomenon, which fits with the project's aim to build an understanding of social decision-making based on individuals' experience within "NHS culture". GT aims to produce a bottom-up theory which is grounded in the data (Charmaz, 2006), and to describe the social mechanisms between individuals and concepts, which felt most appropriate for the current project. Additionally, GT was chosen in line with other recent investigations around this topic, which have effectively used GT methodology to analyse and present their data (e.g. Turner et al., 2022; Schreiber, 2020).

Participants and recruitment

Advertisements were shared via social media and e-mailing lists of UK psychological professional networks (not listed to preserve respondent anonymity). A Qualtrics link was provided to the participant information sheet (PIS, Appendix C) and respondents completed a brief consent form (Appendix D) and provided contact details. Participants needed only to self-identify as having LE of MHD (i.e. no diagnosis or contact with services required).

Initially, all those recruited identified as female and white British, so a second round of recruitment aimed to advertise to NHS clinical psychologists who identified as male or as

being from a Global Majority background. Again, the advert was shared via social media and with psychological professional networks, including professional networks of clinical psychologists of the Global Majority. This led to the recruitment of two further participants who identified as male. At this point in data analysis, new insights were not being suggested by the data, suggesting theoretical sufficiency (Dey, 1999; Charmaz, 2006).

Interviews were conducted via videoconferencing software, mainly in the evenings to fit around my training demands and participants' working hours. As such, a £10 electronic voucher was offered to all participants to thank them for their time. Nine NHS clinical psychologists with LE of MHD took part in the study (Table 1). In order to preserve anonymity of this small sample, demographics are reported in aggregate and are not linked to specific contributors. One participant asked for their ethnicity not to be reported as it may be identifiable. Participants reported working across a range of mental health services.

Table 1: Participant demographics, reported in aggregate to preserve anonymity.

Participant demographics (N=9)	
Age	
Mean (range)	39.3 (32-49)
Gender identity	
Female	7
Male	2
Ethnicity	
White British	8
Not reported to preserve anonymity	1
Disclosure history	
Never disclosed at work	3
Had previously disclosed at work	6
Current service area	
Community child & adolescent services	2
Community adult services	1
Adult forensic inpatient services	2
Community older adult services	1
Community adult learning disability services	1
Health psychology	1
Neuropsychological rehabilitation	1

Ethics

This project was granted ethical approval by the Salomons Ethics Committee (Appendix B). Due to the sensitive nature of the content, particular consideration was given to issues around confidentiality and data security, and around participants' agency over their data. Participants were given the option to withdraw their data from the study up until the point that it was included in the analysis, and were able to read and censor their interview transcripts before finalisation. One participant chose to remove some examples of their own experience, as they felt they may be identifiable. There was also consideration given to the risk of emotional distress, which was acknowledged in the PIS and immediately prior to interview. Participants were advised that they could terminate the interview at any time, without giving a reason, although none chose to do this.

In the development of this project, it was considered that disclosures affecting fitness-to-practice could be made, and that should this occur, confidentiality may need to be broken to meet reporting obligations. It was therefore crucial that participants were aware of the potential consequences of such a disclosure, and this was outlined in the PIS. This understandably may have had an impact on recruitment for the study, and may have excluded the voices of psychologists who were concerned about perceptions around fitness-to-practice.

Participants requested that demographic data be reported in aggregate to avoid associating demographic characteristics with specific quotations. This was necessary to preserve participant trust and anonymity, but may limit the ability of the research to draw inferences based on participant variables.

Procedure

A draft interview schedule (Appendix E) was developed and shared with experts-by-experience to seek feedback. Based on this, some minor changes to language were made. The

schedule used in interviews remained subject to change throughout data collection, in order to probe for areas of theoretical interest.

Interviews typically lasted between 60-90 minutes. Throughout interviews, it became clear that participants were benefiting from slightly more explanation around the meaning of 'culture', so the interview schedule was adapted to include this as standard. Through concurrent data analysis, it was identified that the interview felt split into two halves, the first about 'NHS culture(s)' and the second about disclosure experiences, so theoretical sampling via adaptation of the interview scheduled was used to focus on the link between the two, and the ways in which they interact.

Data analysis

GT as described by Charmaz (2006) and Urquhart (2013) encourages the researcher to conduct analysis alongside data collection, to support theoretical sampling and to probe for areas of theoretical interest. NVivo 12 software was used to support analysis. The first three interview transcripts were analysed using line-by-line coding, to produce codes which were grounded in the data (Urquhart, 2013), and subsequent interviews were analysed using focused coding and episodic coding, to identify and build on codes occurring in the earlier interviews. In addition, memos were written at each stage to aid theoretical development (examples of which can be seen in Appendix F). 1,026 codes were identified across the nine interviews (Appendices G and H), which were then grouped into sets based on their subject, and these sets grouped into categories which could be linked together through relational mechanisms, with a view to integrating these categories into a cohesive theory of the phenomena. This analytic process was reviewed with the project supervisor to assess credibility.

Quality assurance and reflexivity

My own position as an expert-by-experience in this field means I have brought my own ideas, beliefs and experiences to the project conception, data collection, analysis and interpretation. Please see Appendix I for a more detailed reflexivity statement.

A project summary was disseminated to all participants, and to the Ethics committee (Appendix J).

Findings

Figure 2 provides an overview of the grounded theory, depicting the core category "weighing the decision: to disclose or not to disclose?". It summarises the psychological and social processes contributing to psychologists' decision-making about workplace self-disclosure (motivation, safety, identity), and their interactions with the putative sub-categories of "NHS culture" and "clinical psychologist" identity. The categories and sub-categories in this model, along with accompanying quotations, are summarised in Table 2 and described in detail below. Further examples of quotations can be found in Appendix K.

Figure 2: Diagram depicting the grounded theory "Weighing the decision - to disclose or not to disclose?". Categories are presented in yellow, sub-categories of which are presented in blue. Plain text represents a relationship or a psychological/social interaction.

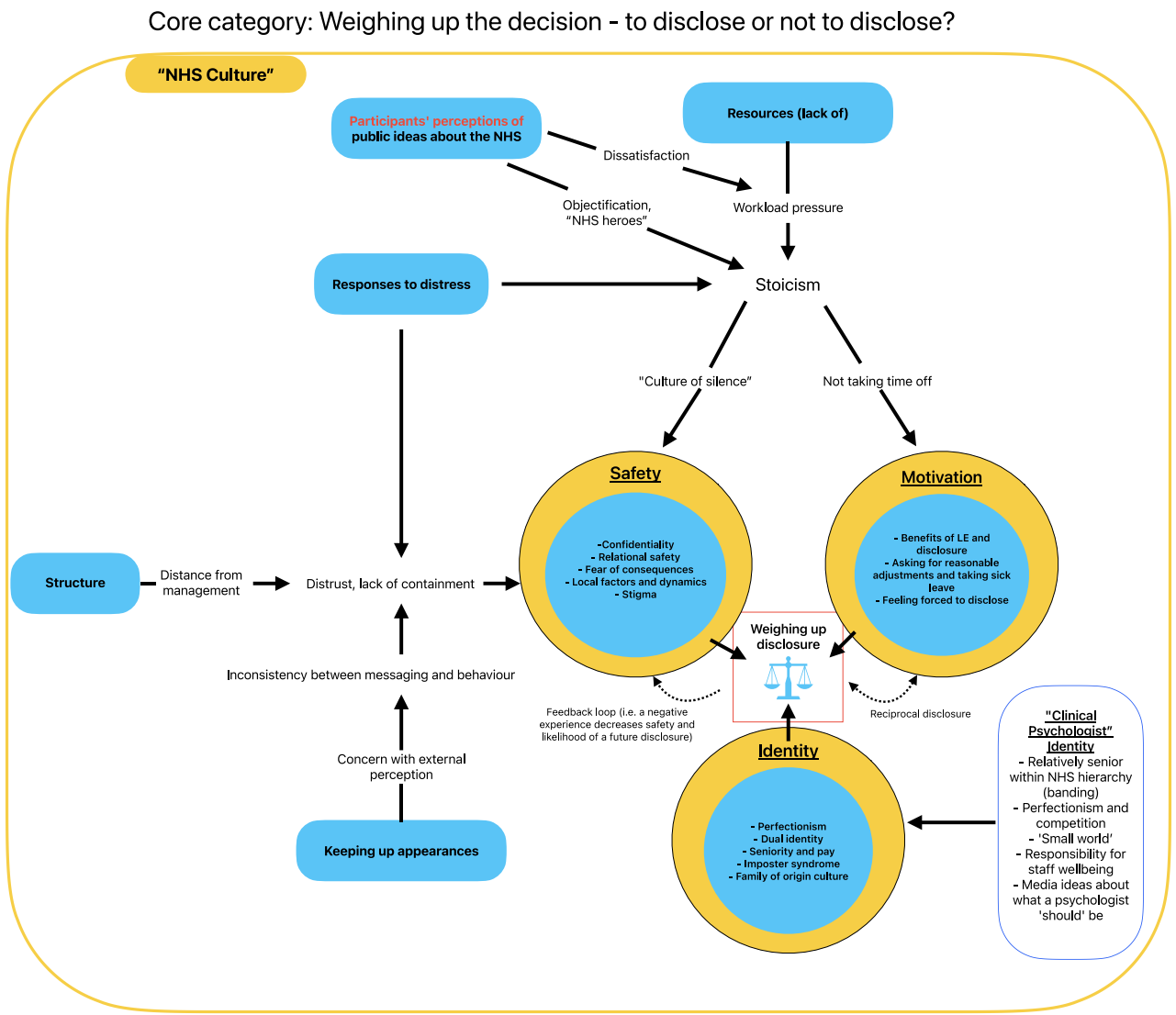


Table 2: Categories and sub-categories within the core category, and example quotations

Core category: "Weighing the decision – to disclose or not to disclose?"

Category	Sub-category	Example quotation
1. NHS Culture	1. Responses to distress	*My view is, particularly within the NHS… is that they don't want to listen, so there's almost like a culture of kind of silence because… you can raise things or raise concerns, but they either will be ignored, or you will get like a completely different response… It's not very overt, I don't think. It's quite subtle, but you sort of realise that actually, really, the message you're getting is that things can't kind of be discussed.* Participant 5
	2. Structure	*The organisational cultural problems, local institutional service problems, all of that is basically… the buck is passed down, right?... lots of hierarchies work this way, I guess. We're humans, we're very good at projecting our own problems into people. And if you have some power over someone, it's far easier to push your unwanted stuff into them and act it out with them… Problem is that I think the NHS… has become such fertile ground for kind of catalysing that process.* Participant 8
	3. Resources	*And what would actually help, I guess would be to be able to hire more staff. And there's a massive recruitment problem. Or be able to keep staff, there's a massive retention problem. I mean that would help, wouldn't it? If we're thinking about workload and that's what we're talking about, a lot of the time caseload and workload and waiting lists… If we're thinking about that stuff, the only thing that's going to help is hiring more staff.* Participant 7
	4. Keeping up appearances	*And the CQC came along and suddenly like, the day before, they instituted a working from home policy, where we all had to like sign in. CQC disappeared and so did the policy.* Participant 1

	5. Participants' perceptions of public ideas about the NHS	*There's this kind of overarching societal discourse about the NHS. And the culture around that and the culture that the current Tory government have created, which really undervalues the NHS. You know, we don't deserve a proper pay rise. NHS waiting lists are too long. These are the messages… that the public are getting all the time, that make people think that NHS workers are lazy or greedy or… So there's that kind of wider societal culture.* Participant 7
2. Motivation	6. Benefits of LE and disclosure	*I think it's given me a bit more insight into that side of things. Hopefully adding to that compassion and understanding… It's really valuable for me as a therapist to kind of know more about what it's like… and that's why I share it, because actually I think it's just enhanced my experiences.* Participant 3
	7. Asking for reasonable adjustments and sick leave	*I feel like I would have thought that she [manager] thought I couldn't - it was just being a bit too over the top… Probably make me - I feel like she would have said no, and she would've made me feel a bit stupid for asking.* Participant 3
	8. Feeling forced to disclose	*I guess sometimes there are gonna be times when we don't have a choice about disclosure. If we need to have time off or we need specific adaptations. Umm, you know, you're then faced with the choice of either you quit or you disclose.* Participant 7
3. Safety	9. Confidentiality	*I've also had experiences with supervisors or managers or colleagues who I one hundred percent would never have told that I was struggling… because they would have not kept it to themselves.* Participant 7
	10. Relational safety	*I felt they treated me like a patient… I could readily identify, almost to the point of techniques, or you know, reframing or different sorts of interventions in our discussion… Which was, just to make it obvious if this doesn't come across on the text, extremely unhelpful, not to mention patronising.* Participant 8

	11. Fear of consequences	*I think there was a worry that people would think I wasn't fit to do the job. I think fitness-to-practice was on my mind at times. That yeah, people would think that I wasn't.* Participant 3
	12. Local factors and dynamics	*In any kind of workplace it might depend on who manages you, or who's around you. But it's just it's one of those odd ironies that… when you specifically work in mental health services, it just always takes me aback, just the difference of experience of how you can talk about mental health is just huge.* Participant 9
	13. Stigma	*I was sent off to occupational health… And I said "…I haven't had this problem since I was 18… would I be a risk or…?" and she said "Oh no, it's we just don't want people that are gonna be like the next Beverley Allitt".* Participant 5
4. Identity	14. "Clinical psychologist" identity	*I think that [psychologists] are generally rewarded for being productive, quiet, compliant and appearing to have it all together.* Participant 5
	15. Perfectionism	*Well if you're feeling quite anxious and… therefore maybe feel embarrassed about how people think about you, and you're a bit perfectionist which means you quite driven, possibly then disclosing… is going to be like 'urgh'.* Participant 1
	16. Dual identity	*I always resist from identifying myself in those [social media LE groups] as either a person with lived experience or as a clinician. Because I feel like they clash. Like I don't know which one I align to more, if that makes sense?* Participant 3
	17. Seniority and pay	*For me, there's often a sense of guilt that you're earning a lot of money in the NHS, you're on a high band, you're kind of being given a relatively high income from the NHS.* Participant 6

18. Imposter syndrome	*To become a psychologist is not a straight-forward profession, and therefore once you're there… they talk about imposter syndrome… so any form of weakness becomes difficult.* Participant 1
19. Family of origin culture	*Your individual cultures are gonna play a part, aren't they?... In terms of like, I don't know, your family experiences, and how that's been promoted when you've been growing up, whether it's OK to talk about lived experiences.* Participant 2

NHS Culture

This category describes participants' experiences and perceptions of "NHS culture" and its relationship to the other categories (safety, motivation, identity) in their decision-making around self-disclosure at work.

Responses to distress

Participants described that perceived responses to concern or distress were indicative of "NHS culture", including a cultural individualism which placed distress within the individual. This appeared to influence clinicians' responsibility for their own workload, and this contributed to work-related guilt. Cultural individualism also impacted participants' perceived responsibility for their own distress and mental health. Participants wondered whether this individualism was indicative of systemic difficulties within the organisation:

> *The overarching ideology… is one in which, if you are struggling, it's your fault… Almost consumer-capitalism-gone-wild in the NHS, whereby systemic institutional problems are reframed and redescribed as individualised pathological ones. So it's your problem. But it's also to do with your pathology, that you are struggling.* P8

Participants perceived some senior staff as lacking compassion for their colleagues, due to a sense that they too had suffered earlier in their careers, and that work-related stress was "part of the job". Participants described that this attitude from senior staff made it difficult to raise concerns about work-related stress or pressure:

> *This old manager… would pass the problem down, she didn't share the problem as much… 'you've got a high caseload, suck it up, that's the job'… She used to say that*

> *quite a lot when people would complain… So she was just generally less compassionate… less able to see other people's points of view.* P3

Participants described a "*manic defensive quality"* (P8) to NHS culture, whereby the challenges of working in the NHS and the concerns raised by staff are denied. Again, participants identified that this apparent avoidance of the reality of the NHS made it difficult to raise concerns with management, as it contributed to a sense that concerns weren't listened to or taken seriously:

> *There's this manic quality where the reality is just denied. The reality is just, I'd say, disavowed. You know, it's known in some sense, but then it's turned away from. So that… Things are kind of redescribed as working when clearly they're not.* P8

Stoicism was frequently described within NHS culture. This appeared to be related to the position of the NHS as a public service, and to the objectification of NHS staff:

> *NHS workers are supposed to just put their own needs to one side - if they even have needs in the first place, that's probably a query, isn't it? - in order to meet the needs of service users… we're not always necessarily treated like humans. We're treated a little bit like we just exist to serve other people, and that means that there isn't space for us to have our own difficulties or our own needs.* P7

Participants identified "us and them" rhetoric within NHS culture, with NHS staff, including leadership, "othering" service users (SUs) and experiences of MHD. Participants noticed a need within the NHS to place "poor mental health" in the "other", and emphasised

that "*we don't do that in services"* (P6). Participants explained that this "us and them" rhetoric presented a barrier to speaking about their LE of MHD at work:

> *Those views come out in team meetings, don't they, that stigmatising language, those stereotypes… So within that kind of culture, it's difficult to then say, "well, actually, that's me. You're talking about me when you say that".* P7

This "us and them" rhetoric may also be reflected within SU communities:

> *In those… lived experience groups, I feel like if they knew that I was also a clinical psychologist in mental health services, it would almost be like I was a bit of a traitor.* P3

Structure

Participants overwhelmingly described a hierarchical structure within the NHS, with pressure "passed down". For some, pay transparency contributed to this hierarchical dynamic, and added pressure to "set an example". Participants also described distance and disconnection from management, with some realising they didn't know the senior leadership team in their Trust, and that "lacking a figurehead" resulted in low cohesion within the organisation. Other participants wondered whether this disconnection from leadership might be due to managers' distance (professionally or chronologically) from clinical work:

> *The Executive Board have no idea what a typical day is like for a clinician on the floor… that might be because they've never worked clinically… or… it's been such a*

long time since they worked clinically that things have changed, or they've just forgotten what it used to be like. P7

Participants described that the management structure "above" them felt unclear ("*a black hole"*, P5), and they were often uncertain about where messages came from within the hierarchy. While psychologists hold a relatively senior position in terms of banding, they often felt they had little influence at an organisational level due to the management structures.

Resources

Participants described lacking resources, including staff, and this, in conjunction with ever-increasing demand and seemingly unnecessary bureaucratic obligations, had an impact on their perception of the culture, and on staff wellbeing:

It's been a combination of things. Less staff, higher risk, higher acuity, generally more people accessing mental health services… there's only so much you can do with the resources you have. And that's really demoralising. And that feeling of burnout… burnt out and stressed. P3

Keeping up appearances

Participants described a mismatch between workplace messaging and behaviour ("*they don't practice what they preach"*, P2):

They send official messages about how it's really important that we look after ourselves, as we work in a difficult job… however… the actual workload that we are given, and the targets, and the time scales, and the lack of staffing that we have… in practice the culture is much more… you have to get things done. P3

Some participants described hostility in workplace messaging, and noted that this appeared inconsistent with NHS and Trust values. This incongruence between messaging and behaviour fostered feelings of distrust of leadership, and a lack of containment among staff.

Participants' perceptions of public ideas about the NHS

An important facet of NHS culture appeared to be the public perception of the NHS, with participants reflecting that they perceived a public sense of what the NHS "should" be. Participants described the impact of growing public (and media) dissatisfaction with the NHS, especially in the wake of the COVID-19 pandemic:

> *It's very quickly just become quite vitriolic towards NHS workers again, because the quality of care just isn't - it isn't good enough and the waiting lists are too long. And people are really angry about that, understandably…* P7

This perceived public dissatisfaction with the NHS (and sense of what the NHS "should" be) appeared to contribute to increasing demand and unachievable workload expectations, and to the objectification of NHS staff as described above:

> *I think a lot of it comes from the idea that it's nationalised and it's free for all… and it's always under stretch and it's always under pressure and it will always be available... But also I just think where it sits within our culture, the way it's set up. The really good things about the NHS are also what make it difficult to work in.* P6

Motivation

This category describes participants' motivation for self-disclosure, which may be positive (to provide some benefit) or negative (to request adjustment or support), and often both. Motivation was an important consideration for participants when weighing the decision around self-disclosure, and appeared to interact with the sub-categories of "NHS culture" described above.

Benefits of LE and disclosure

Participants mostly expressed some pride or value in their LE of MHD, and discussed this as one possible motivation for disclosure at work. Participants felt that their LE enhanced their compassion and understanding, and that they had *"qualitatively different relationships"* (P1) with SUs. Participants also described using their LE to inform team discussions or teaching, and to shape their clinical practice:

> *When we're talking about [therapy] as a possibility I will sometimes share that I've had [therapy], that I found it really helpful, and the reasons why… Anything I can do to promote, you know, "actually let's not just give them loads of meds, let's think about the therapies that can help", I want to do. And using my personal experience is part of that*. P3

Asking for reasonable adjustments and taking sick leave

Another, more practical factor in psychologists' motivation to self-disclose was the need for occupational adjustments, such as sick leave or adjustments to duties. Participants expressed reticence around requesting adjustments, feeling that they had to "*either quit or disclose"* (P7). MHD were sometimes felt not to be a "*good enough reason to be off sick"* (P3). Participants described "*enormous guilt"* (P8) when taking sick leave within NHS

culture, and a sense that they were letting their colleagues and clients down. Participants expressed worry that their leave would negatively impact their colleagues, as the team may need to pick up their workload. Participants wondered whether this contributed to resentment among colleagues, and increased stigma around staff taking time off for their mental health. Not taking sick leave was described as an integral part of the NHS "slog culture":

> *There's a lot of culture around working when you're tired, not taking sick leave… I think it's quite hard.* P6

Feeling forced to disclose

Some participants also felt they lacked agency over their disclosure, either because their mental health was sufficiently poor as to necessitate a disclosure, or because of other non-concealable evidence, such as self-harm scars:

> *So I haven't [disclosed] out of choice. I have, um, where I've kind of been quite unwell and so it's - I've had to kind of share… but otherwise I wouldn't.* P5

Safety

This category includes participants' considerations around stigma and confidentiality, fear of consequences, and the importance of relationship quality and "psychological safety" on their decision-making.

Stigma

Participants spoke about the impact of stigma at every level, including self-stigma and shame, stigma and discrimination from colleagues, and societal stigma. Self-stigma and shame were common among participants, and some reflected that it felt difficult to

distinguish between their internal feelings of shame and the impact of external stigma and discrimination. Participants also acknowledged the wider culture and stigma around mental health, and that this also contributed to their sense of safety when considering self-disclosure at work:

> *I've worked in teams where there's been quite a lot of black humour used… some stigmatising comments come out… that can make it really really difficult, if that team is completely comprised of that, to… be open about it.* P1

> *NHS culture, and our working lives, are within a context of societal stigma around mental health problems.* P7

Confidentiality

Confidentiality was also an important consideration for participants when thinking about self-disclosure, particularly for those whose confidentiality had previously been broken. This appeared to be particularly important in light of the stigma identified. Participants explained that there were some colleagues (mainly managers) to whom they would never disclose, as their disclosures would not remain confidential:

> *I did have a manager at the time as well, who wasn't confidential, so I like… I knew everyone else's business. I knew who was going for IVF. Who was doing this, who was doing that... So there's no way I would have told her because I might as well have just stood with a microphone in the car park.* P5

However, some participants felt that they had never been concerned about confidentiality following a disclosure, and attributed this to a sense of support and safety within the team.

Relational safety

Many participants identified that their disclosures might vary depending on the recipient, including their relationship intimacy, profession, and hierarchical position. Many participants had disclosed their LE of MHD in supervision, and noted the quality of their supervisory relationship was an important factor in this decision. Some participants reflected that feeling supported was facilitative for self-disclosure, whereas others identified that their supervisors had been "patronising", "invalidating" or "psychologising". Several participants identified therapeutic techniques in their supervisors' responses, and felt they were "*treated like a patient"* (P8), which felt particularly "othering" within the context of the "us and them" culture in the NHS. Disclosing in supervision required careful navigation of personal and professional boundaries, and this concern was sometimes a barrier to self-disclosure.

Participants reflected that it felt more difficult to disclose their LE to people "above" them in the hierarchy. There was some variation among participants regarding whether it felt easier, or harder, to self-disclose to psychologist peers; some felt that the shared experiences among clinical psychologists would facilitate sharing, whereas others were more preoccupied with a sense of competition and comparison with peers.

Participants described psychological safety within relationships as facilitative for self-disclosure at work, and that this included a feeling that they wouldn't be judged:

> *…Quite quickly it became evident that there was a culture of psychological safety that made that quite possible to have that conversation around [disclosure]… Whereas I've been in teams before where… it doesn't feel safe to have it - I suppose "safe"*

> *being that it's possible to be vulnerable… But also for that to be seen as… a valued behaviour, rather than… a negative thing.* P9

Participants generally described their experience of NHS culture as "not safe", that they felt judged, and that managers "*did not have your personal interests [at heart]"* (P5):

> *It's about creating a culture where people feel safe enough to [disclose]... that is what I do not get in the NHS… I don't think it feels like a very safe culture… I would say it is not generally, across the board, a very safe working environment.* P5

Fear of consequences

The permanence of a disclosure, and the threat of it remaining "on your record", was an important consideration in weighing the decision about self-disclosure:

> *Once you've uncorked that conversation, you can't put the genie back in the bottle again… I'm forever gonna be, you know, seen as being not capable… I can never think about disclosing… because if I did, I'd kind of be, you know, marked.* P9

Some participants had experience of formal investigative procedures, including occupational health and fitness-to-practice inquiries. Not all participants had experience of this, but those who did described feeling "scrutinised" by these processes. Those who didn't have direct experiences also expressed fear of these processes following disclosure, and that this was an important factor in their decision-making:

> *And then I ended up… going through a fitness-to-practice hearing, which was horrific… I felt very voiceless. I felt powerless. I felt like I didn't have a say in the process. I felt… done-to, and I felt like I couldn't object really, so disclosure felt like a very painful and tricky process.* P5

Local factors and dynamics

Participants described an influence of local team relationships and personalities on their sense of safety to self-disclose. Close, supportive relationships with colleagues appeared facilitative for self-disclosure. Conversely, some participants described more distant relationships with colleagues; this appeared particularly true for participants who worked out-of-office or remotely, and these participants had a sense that their colleagues "*didn't make an effort to get to know*" them (P1). Some noted that it felt unusual to work so closely (and emotionally) with colleagues, but not know anything about their personal lives, and wondered whether this might be unique to "NHS culture".

Participants described how individual differences in manager, or management style, could affect team dynamics, morale, and psychological safety:

> *I think it definitely varies between teams. And I think that's very much to do with the manager… The teams I work in - their well-being is as good as it can be, given the wider culture, because they've both got really supportive managers.* P3

Participants reflected that more "corporate" management styles felt unhelpful when considering self-disclosure, and that excessive workloads might also have an impact on managers' ability to provide supportive, compassionate responses to disclosures. However, many participants spoke about very positive experiences with managers, and described that a

"good manager" would "protect" their team from the wider culture. Participants described their managers "holding" anxieties around targets and requirements "*at a real detriment to themselves"* (P5), and these managers were felt to be alongside their team. Participants described their most positive disclosure experiences with these managers, but made a clear distinction between the safety of the managerial relationship and the "wider culture".

Identity

Participants considered the impact of their identity, both personally and professionally, on their decision-making around self-disclosure.

"Clinical psychologist" identity

Participants reflected on their identities as clinical psychologists, and the "culture of clinical psychology" and its impact on their decisions around self-disclosure. Participants described a culture of constant competition with peers, and the need to present as "perfect" to be successful. Presenting an image of "the perfect candidate" made some participants feel they couldn't have "flaws".

Participants also discussed ideas about what a clinical psychologist "should" be. Participants described feeling expected to be "*competent"*, "*unemotional"*, "*quiet and compliant*", and this was linked to both the way psychologists are conceptualised in teams, and cultural stereotypes of psychologists.

Participants also reflected that psychologists could be seen as "*invulnerable"* and not needing emotional support. This appeared to affect colleagues' perceptions of them, with one participant's colleague telling them they "*wouldn't understand"* what a SU was experiencing (P5). This was also reflected in experiences of wellbeing provision, with some participants being tasked with providing staff wellbeing support, with no consideration of their own needs:

> *If the clinical psychologists are looking after everybody else, who's looking after the clinical psychologists?* P7

With regard to their MHD, many participants felt that they should be able to "*psychologist themselves out of it"* (P9), which appeared to be both internally-driven, and linked to experiences with colleagues. This sense of responsibility for self-healing also led them to question their clinical competence, and was associated with shame:

> *There's an additional barrier, because you feel like if it's your job to do this for other people, it makes me feel like I should be able to do it for myself, but also makes me feel like I'm not good enough at doing it for other people.* P4

Perfectionism

Several participants identified with being a "perfectionist" and wondered whether this was linked both to their "clinical psychologist" identity, and to their MHD. Participants hypothesised that perfectionism may lead to a preoccupation with the way one is perceived, and this could contribute to MHD. Again, this was identified as a barrier to workplace self-disclosure, as MHD were seen as "flaws" among the participants:

> *This career is going to appeal to people who have perfectionistic tendencies... But that means that it's very difficult for us… to turn around and say, "well, actually, I do really struggle with this, and I'm not perfect…". But you have to almost pretend to be… And it's difficult to shake that off.* P7

Dual identity

Many participants described being drawn to psychology due to their LE of MHD, but grappled with their "dual identities" – as both SU and psychologist – and described a tension between the two. Some participants expressed uncertainty about which identity they aligned with, internalising a sense that the two identities "*clash"* (P3 & P1).

Psychologists with dual identities were described as "problematic" for a team, and this was cited as an important consideration when thinking about self-disclosure:

> *… such an othering of people with mental health needs, that it's kind of talked about as if "that couldn't be us", and any confusion around that boundary is problematic.* P6

Some participants spoke about working alongside peer supporters, and the impact this had on their dual identity. While many participants spoke positively about peer roles and their importance in services, some expressed concern that the role emphasised the 'gap' between clinicians and SUs, and contributed to the "*erasure"* (P7) of professionals with LE.

Imposter syndrome

Several participants talked about "imposter syndrome" (an internalised sense that other psychologists were more competent), and its effect on their professional identity and their willingness to self-disclose their LE at work:

> *[Disclosure] triggered all of these underlying feelings of… "what am I doing in this job?" and you know, "another psychologist would be doing this so much better"… it made it unbearable.* P4

Seniority and pay

Participants had differing views about the effect of seniority on their decisions around self-disclosure. Some felt that seniority gave them more power and agency over their disclosure, whereas others felt that the increased responsibility made it harder to talk about their LE:

> *Now I'm in a more senior role in my team, I feel more confident in my role in the team… I have more power in the team. I feel that's a good position to share that I've had therapy and actually found it really useful.* P3

> *I think also the further you go into your career… the kind of seniority that you get to, that you're at, can have an impact… on how safe it feels to disclose… There's a certain ethos that… when you are up the chain… there isn't very many people you can have these conversations around. Because there's this kind of idea where… you're a consultant now… you basically need to get a handle on this.* P9

Participants discussed psychologists' level of pay within the NHS, comparing it with other mental health professionals'. For some, this contributed to shame, imposter syndrome, and a sense that they should "*have it all together"* (P5).

Family of origin culture

Participants reflected on the influence of their families of origin, particularly the effect of their families' approaches to talking about emotions on their willingness to self-disclose:

> *I guess in terms of culture around that, I think it's your own personal kind of family culture, of what it's like talking about your personal experiences, and self-disclosure, and your own mental health.* P4

Hope for the future

This final category that emerged in the data did not directly contribute to the core category "weighing the decision", but nevertheless felt important to capture. Participants expressed some hope for the future, in terms of reducing mental health stigma, conducting research, and fostering a more supportive workplace culture for mental health staff to self-disclose their LE:

> *I hope that it changes… I think in psychology, there is a recognition - this will be why you're doing the study - that there is a big proportion of psychologists that [have LE]… And I think it is trying to be promoted through training, so maybe that will filter through into psychology generally.* P2

Discussion

This project set out to explore clinical psychologists' experiences and perceptions of NHS culture, and its impact on their decisions about workplace self-disclosure of LE of MHD. Findings suggested three important domains for psychologists when weighing up the decision whether to self-disclose: safety, motivation, and identity. Psychologists' perceptions of "NHS culture" appear to have some influence on these domains.

NHS culture

Psychologists identified a "distance" between clinicians and management as a barrier to fostering a safe, supportive environment (and consequently to sharing LE). This

challenging relationship between management and clinicians is reflected in recent research, which has identified barriers to engagement related to financial strain, workforce challenges, and bureaucracy (Ng, 2022).

The financial climate of the NHS was referenced frequently by participants. This affects staff recruitment and retention, workload pressures, and working environment, contributing to a "culture" which is experienced as pressured and stressful. Recent figures suggest that 45% of NHS staff experience ill-health due to work-related stress (NHS Survey Coordination Centre, 2023). Not only may stress exacerbate MHD for staff (Dobson & Schnall, 2018), this research suggests it could foster an environment where psychologists feel unsafe disclosing their distress.

A mismatch between the NHS's messaging and behaviour led to distrust and lack of containment for participants. This too is reflected in the literature; while supportive messages from leadership may help to foster psychological safety, inconsistency between these messages and behaviour can lead to suspicion and mistrust among staff (Lee et al., 2004). This mistrust may reduce psychological safety and present a barrier to psychologists sharing their LE at work.

Participants' perceptions of public ideas about the NHS appear to contribute to their perception of NHS culture, in both the expectations of the service, and the objectification of its staff. This objectification may be internalised as self-objectification (the invalidation of one's own needs, as a "public servant"). There has been a flurry of research into the objectification and self-objectification of nurses during the pandemic (e.g. Einboden, 2020; Mohammed et al., 2021), but little research into its impact on identity and behaviour. This model suggests that objectification (and self-objectification) discourages psychologists from sharing their LE at work, as it appears to lead to a cultural stoicism which denies or minimises distress.

Participants often used psychodynamic defences to describe behaviours within NHS culture (e.g. splitting, denial). This is reminiscent of Lyth's work (1960, 1988) on containing anxiety in institutions. This project's findings suggest that Lyth's observations remain relevant in the present-day NHS.

Motivation

In the model, motivations could be conceptualised as "positive" (e.g. teaching) or "negative" (e.g. requesting adaptations), comparable to other models of self-disclosure, including the "approach-focused" and "avoidance-focused" goals in the DPM (Chaudoir & Fisher, 2010). This model identifies that NHS culture, particularly a resistance to taking sick leave, may interact with this motivation domain to inform psychologists' decision-making around self-disclosure at work.

Safety

Psychological safety can be defined as a belief that the environment is "safe" to take interpersonal risks (Edmondson, 1999). A lack of psychological safety in groups can lead to a "defensive silence" (Brinsfield, 2013), which includes the concealment of LE (Reynolds, 2019).

The model identifies a feedback loop, describing a decrease in psychological safety (and therefore likelihood of future self-disclosure) related to negative disclosure experiences, including broken confidentiality and feared consequences. A similar mechanism is described by the DPM (Chaudoir & Fisher, 2010). In this model, the feedback loop pertains largely to the "safety" domain, and previous experiences of fitness-to-practice and occupational health processes provide important information for psychologists considering future self-disclosure.

Fitness-to-practice investigations present a serious concern for psychologists when considering self-disclosure of LE at work. This is not unfounded: HCPC guidance details possible outcomes ranging from a "caution", to being "struck off" (HCPC, n.d.), with appeals

coming at considerable personal financial expense. Additionally, criteria for investigation are undefined: "*If the registrant has a… mental health condition that may present a risk to their ability to practise safely or effectively…*" (HCPC, n.d.). Within a stigmatising culture, well-meaning colleagues may misinterpret the impact of LE on fitness-to-practice, and this fosters an unsafe and fearful environment for self-disclosure.

Consistent with SPT (Taylor & Altman, 1975), psychologists described self-disclosure was facilitated within intimate, positive relationships with colleagues, and that non-judgement and support were features of these positive experiences.

Identity

Participants described the effect of the "clinical psychologist" identity on their own professional identities, and the ways in which this presented barriers to openness about LE of MHD. Participants spoke about a culture of perfectionism and competition within clinical psychology, and this making it "*difficult to have a flaw"*. Previous research has identified a negative relationship between perfectionism and self-disclosure behaviours (Grice et al., 2018). The theory also proposes an effect of imposter syndrome on psychologists' identity and self-disclosure. These effects may be exacerbated by the "*small world"* of clinical psychology, feeding into concerns that disclosures may not remain confidential and may have a lasting impact on career opportunities.

The model also describes the influence of stereotypes about psychologists on self-disclosure behaviour. Literature has previously identified "fantasies" that psychologists are "really stable", rendering it difficult to disclose the opposite (Charlemagne-Odle et al., 2012).

Psychologists described struggling with their "dual identity" (psychologist and SU). Most research on "dual identity" is concerned with ethnic and national identities, conflicts between which can lead to stress and "identity denial" (Cardénas et al., 2021). This was reflected in participants' struggles over which identity they aligned with, as though the two

were mutually exclusive. The presence of peer supporters in the NHS appeared to exacerbate this struggle, as some psychologists felt that it emphasised the supposed experiential "gap" between SU and professional.

Seniority and pay also appear to represent important facets of psychologists' professional identities, with this being particularly transparent in the NHS with the hierarchical Agenda for Change structure.

Psychologists also noted a possible effect of family of origin attitudes and beliefs on their self-disclosure behaviour. This was only briefly described in the current study, but literature suggests that cultural background is likely to influence self-disclosure behaviour (e.g. Leary, 1997).

Implications

Findings suggest that a shift in NHS culture could be helpful to support clinical psychologists to self-disclose their LE at work, particularly in the domains of "safety" and "motivation". The King's Fund (n.d.-b) developed a tool to help NHS organisations assess problems areas within their culture, many of which were identified here. The recommendations of the tool may address some of the processes which are experienced as unhelpful when considering self-disclosure. An accompanying training programme was developed with NHS England (Culture Transformation Team, 2021); pilot results have suggested modest improvements in staff engagement and nurse turnover (ibid.).

The NHS has fewer clinicians at board level than other health services internationally (Veronesi et al., 2012). Evidence suggests that promoting clinicians to management (rather than hiring managers) can positively impact care quality and patient satisfaction (ibid.), and findings of this study suggest this could facilitate a more positive relationship between clinicians and management.

Participants expressed some hope for the future, including hope for future generations of clinical psychologists. This model suggests that it may be beneficial for training courses to consider the impact of the "clinical psychologist" identity, including challenging preconceptions or stereotypes about psychologists. This could be achieved by employing staff with LE of MHD or encouraging open discussion of LE among psychologists and trainees. A recent pilot study has indicated promising results of a self-help programme for mental health professionals with LE of MHD, to support their decision-making around workplace self-disclosure (Scior et al., 2021); this could also be incorporated into training in the future.

Limitations and research directions

The limited scope of this project necessitated an adapted GT methodology, including reduction in the extent to which theoretical sampling could be performed and theoretical sufficiency reached. With greater access to resources, time, and multiple researchers, a larger GT study may have developed the emerging theory further. Additionally, the contribution of experts-by-experience could have added validity to the study, including the use of expert-by-experience coders. Further research in this area could benefit from the contribution of experts-by-experience throughout study development, data collection, and analysis.

Despite efforts to address this, this project was limited in its sample size and diversity. Seven of nine participants identified as white British and female which, while broadly representative of the profession (Longwill, 2015), does not represent the views of ethnically minoritised clinical psychologists in the NHS. The author's own demographics (white, female) may also have contributed to an opportunity which felt safest for psychologists of similar backgrounds (Does et al., 2018). The importance of demographic factors in self-disclosure is not addressed, as demographics were reported in aggregate and not linked to participants. Concern around confidentiality may have discouraged other potential contributors, meaning that the current sample represents the views of psychologists more

willing or able to speak about their experiences. Had time not been limited, this project could have expanded data collection with an anonymous survey, and this could be a productive approach in future. It would be of particular importance to seek the experiences of minoritised clinical psychologists, including psychologists of the Global Majority, as this group is under-represented not only in this project, but in most previous research (see Section A).

During recruitment the author was approached by several ex-NHS clinical psychologists who wanted to participate and share their experiences, but were not eligible. A richer understanding of the experience of NHS culture for clinical psychologists with LE, and its possible importance in their decision-making, could be sought by expanding criteria to include ex-NHS psychologists.

Conclusion

The current project set out to investigate NHS clinical psychologists' experiences and perceptions of "NHS culture" in relation to self-disclosure of their lived experience of mental health difficulties. Findings suggest that participants' experiences of "NHS culture" have an important interaction with the psychological and social processes underlying their decision-making about self-disclosure (safety, motivation, identity). While many of the processes constituting the current theory are described elsewhere in the literature, this model integrates these social and psychological processes within the context of an experienced "NHS culture".

While the proposed grounded theory provides one possible explanation of the relational impact of "NHS culture" on psychologists' self-disclosure at work, limitations of the study mean that the findings may not represent the profession more widely. Further research would be beneficial, both to increase the representativeness of the sample, and to probe the areas less well-described by the current theory.

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Section C: Appendix of Supporting Material

List of appendices

Appendix A – HRA approval letter

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Appendix B – Salomons Ethics Committee approval letter

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Appendix C – Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of Project: Clinical psychologists' understanding of 'NHS Culture(s)' and its role in their experiences around self-disclosure of lived experience of mental health difficulties

Name of Researcher: Vita Bowman, Salomons Institute for Applied Psychology, CCCU

IRAS Project ID: 306847

What is this study about?

The prevalence of mental health difficulties among clinical psychologists is high, but is rarely spoken about at work. Being open about mental health difficulties at work can have benefits for the psychologist and for their clients, and may help reduce mental health stigma. However, there are lots of reasons clinical psychologists may choose not to talk about their mental health at work, including worries about stigma, confidentiality, and concerns around fitness to practice. We're interested in learning about clinical psychologists' experiences of talking about their own experience of mental health difficulties at work in an NHS setting. We're interested in a range of ways people may do this, and a range of purposes it may have, or needs it may meet.

Specifically, we're interested in hearing about how clinical psychologists understand 'NHS Culture(s)', and its role in experiences around discussion of lived experience of mental health difficulties. Findings from the study may help to contribute towards the ongoing development of appropriate support to clinical psychologists (and other mental health professionals) working in the NHS, and appropriate valuing of these lived experiences.

We are interested in interviewing clinical psychologists currently working in the NHS, who have lived experience of mental health difficulties (past or present), with or without a diagnosis. This may include low mood and depression, anxiety disorders, post-traumatic stress or other psychiatric conditions.

Participation in this study is voluntary. Knowing what is involved will help you decide if you want to take part in the study. Please read this information carefully, and feel free to contact the researcher at vb213@canterbury.ac.uk for more information or if anything is unclear.

You can request a copy of this Participant Information Sheet to keep.

Who is running the study?

The study is being carried out by me, Vita Bowman, trainee clinical psychologist, for my Doctoral research project, under the supervision of:

Dr Fergal Jones, Research Director for the Clinical Psychology Programme, Salomons Institute for Applied Psychology, Faculty of Science, Engineering and Social Sciences, Canterbury Christ Church University

What will the study involve for me?

You will have an interview of 60-90 minutes on Zoom with me, at a date and time that is convenient for you. The interview will be audio recorded. I will ask you questions relating to your understanding and experiences of 'NHS Culture(s)', any disclosures you may have made at work regarding your mental health, and your experiences of being a clinical psychologist with lived experience of mental health difficulties.

The audio recordings will be transcribed by me, and no one else will have access to the recordings. Afterwards, you will be able to review the transcript of your interview, if you wish to ensure an accurate reflection of the discussion. You may identify any areas of the transcript you would not want to be used as anonymised quotes in the final analysis, and may withdraw your data at any time up until they are included in analysis. If you do wish to withdraw from the study, it would be helpful if you could let us know within 2 weeks of the interview. You will have the opportunity to review and comment on the findings of the study before it is submitted, if you so wish.

During analysis, I might find things I'd like to know more about or have further questions I'd like to ask you. In this case, I may invite you for a second, brief interview to ask some follow-up questions. This will also be conducted via Zoom, and is likely to last for 30 minutes or less. It will be audio recorded and transcribed by me, in the same way as the initial interview. You do not have to accept this invitation if you don't want to. As above, if you do accept this invitation, you can withdraw from the second interview at any time without giving a reason.

What are the possible benefits of taking part?

To thank you for your participation in the research study, we will offer you a £10 Amazon voucher. You can still receive this voucher if you withdraw from the study.

We also hope that by sharing your experiences of being a clinical psychologist with lived experience of mental health difficulties within 'NHS Culture(s)', we can further develop our understanding of the requirements for more visible valuing of these experiences and/or effective support for clinical psychologists, and other mental health professionals, in the NHS. We hope the interview will offer you an opportunity to reflect on your experiences and your own understanding of the social processes involved.

What are the possible disadvantages or risks or taking part?

We know this isn't always the easiest topic to discuss, and could remind you of emotional distress. If you think that talking about these issues may lead to a high level of distress, we would recommend that you don't participate at this time. That being said, sometimes we can be surprised by our emotional reactions when talking about these issues; we will be able to stop the interview at any time, or you can

refuse to answer any questions without giving a reason. We can then discuss what sources of support may be helpful, if applicable.

We're very conscious of issues of confidentiality around this topic. Interviews will remain strictly confidential, except in the unlikely event that you say something which leads me to be concerned about a risk of serious harm to yourself or someone else (including potential harm to clients), in which case information may need to be shared with the relevant authorities as required by law. Where possible, this would be discussed with you first.

What will happen to information about me that is collected during the study?

We will need to use information from you for this research project.

This information will include your email address, and some demographic information. People will use this information to contact you about the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

You can stop being part of the study at any time, without giving a reason, but we may keep information about you that we already have.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- by asking one of the research team
- by sending an email to vb213@canterbury.ac.uk

By providing your consent, you are agreeing to us collecting personal information (including your email address) for the purposes of this study. Your information will only be used for the purposes outlined in this Participant Information Sheet. Data management will follow the 2018 General Data Protection Regulation Act and the Canterbury Christ Church University Research and Enterprise Integrity Framework (2020). For further information on this, please see the University's research privacy notice: https://www.canterbury.ac.uk/university-solicitors-office/docs/research-privacy-notice.doc. All information, including audio recordings and anonymised transcripts, will be encrypted and stored securely on a password-protected computer. Audio recordings will be erased following transcription. Study findings, including anonymous quotes from transcripts, may be published (e.g. in a doctoral thesis, academic journal and conference presentations), but if there are specific quotes you would like to be excluded from the thesis, just let us know. Additionally,

after the interview you can let us know if you feel there is any information that may make you identifiable – we can remove this from the transcript.

After the conclusion of the study, data will be stored securely by the Salomons Institute for Applied Psychology for a period of 10 years and then destroyed.

In the event that you withdraw from the study, any recordings and personally identifiable information will be erased. Please note that once your data has been anonymised and included in the analysis, it may not be possible to remove it from the study. If there are particular quotes you would not like to be published, this can be arranged.

How can I learn more about the study?

If you have any questions after reading this Participant Information Sheet, or if you would like to know more at any stage during the study, please feel free to contact Vita on vb213@canterbury.ac.uk

Will I be told the results of the study?

Participants will have the option to receive feedback about the overall results of this study when the study concludes in 2023. This can be in the form of a one-page summary, or a copy of any resulting publication. You'll be given the option to receive this feedback at the end of the interview. Additionally, you will have the opportunity to review and comment on the findings of the study prior to submission, if you so wish.

What if I have a complaint or any concerns about the study?

The ethical aspects of this study have been approved under the regulations of the Salomons Institute for Applied Psychology Research Review panel.

If there is a problem, please let us know. You can contact me via the University at the following address:

Vita Bowman, trainee clinical psychologist
Salomons Institute for Applied Psychology
Canterbury Christ Church University
Lucy Fildes Building
Meadow Road, Tunbridge Wells
TN1 2YG
vb213@canterbury.ac.uk

Alternatively, you can contact my supervisor, Dr Fergal Jones, fergal.jones@canterbury.ac.uk

If you wish to speak to someone independent from the study, please contact the Programme Director, Professor Margie Callanan, margie.callanan@canterbury.ac.uk

If you would like a copy of this participant information sheet for your records, please email the researcher, Vita Bowman, at vb213@canterbury.ac.uk

Appendix D – Consent form

OK, I want to take part – what do I do next?

If you have read the Participant Information Sheet and would like to take part in the study, please complete the following brief form and provide your email address below. Any details provided will help to capture a diverse range of voices. I may be in touch shortly to arrange an interview.

Please enter your email address: _____

☐ I confirm that I am a qualified clinical psychologist currently working in the NHS

Please indicate the nature of the service in which you are currently working, without providing specific details or names of Trusts/teams *(e.g. community adult mental health service; forensic inpatient service; substance misuse service; neuropsychological rehabilitation; etc.):* _____

Please indicate whether you have ever spoken about your own lived experience of mental health difficulties at work:
☐ Yes, I have spoken about my lived experience at work at least once
☐ No, I have never spoken about my lived experience at work

Consent form

☐ I confirm that I have read the Participant Information Sheet (version, date) and wish to take part in the study.

☐ I've had the opportunity to have my questions about the study answered

☐ I agree to the interview being audio recorded

☐ I agree to the researcher using anonymised quotes in the analysis (and I understand I can withdraw specific quotes as needed)

☐ I understand that participation is voluntary, and I can withdraw from the study at any time, up until my anonymised data is included in the analysis.

Appendix E – Initial interview schedule

Note this schedule is subject to amendments throughout the project via theoretical sampling to probe for topics of theoretical interest.

Preamble

- *Thank you for agreeing to take part in this research. Your experiences are invaluable, and I really appreciate you taking time out to speak with me today.*
- *As you know, all the information I collect today will be anonymised. You won't need to tell me any identifying information. There's no need to identify particular Trusts or teams, and you don't need to tell me your name or anything else about you, if you don't want to. You may like to give me a general idea of the sort of service you work in, if you feel it would be relevant.*
- *If you do tell me anything which may be identifiable, it can be removed from the transcript. I'll remove all the obvious stuff (names of people, places, Trusts etc.), but if there's anything else you feel may make you personally identifiable, just let me know.*
- *As a psychologist, you already know the legal limits of confidentiality. If you tell me anything today about potential harm (including potential harm to clients), I may need to share that in order to keep people safe. Where possible, I'll talk about that with you first.*
- *This can be sensitive territory. You feeling comfortable is the most important thing. If I ask you anything that you don't want to answer, or if you'd like more time to think about anything, just let me know. We can take a break, or move on, at any time. Similarly, if you decide you don't want to continue with the interview, just let me know and we can stop.*
- *I'm going to be asking you a range of questions about your perceptions and experiences, but if there's anything I haven't asked which you feel may be relevant or you would like to clarify, please do let me know.*
- *Before we start, do you have any questions you'd like to ask me about the interview or the study?*

Without identifying any particular trusts or services, how would you describe NHS culture(s)?

> *And perhaps more generally, if necessary: what does 'culture' mean to you?*
>
> *For clarification: I am taking an anthropological stance to 'culture' – it's something an organisation* is *rather than something it* has *– and it's made up of beliefs, attitudes and behaviours. So when I think about culture, I'm thinking about the beliefs, attitudes and behaviours of an organisation.*

Where do you think that idea has come from? What is it that gives you a sense of that culture? What contributes to it?

> *Are there any specific beliefs, attitudes or behaviours which have influenced your perception of that culture?*

If you can remember, when was your first experience of 'NHS culture'? In training? As a service user? Something else?

What role, if any, do you feel you play in it?

Are there any particular policies/documents which you think have influenced your perception of NHS Culture(s)?

Does NHS culture vary across teams and Trusts, or does it seem consistent?

There's a difference here, between a culture within a team and a more overarching NHS culture. If you can, can you try to consider that more overarching NHS culture? If it's helpful, you can tell me a bit about different cultures across teams, too.

How do you think NHS culture(s) impacts on staff's ability to talk about their mental health at work? Does it have any influence?

Is its impact different for clinical psychologists specifically? Why?

Of course, we know that there are many cultures influencing our behaviours and decisions, not just NHS culture. *[We talked a little already about different cultures within teams].* Are there any other cultures which you think are relevant to this topic?

Any other cultures which might impact decisions around self-disclosure?
How do other cultures interact with NHS culture, when we're thinking about self-disclosure?

And now thinking about your own experiences, if that's ok; I wonder whether you've ever shared your experiences of mental health difficulties with colleagues or managers while working for the NHS?

If yes, Can you tell me a bit about that? Why did you choose to disclose? To whom? What made it possible? Did you have any worries about it?

What was the response to your disclosure? Did it fit with your expectations?

What was the culture like at that time? In what way did it influence your decision-making around your disclosure?
Was that helpful?
Was that unhelpful?

We know that what we disclose can really vary depending on who we're disclosing to. You've told me you felt able to disclose to [X person] – were there other people at work at the time who you would've felt less able to disclose to? Why do you think that is?

If no, Can you tell me some of the reasons why you chose not to talk about your experience?

What was that like?

Did the NHS culture at the time have any impact on your decision not to talk about it?
Was that helpful?
Was that unhelpful?

What other factors influenced your ability to talk about your lived experience at work?

- *Professional identity?*
- *Stigma?*
- *Concerns about fitness-to-practice?*
- *Concerns about confidentiality?*
- *Power relations?*

Can you tell me a bit about your perception of your 'professional identity'? What does that mean to you?

And do you think this has/had an impact on whether or not you've spoken about your lived experience at work?

Is there anything else you'd like to say about NHS Culture, especially with regard to your lived experience of mental health difficulties?

Thank you for your time. It's been really valuable to hear your experiences. Before we finish, is there anything we've missed which feels important?

Was there anything we spoke about today which you'd like to remove from the transcript, or anything which you think might make you identifiable?

Would you like to receive feedback on the results of this study, when it concludes in 2023?

Appendix F – Selected memos & memo excerpts

Memo – February 2022

Helps:
- Having a small team who you spend face-to-face time with - feels supportive
- Flexibility re. job role, adjustments, requests
- E.g. being able to work from the office during the pandemic (instead of WFH) because being home alone not good for MH
- Looking out for each other - finding feet together (in pandemic)
- Being a constant presence in the office - or having a constant presence in the office - feels supportive
- Managers
- Recent increase in discussion among psychologists re. lived experience and how to value it
- Twitter communities - speaking openly about being a CP with MH
- Coming from a peer support background - means LE is on CV so jobs already know about it
- Supportive response - flexibility of job plan - 'can do' attitude
- "we support you, we want you to be doing this" rather than "no you can't do it".
- Qualitatively different relationships with clients (than psychologists without LE of MH)... got a better idea of how far you can push it. Less afraid of consequences for client? 'Doing it as a service user with a psychologist title'
- Taught therapy by people doing therapy on me - deeper understanding of SU experience - e.g. can apologise more authentically when things are bureaucratic/paperwork/annoying/time consuming.

Hinders:
- Red tape - Band 7+ encounter more red tape than lower bands?
- Specific things clinical psychologists have to face (within NHS culture): -'acting up' in a preceptorship (being paid band 7 but doing band 8 work); - more leadership responsibility than other colleagues;
- 'One of many' staff members - people don't have the time to stop and chat
- Snowed under
- Paperwork, bureaucracy
- Reactive policies - "this is to avoid us going to coroners court"
- ?Fear of litigation
- Overworked, big caseloads = cutting corners to save time? Being risk-averse/over-cautious
- Tick-box tasks which don't benefit the client - but are a requirement/target
- Colleagues don't make an effort to get to know you (as a trainee)
- People are so busy, if you don't have a reason to talk to them, they won't talk to you
- Mandatory training - feels irrelevant and waste of time
- Needing to maintain 'reputation' of service/trust - e.g. working very long hours, not taking breaks - at detriment to staff
- CQC visits - policies in place just to placate CQC and then disappear - public 'image' of service (and CQC rating) does not reflect reality of workplace
- Underfunded, understaffed - how to communicate needs without failing targets? Ethical issue - need to fail patients in order to communicate need, but unethical to fail patients..... so work staff into the ground?

- Stress in team = 'dark humour', desensitisation, stigmatising comments re. MH
- Difficulties with HR 'not wanting to employ me' - ?due to potential need for sick leave
- Stigma within HR - e.g. making assumptions that someone with MH might use lots of sick leave, or that they may present a risk to their clients
- Psychology is a small world - if you're 'out' at work, it's likely that other psychologists in other services will hear about it - confidentiality
- Perception of psychologist as 'perfectionistic, driven, competitive' white middle class woman - we have to keep up appearances/standards, making having a flaw difficult (for professional identity) - is this driven by psychologists ourselves or by ?public opinion, ?clients' perceptions?
- 'Black box' of psychology - general public don't know much about what a psychologist does (as opposed to a nurse, an OT, a physio etc.) --> feeds into perceptions of psychologists as perfect/untouchable/unaffected/?magical
- Imposter syndrome in psychology - have to jump through so many hoops to e.g. get onto training, then having/admitting 'flaws' (MH difficulties) becomes very difficult - because we have had to create a professional image of ourselves which is 'perfect' in order to outcompete thousands of our peers.
- Perfectionism in psychologists (?can I find a ref for this) = harder to admit flaw? But also linked to more MH difficulties - anxiety/eating disorders?
- Worry about accessing help - because might bump into someone you know
- MH 'invisible' and therefore harder to disclose than physical health problems
- Peoples' responses - patronising - 'look at you, you've done so well'
- Thoughtless comments / jokes - e.g. re sectioning - feel stigmatising and shaming
- Self-stigma - the fear of potential responses/stigma/action is enough to stop us disclosing (even if in reality it would be fine)

Memo – March 2022

Helps:
- Specific managers within specific teams can feel supportive - but this is separate from the overarching trust/NHS culture
- Psychology privelege - advocate for SUs - position of power
- Leadership position, modelling that it's ok to have LE
- Coproduction a large part of CP role - so more at forefront of our minds? So easier to discuss LE with other psychologists?
- Sharing experiences in peer supervision is helpful - sharing with someone who might have had the same experiecnes as you. clinical psychology is hard - getting on the course is hard. there is a camaraderie with other CPs who have been through it.
- feeling cared for, feeling empowered, feeling safe. Confidential. Trust, warmth.

Hinders:
- trust communications - the way they talk to staff (threatening) - don't practice what they preach
- Tokenistic initiatives for staff wellbeing - fall by the wayside or staff aren't given any time to engage with the offer

- Culture feels unsafe, not got staff's personal interests at heart.
- Policies differ across trusts - so if move jobs sometimes the policies (including benefits/allowances/adaptations/flexibility) are not consistent
- Staff feeling really pushed. Not able to deliver what they should (targets). Lots of vacancies, lots of sickness, understaffed.
- Managers priorities are targets rather than staff wellbeing - even losing sight of retention
- Talking about MH not encouraged at work
- Feeling vulnerable, exposed
- Worries about how colleagues will respond
- Fitness to practice concerns (i.e. worried that colleagues will think not fit to practice)
- Psychology a small world - confidentiality
- Unsafe, judgemental - worrying how you will be perceived
- The forum isn't there at work (for self-disclosure) - e.g. RPG
- Managers too busy to give time to emplyees (to talk about sensitive issues like MH)
- you're a container. you do a lot of holding emotional stuff, so your stuff has to be out of the way. you need to be in a good enough place to hold all this stuff. there's not any room for it when you're carrying everybody elses'.
- So much going on, no time to think about it. 'go go go'
- NHS authoritarian leadership style (rather than compassionate)
- Staff wellbeing not a priority for NHS especially at the monent. "maybe when we're not in a pandemic, when the NHS is in a better way, maybe this stuff can be thought about".

Individual factors (which might interact with NHS culture factors):
Family culture, country of birth, spirituality, age etc.

Memo – March 2022

Helps:
- Individual managers are incredibly supportive (on a personal level) but on a service level they are pushing targets (under a huge amount of pressure)
- Manager - flexible, supportive
- Psychology holds power - better able to manage workload as have a waiting list
- "wellbeing is as good as it can be [with support of good manager], given the wider culture"
- Certain types of MH services having better reputations for staff wellbeing - e.g. CAMHS bad, OA/LD good?
- Supportive groups on social media e.g. twitter.
- Disclosure is facilitated (forced) when unable to perform certain parts of job, e.g. doing therapy for a trauma you have also experienced.
- having a colleague disclose to you first - and sharing experiences.
- in forums where staff are encouraged to think about SU perspective - it can feel easier to self-disclose own experiences in order to support this
- LE is really valuable to me as a therapist, to know more intimately what it is like (to use services)
- Colleagues respond interestedly, positively
- CP having power in the team places us well to advocate for therapy and accessing support
- and that anyone can have therapy and it is ok

Hinders:
- Official messages about self-care and reflective spaces - do not match up with targets/workloads/understaffing
- priority is targets / getting things done. Self-care is an added bonus if you can manage it.
- very stressed, very overworked, don't have time to attend wellbeing events put on by management - ???and then management cancel the events because no one attends - no one wanted to attend our wellbeing event? Must not be needed?
- Mismatch between messages and reality on the ground - ignorance?
- Targets trump mental health - even for clients - discharge is prioritised over wellbeing.
- Trust tell us to practice self-care - so pressure for targets comes from individual managers. But get the impression that the managers are pressured by Trust management to meet targets. Managers pressure staff against their will - they personally care more about staff.
- Staff pressures not listened to - case coordinators saying 'i literally can't take any more' and they are forced to
- Some managers don't feel like they care about you
- Lack of transparency re. where messages are coming from - so much middle management - not coming from immediate manager, but they are the person who has to push targets
- Manager - inflexible - won't allow you to take annual leave etc.
- Much more difficult to access services now - have to fight harder for between-teams referrals - twice the paperwork (e.g. having to refer someone twice or provide more docs for each referral).
- Moral injury - not able to do the job we want to do
- Pressure to discharge people before clinically appropriate
- Tokenistic wellbeing initiatives - "presumably they've read a paper somewhere saying 'this will help reduce stress', when actually we just need more staff".
- Left to psychologists to provide wellbeing support for colleagues - without having managerial power to do anything about pressures
- Anything offered by psychology has to be really tangibly helpful - because staff are giving up precious time to attend. If they have one bad experience they will not attend again.
- Psychologists - want to help/support (identity) - so overwork to try to protect colleagues?
- No time to read policies
- Poor manager = unsupportive, morale low, lots of sickness --> more overwork
- Knowing waiting lists are so long adds pressure to the clinical work
- Complaints on social media / articles in the media deriding MH services - damage staff morale - contribute to moral injury
- Sickness - when staff off sick, colleagues have to pick up the workload (not covered by eg. agency or locum) - leads to bad feeling / envy / blame / resentment --> stigma and stigmatising comments among team
- Someone goes 'off with stress' - well, we're all stressed - ?weakness, ?envy, ?incompetence
- Going off sick - guilt - going to make things harder for myself when i come back - my clients won't get the same level of support without me. It's not just you - it affects whole team and clients. I'm letting them down.
- Comparing self to colleagues - everyone in the NHS is in a stressful position - they can handle it, surely I should be able to, too...

- If I (take time off, flexible work, have adaptations), that's going to make someone else's job harder (it's already hard) - because there's no stretch in the system, no leeway, and no cover/extra staffing.
- Colleagues might not think i'm 'ill enough' especially if we're connected on social media and they can still see I'm going for e.g. daily walks
- People will think I'm not fit to do the job. Chose not to disclose to a manager in case he thought I couldn't do my job (and it was never really an issue with clients - only in supervision etc.).
- manager (on training) asked if I thought I could finish training
- Even when attending therapy sessions, felt guilty to be away from work and felt pressure to return to work immediately after (even when this didn't feel safe/comfortable)
- manager: uncaring. made me feel i wasn't good enough at my job. made me feel like i was asking for too much. managerial/corporate - authoritarian? Not on the side of the staff. Would've made me feel stupid for asking (for adaptations).
- this linked to work efficiency, targets, numbers. ?pressure from above. "you've got a high caseload, suck it up, that's the job". "when I was a nurse I had a caseload of 60, get on with it". Less compassionate. Less able to see other peoples' points of view.
- funding - e.g. training courses - funding is hard to come by, so feel pressure to complete training course when it is offered (rather than delay and potentially lose out on chance to get it funded again)
- Clinical psychologist - Boundaries of clinical supervision - need to talk about my clients, not myself - not personal therapy - blurring lines. But need to notice and reflect when a client triggers your own MH - how much is ok to share? How much is crossing a line?
- identities as 'person with lived experience' and 'clinician' clash. Can't out myself as a clinician in groups for PWLE. Have to choose which I align to more. As a psychologist I feel like a traitor in groups for PWLE. Or if I did out myself - that then there'd be too much expected of me. I'd be expected to change the system from within, singlehandedly - which isn't realistic.
- not identifying with the 'psychologists with LE' movement - because don't know if I have 'enough' experience. 'not mad enough'?
- I'm a psychologist first (because MH difficulties came later in life). Other CPs with LE were SUs first and then did training. perhaps this is the difference
- 'us and them'. peer support movement - misses the fact that there are already lots of people working in MH services with LE. could there be a way to include those staff in the peer support movement?

NHS culture used to feel different. 7-8 years ago. Was it less demand or were we better staffed? Probably both. Austerity. Brexit. Pandemic. Public awareness of MH. Inpatient beds drastically reduced (closing hospitals). Acuity in the community much higher.

COVID NHS heroes discourse - even though we worked through the pandemic, we're not in physical health, so that's not for me.

Memo – May 2022

Helps:
- Supportive colleagues
- Openness around how we're feeling
- Having a good manager - means they protect you from workload stress (???at what cost to them)
- More flexibility around working hours for psychologists than other NHS professions e.g. nursing
- What's already acknowledged in the team can make it easier to share experiences - e.g. people with ADHD diagnosis trigger other people to think about their own difficulties
- Colleagues self-disclosing
- Clinical psychologists talk about MH more than other professions - especially when one person is brave enough (my words) to start the conversation

Hinders:
- Staff wellbeing agenda is reactionary and 'desperate' - tone deaf
- ?patronising
- What they say doesn't match with what they do. Actions speak louder than words?
- Pressure, workload, demands
- 2 ends of the spectrum - clinicians at one end and 'comms' at the other - comms don't have any experience of what it's like on the ground
- Guilt - that you're not working hard enough if you're not completely swamped
- Physical health disclosures are more acceptable
- Sliding scale of acceptability in mental health disclosures (i.e. depression/anxiety more acceptable than PD/BPD/psychosis/ED etc.)
- What does this mean about my competence? What are people going to think about my competence?
- We just get on with it. We are fine, and we do our jobs for people who are not fine. (?us/them)
- "CBT yourself out of it". As psychologists we should be able to fix ourselves. (And if we can't - maybe we're not good enough psychologists?)
- Witnessing other colleagues with MH difficulties being seen 'in a negative light' - especially for taking time off work.
- Preconceptions around what MH looks like - "i didn't look like I was struggling"
- Policy - if someone's off sick we don't cover them - rest of colleagues have to pick up the workload - leads to bad feeling
- Self-disclosing and it not being reciprocated - someone 'just listening' is actually unhelpful
- Fear of judgement from manager
- Can I contain people if I don't feel contained myself?

Generally the overall workplace culture is uncaring, inauthentic, target-driven. Having a 'good manager' protects you from the rest of the culture.
Lots of CPs with LEMH move away from NHS..... need to investigate why this is. Follow up study with ex-NHS psychs? What have we missed by excluding ex-NHS staff in this study?

Memo – May 2022

Helps:
- Really good managers hold the anxiety in their teams - but at a detriment to themselves
- Feeling supported by team makes it easier to self-disclose - ?consistent parenting. Predictable response. As opposed to unpredictable/inconsistent from management/comms (behaviour not matching up with what they say).

Hinders:
- Lack of recognition of how hard things are
- Lack of staffing - you've got to just get on with it
- "Institutional hazing" (my word) - from older staff, 'we had to put up with it so you do too'
- 'Angry' and 'Aggressive' messaging from Trust leadership - re. meeting targets
- Management being 'really inaccessible' - e.g. never having met the Trust chief executive
- They don't want to listen. Culture of silence
- Not overt. Subtle. Passive-aggressive
- Not having access to management - or a seat at the table
- Trusts/departments needing to protect themselves (and prioritising this over e.g. staff wellbeing)
- Disconnect between 'reality' and 'what the senior people think is going on'
- Physical health more acceptable to talk about than MH
- CPs are 'productive', 'quiet', 'compliant', 'have it all together'. 'Invulnerable'.
- E.g. covid response - clinical psychologists were asked to offer an 'on call' rota for staff who were struggling - but where do the psychologists go? Who supports them?
- Managers listen to MH concerns and don't act - burnout/stress/overwhelm is normalised and expected

Management don't want to listen → Culture of silence → Stoicism → Not taking time off, burnout → Desensitisation, compassion fatigue → Stigma, discrimination → NOT SAFE TO DISCLOSE

Memo – July 2022 – A really good manager?

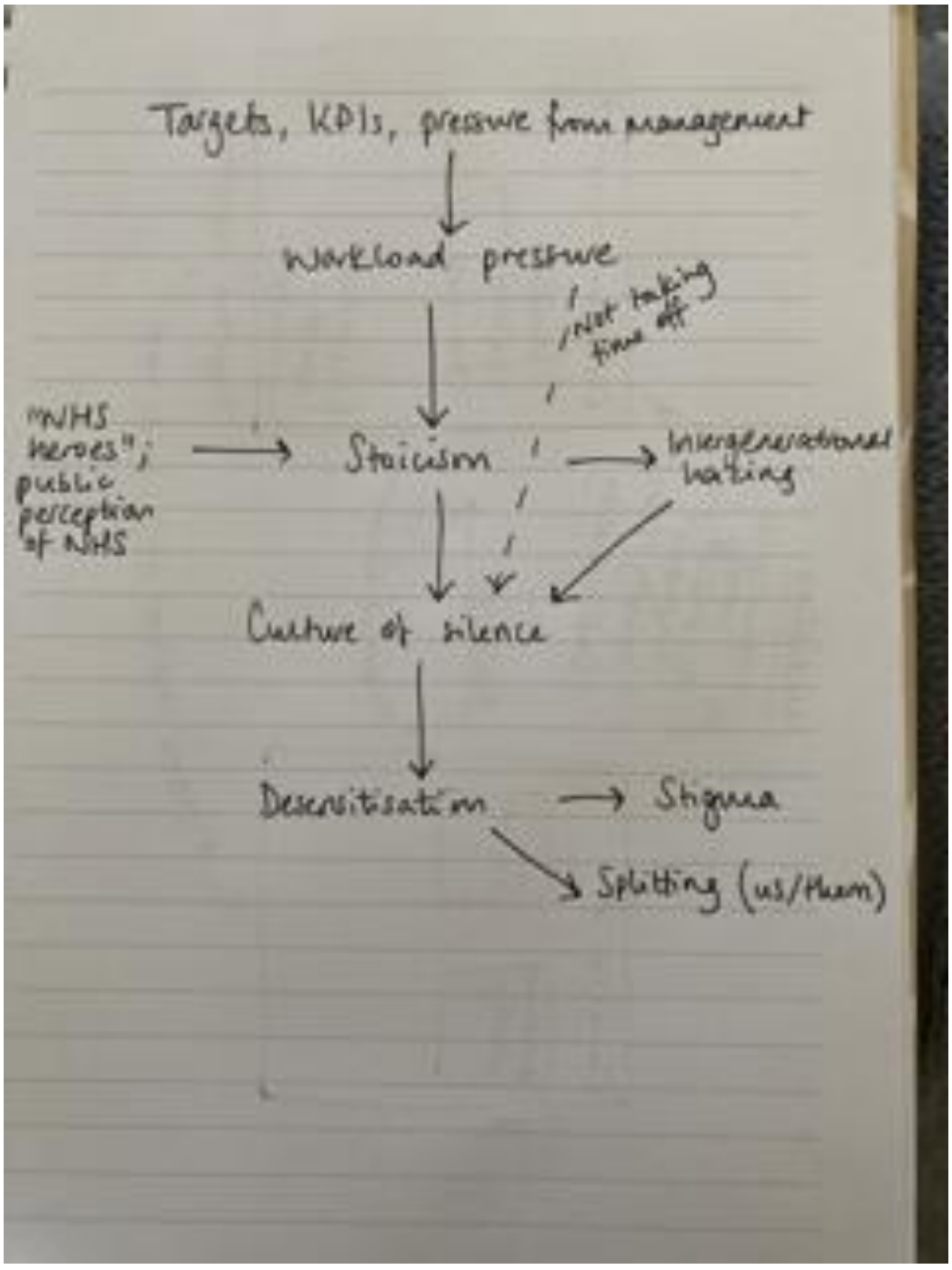
As I move through the interviews, I keep getting an image in my mind of a 'really good manager'.
'A really good manager' protects their team from the culture – at a detriment to themselves. Shielding the team from the ?hostile culture. Sacrificing themselves for their team's wellbeing. I keep getting an image of an umbrella, and the pressure (from the NHS, trust, higher up leadership?) is like rain falling on the umbrella. The team are safe underneath it.

Maybe a 'less good' manager has holes in their umbrella? Or has given up holding the umbrella at all – the rain is too relentless, everyone's going to get wet anyway.

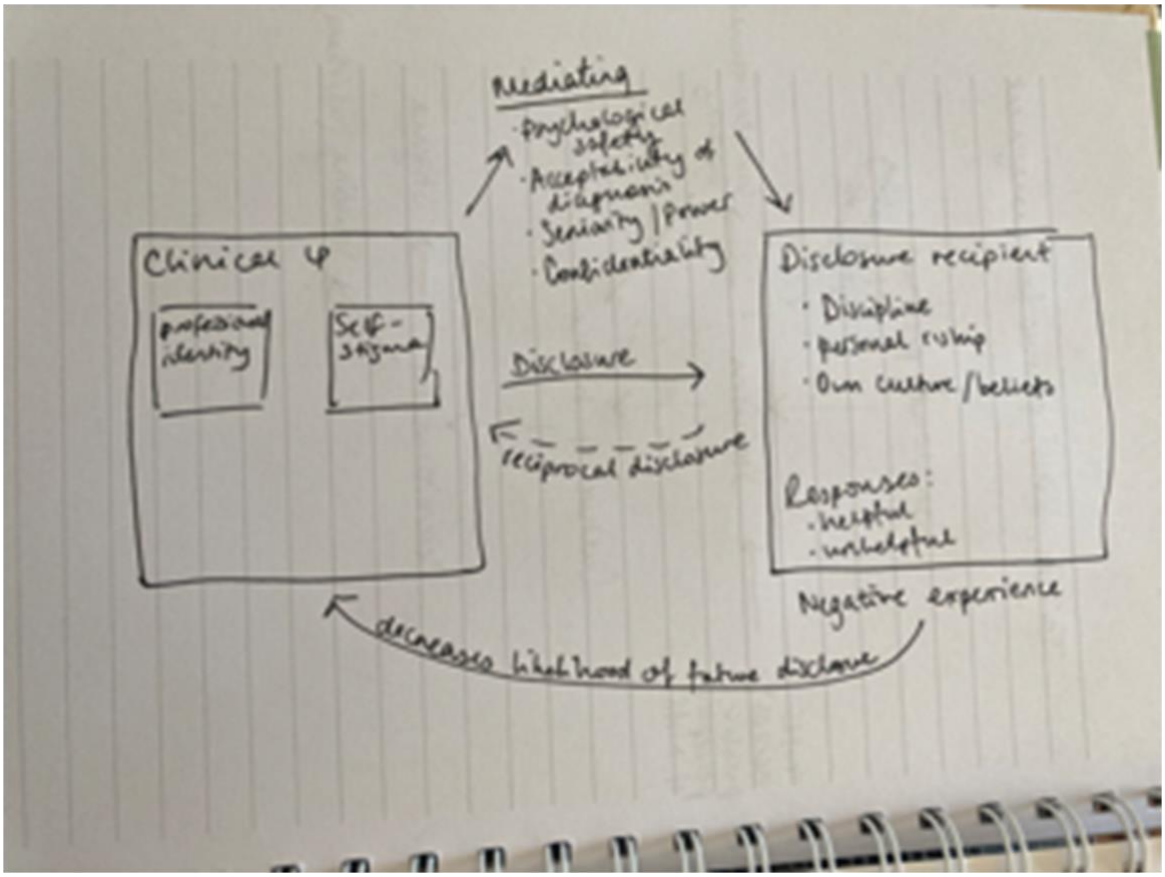
What does this say about the culture, that managers have to 'protect' their teams from it? And who is protecting the managers?

Memo – January 2023 – What contributes to NHS culture?

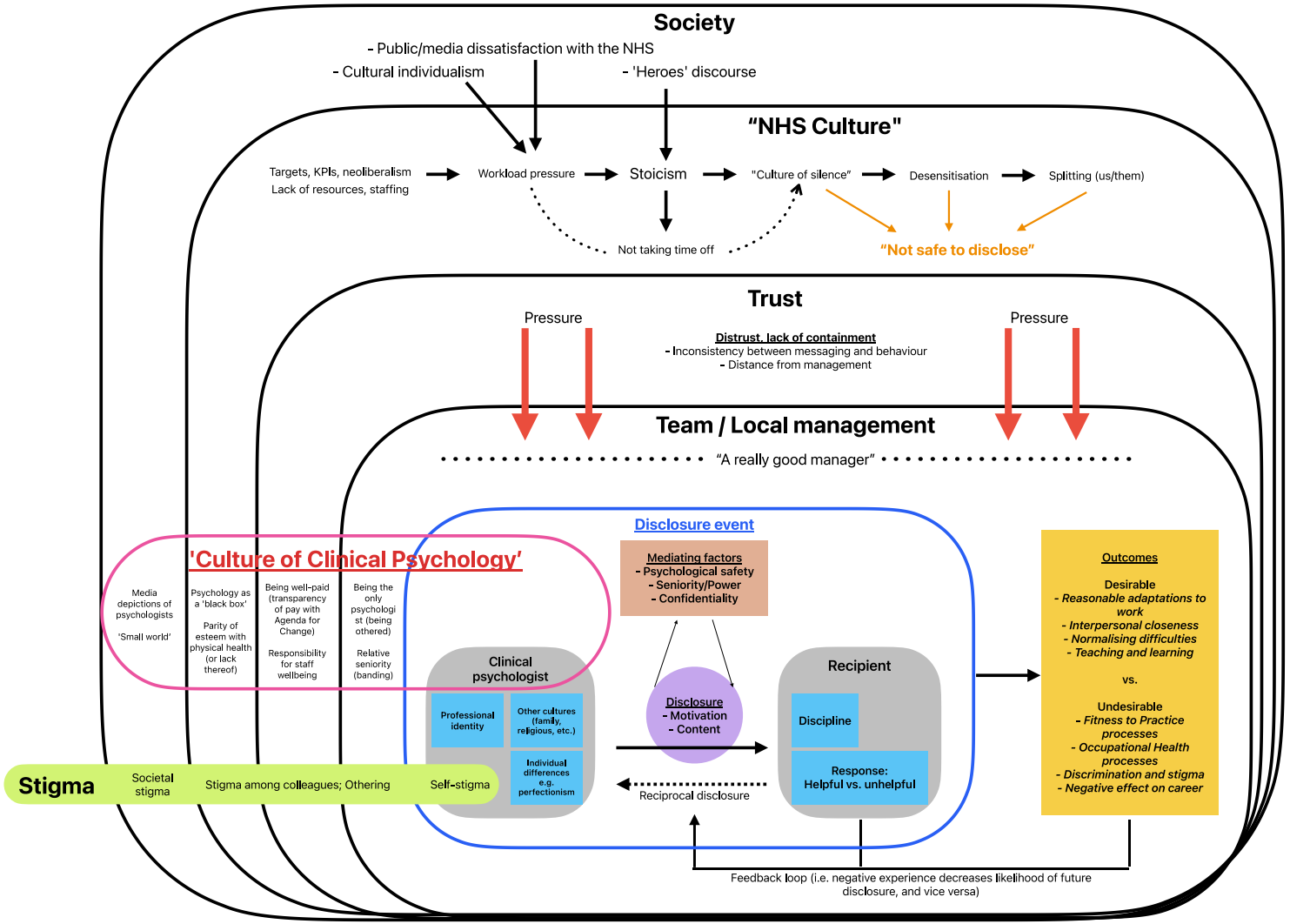
I've had to draw some of my thoughts out to make sense of them.



Memo – January 2023 – the disclosure process



Memo – February 2023 – Cultures on cultures on cultures – 'Stigma written through it like a stick of Brighton Rock'



Appendix G – Coding matrix

Category	Sub-category		Code
NHS Culture	Responses to distress	Individualism	'If you're struggling, it's your fault'
			Cultural individualism
			individualisation of mental distress
			Management style affecting team work style (i.e. individualistic vs. collaborative)
			Mental health being seen as 'within one's control'
			Placing responsibility for own wellbeing on staff
			Taking individual responsibility for workload management
			Working individualistically (i.e. on own caseload) as a barrier to self-disclosure
		Intergenerational hazing	Intergenerational hazing
		Manic defense	'Manic defense' - reality of culture or experience is denied
			Management denying they are responsible for policies
			Trust management believing the culture is positive
			Management unwilling to consider that problems exist
		Stoicism	'People just drag themselves through really hard times'
			'Putting a professional stance back on'
			'Stoically continuing on'
			'Undefended' habitus at work - and acknowledgement that not everybody needs that
			'We just get on with it'
			'You're a consultant now, you need to get a handle on this'
			'Your stuff has to be out of the way'
			Being encouraged not to take annual leave during busy periods
			Being praised for coping
			Choosing to conceal a vulnerability at work
			Compartmentalising
			Concealing distress at work
			Culture of silence

Don't make a fuss
Emotional difficulties being left 'unspoken' among teams
Emotions being unprofessional
Expecting NHS staff to be resilient
Expecting resilience under pressure
Feeling duty to remain fit for work (due to NHS being a public service)
Feeling guilty about taking time off
Feeling guilty about work left undone
Keeping up appearances
Leaving it at the door
Manager suffering in order to protect team
Masking difficulties at work
NHS culture being emotionally distant from the work
NHS culture encouraging staff not to emotionally experience the work, but consider and reflect analytically
NHS staff as 'inhuman', not having their own needs
NHS staff having to be strong
Not being resilient is a liability
Not looking like you're struggling
Not taking sick leave
Performing at work despite emotional or personal distress
Presenting an 'I can cope despite' demeanour
pretending to be fine
Pretending to be okay leading to burnout
Proving to myself that I can be competent even when struggling with MH
Psychologists as invulnerable or immune
Psychologists being expected to be unemotional
Psychologists being expected to have it all together
Psychologists not being seen as needing support
Putting on a front

		Returning from MH sick leave and never talking about it again
		Self-disclosure of MH seen as unprofessional
		Taking extreme workload as 'part of the job'
		The system already being 'full' and not having room for staff vulnerability
		There isn't room for vulnerability at work
		Withstanding high levels of demand
		Work-related stress being understandable
		Working in MH but not prioritising MH
		Working in the NHS impacting negatively on staff's MH
		Working in the NHS requiring endurance
		Working with constant knowledge that you're not doing enough
	Us and them (splitting from service users)	Being treated like a patient by colleagues
		Choosing not to disclose based on colleagues' judgements about service users
		Discrimination against SUs within the team
		One rule for clients (it's good to talk), another for psychologists (don't admit vulnerability)
		Paranoid-schizoid (SUs all bad, Staff all good)
		Reducing clients to statistics
		Reflecting on psychologist identity, born out of problematic history of profession which promulgated the 'us and them' divide and othered those with MH needs, and difficulty in reconciling professional origins with modern inclusive ideals
		Team treating SUs with different diagnoses differently
		Trusts not recognising their staff may also be service users
		us and them (staff and service users)
Structure	Hierarchy	'No matter what band you are, you are human'
		'The buck is passed down'
		Being easier to disclose the more senior you are (as this comes with more power and influence)
		Being harder to disclose the more senior you are
		Culture of team mitigating effect of seniority on self-disclosure

		Distance between floor staff and management or CEO
		Having a relationship with senior management is facilitative (e.g. for reasonable adjustments)
		Local management being put under pressure to meet targets
		Making change being difficult due to inaccessible management
		Management being inaccessible
		Management being less receptive the more senior they are (i.e. as you move up the management ladder)
		Management not understanding the experiences of staff on the ground
		Management not working clinically
		Middle management acting as a go between and causing problems
		Needing to set an example (as a Band 7+)
		NHS culture being hierarchical
		Sense of lack of transparency in management structures
		Using powerful position to advocate for good practice
		Using powerful position to advocate for SUs
		Where you sit in the hierarchy affecting safety of disclosure
	Lack of transparency in management structures	Lack of transparency from supervisors
		Making change being difficult due to inaccessible management
		Management being inaccessible
		Management being les receptive the more senior they are (i.e. as you move up the management ladder)
		Middle management acting as a go-between and causing problems
		Not knowing who the chief executive is
		Sense of lack of transparency in management structure
Resources	Lacking resources	Feeling pressured to continue (with project, training, etc.) due to limited funding
		Funding pressures affecting quality of care for SUs
		Having to 'fail' service users in order to make case for more funding or staff
		Lacking practical resources, space, chairs etc.
		Lacking resources

	Lacking resources leading to decisions being made against best interests of SUs
	Limited funding for training in NHS
	Not having the resources to set up good services
Staffing and workforce	Being understaffed
	Demonstrating to commissioners that more staff are needed
	Having to 'fail' service users in order to make case for more funding or staff
	Lack of planning to cover unwell staff's shifts
	Managers' priority being targets and waiting lists, rather than staff wellbeing or retention
	Material factors impacting on NHS staff MH (too many hours, too little pay)
	Recruitment and retention problems affecting staff wellbeing
	Systemic workforce issues impacting on team's perception of unwell colleague
	Workforce issues impacting on workload for staff
Demand	'Everybody is at capacity'
	'If I take time off I'm going to pay for it'
	'Part of the job'
	'People just drag themselves through really hard times'
	'Pressure to do more and more with less and less'
	'Slog culture'
	'The team had to mop it up'
	'We need to get everything done as soon as possible'
	Acuity of work increasing (as well as demand)
	Always pushing a bit more
	Being encouraged not to take annual leave during busy periods
	Being encouraged to take breaks (but not being able to do so)
	Being understaffed
	Breathing space being a luxury
	Caseload expectations feeling impossible
	Colleagues resenting psychology-led wellbeing initiatives (Because no time)
	Constant demand for more affecting sense of job competence

Constant sense that you could be doing more
Demonstrating to commissioners that more staff are needed
Describing high workload
Emergency or urgent situations being frequent in the NHS
Exhaustion being a constant among staff
Fearing punishment for not meeting demand
Fearing returning to work after sick leave due to the anticipated workload and catch up
Feeling burnt out
Feeling frantic
Feeling guilty about adding to a colleague's workload
Feeling guilty about not being overworked
Feeling guilty about taking time off
Feeling guilty about work left undone
Feeling overwhelmed
Feeling overwhelmed with workload
Feeling pressure due to how long clients have been on the waiting list
Feeling pressure to do more
Feeling pressure to provide excellent care when people have been waiting so long for it
Feeling pressured
Feeling stressed
Feeling unsure where (workload) pressures originate from
Firefighting
Funding pressures affecting quality of care for SUs
Having to 'catch up' after taking time off work
Having to 'fail' service users in order to make case for more funding or staff
Hearing stories of bad practice in the NHS
If I were good at my job, I wouldn't be feeling this pressure
Increasing demand

Intergenerational hazing
Internalising the pressure from the culture
Knowing nobody will take over your caseload if you're off sick
Lack of planning to cover unwell staff's shifts
Lacking practical resources, space, chairs etc.
Lacking resources
Lacking resources leading to decisions being made against best interests of SUs
Limited funding for training in NHS
Local management being put under pressure to meet targets
Longer waiting lists increasing pressure on staff
Managers being pressured
Managers being so overworked they don't have capacity to think about others
Managers' priority being targets and waiting lists, rather than staff wellbeing or retention
Material factors impacting on NHS staff MH (too many hours, too little pay)
Media rhetoric that NHS is not good enough
Moral injury
Needing to overwork to maintain reputation of team
NHS being very stretched
No leeway
No space to think about staff MH with the NHS in its current state
Not being able to make referrals to other teams because waiting lists are closed
Not being able to meet waiting list
Not being expected to work overtime
Not doing enough
Not feeling able to take time off because need to be available to team
Not having the resources so set up good services
Not having the time
Not having the time at work to talk about MH
Not having time to engage with wellbeing initiatives

Not taking sick leave
Pace of work differing between client groups
Paperwork adding to workload
Paperwork putting people off doing clinical work
Paperwork taking up clinical time
Pressure on managers leading to toxic team dynamics
Pressure to be helpful for colleagues being amplified by workload pressures
Pressures being universal across NHS
Prioritising performance targets over staff wellbeing
Prioritising workload or clinical work over conversations about MH
Prioritising workload over social needs
Provision not meeting need
Psychology is a protected role in a very stretched system - leads to resentment or envy
Rejecting referrals
Relentless demand for services
Rigid service thresholds contributing to crisis (and more work)
Sacrificing good practice in favour of meeting targets
Squeezing full-time work into part-time hours
Staff trying to do the best they can
Systems already too stretched, that adding further complexity (staff MH) makes it too difficult
Taking extreme workload as 'part of the job'
Taking time off 'letting the service down'
Taking time off having an impact on colleagues
Taking time off impacting on clients
Taking time off increasing colleagues' workloads
The NHS being at breaking point
The system already being 'full' and not having room for staff vulnerability
There isn't room for vulnerability at work

		Trust policies placing more pressure on staff
		Unhealthy work ethic creating a vicious cycle
		Unplanned, last-minute time off results in work getting 'dumped' on others
		Wanting to provide a good service and not being able to
		Withstanding high levels of demand
		Work-related sleep deprivation impacting on MH
		Work-related stress being understandable
		Workforce issues impacting on workload for staff
		Working in the NHS requiring endurance
		Working overtime
		Working with constant knowledge that you're not doing enough
	Bureaucracy	'Red tape'
		'Tick box' requirements taking up time
		Feeling frustrated with arbitrary policies
		Feeling risk management policies are too risk averse
		Implementing policies reactively
		Introducing policies to manage external perceptions
		Paperwork adding to workload
		Paperwork putting people off doing clinical work
		Paperwork taking up clinical time
		Psychologists having comparatively more responsibility for 'red tape'
		Questioning rationale for paperwork - who does it benefit
		Service user participation increasing red tape
		Trust policies placing more pressure on staff
Keeping up appearances	They don’t practice what they preach	Correcting self - difference between what the Trust 'wants the culture to be' and 'what they want us to think the culture is'
		Inconsistency between Trust messages and behaviour
		Not having time to engage with wellbeing initiatives
		Receiving conflicting messages from management
		Staff wellbeing initiatives being tokenistic

		They don't practice what they preach
		Trust messaging to staff being inconsistent with Trust values
		Wellbeing initiatives being withdrawn due to lack of engagement from staff
		Workplace messaging (e.g. screensavers) being aggressive or hostile
	Tokenistic/performative concern for staff wellbeing	Not having time to engage with wellbeing initiatives
		Psychologists being expected to support team wellbeing
		Punishment of those who take time off is contradictory with NHS drive for efficiency
		Staff wellbeing initiatives being tokenistic
		Staff working more efficiently when they are well
		Trusts providing wellbeing services for staff
		Management not valuing staff wellbeing – placing value on productivity
		Managers' priority being targets and waiting lists, rather than staff wellbeing or retention
		Optimising patient care at the expenses of staff wellbeing
		Prioritising performance targets over staff wellbeing
		Wellbeing initiatives being withdrawn due to lack of engagement from staff
		Wellbeing provision being insufficient
		Wellbeing provision feeling patronising
		Wellbeing provision feeling superficial
		Wellbeing provision not matching intensity of staff need
		Team wanting staff member to be sacked, as then get replacement
Participants' perceptions of public ideas about the NHS		'Part of the job'
		'The NHS will continue'
		Being dedicated to the NHS
		Clap for Carers during pandemic
		Collective action in the NHS feeling unlikely
		Comparing NHS work to war-time rhetoric
		Entering NHS workforce linked to values (i.e. not pay)
		Expecting NHS staff to be resilient
		Feeling united by sense of public duty (working in NHS)

Media representation of healthcare workers changing quickly since COVID-19
Media rhetoric effecting public perception of NHS workers
Media rhetoric that NHS is not good enough
Narratives about NHS staff
Negative media messages about NHS being demoralising for staff
Neoliberalism
NHS as a free resource for all
NHS being undervalued
NHS staff as 'inhuman', not having their own needs
NHS staff existing to serve other people
NHS staff having to be strong
NHS workers being celebrated in the pandemic
Not identifying with 'NHS heroes' label as MH services not on 'front line'
Perception that quality of life should be increasing with time, leads to higher demand for quality services, which can't be met
Public dissatisfaction with NHS affects perception of healthcare workers
Public expectation of NHS provision
Public frustration with NHS
Public perception of NHS (workers)
Public perception that healthcare workers are lazy
Public persona of the NHS
Reality of working in NHS is to be expected
Reflecting on dominant narratives about NHS culture
Reflecting on the unusual arbitrary veneration of NHS workers in the pandemic (C for Cs)
Taking extreme workload as 'part of the job'
The NHS as a business rather than a public resource
The NHS being at breaking point
The way the NHS sits within the national consciousness
Working in the NHS requiring endurance

Motivation	Asking for reasonable adjustments	Being made to feel stupid for asking for reasonable adjustments
		Being made to feel that reasonable adjustments are 'excessive'
		Being treated as 'difficult' for requiring reasonable adjustments
		Colleagues feeling envious of reasonable adjustments
		Having a relationship with senior management is facilitative (e.g. for reasonable adjustments)
		Not feeling able to ask for reasonable adjustments from manager
	Benefits of LE and disclosure	Being aware of SU's experiences of diagnoses (due to own experiences of diagnoses)
		Being more aligned with service users experiences due to LE of MH
		Experiences bringing something intangible (but positive) to clinical practice and relationships
		LE being a professional asset
		LE being valued at job application
		LE facilitating a more casual relationship dynamic
		LE facilitating normalisation of MH difficulties for SUs
		LE facilitating qualitatively different therapeutic relationship with SUs
		LE helping to broaden understanding of MH (and therefore enhance competence)
		LE making me a more compassionate psychologist
		Shared experiences facilitating disclosure
		Using LE to advocate for a specific approach or treatment plan
		Using LE to advocate for the SU position
	Feeling forced to disclose	Choosing between quitting and self-disclosure, when requiring job adaptations
		Disclosure being forced due to significantly poor MH
		Having to disclose during a mental health crisis
		Invisibility of MH requiring active disclosure
		Visible evidence of LE (e.g. self harm scars) acting as a disclosure
	Taking sick leave	'If I take time off I'm going to pay for it'
		'Us and them' between stressed staff and colleague 'off sick'
		'We're all stressed' - colleague taking time off leading to resentment among team
		Being aware of how colleagues perceive you when you're off sick

		Being ridiculed for needing time off
		Fearing returning to work after sick leave due to the anticipated workload and catch up
		Feeling guilty about taking time off
		Feeling like you're letting clients down (when taking sick leave)
		Feeling responsibility to catch up on work missed while on sick leave
		Having time off for physical health is more acceptable than for mental health
		Having to 'catch up' after taking time off work
		Knowing nobody will take over your caseload if you're off sick
		MH not being a 'good enough' reason to be off sick
		Not feeling able to take time off because need to be available to team
		Not feeling believed about MH problems (just trying to get time off work)
		Not taking sick leave
		Punishment of those who take time off is contradictory with NHS drive for efficiency
		Resentment about colleague taking time off leading to stigma among team
		Returning from MH sick leave and never talking about it again
		Self-reflection and noticing the need for time off being pathologised
		Sickness having an impact on colleagues
		Taking time off 'letting the service down'
		Taking time off having an impact on colleagues
		Taking time off having an impact on colleagues' perceptions of you
		Taking time off impacting on clients
		Taking time off increasing colleagues' workloads
		Taking time off work
		Taking time off work not necessarily helpful
		Unplanned, last-minute time off results in work getting 'dumped' on others
Safety	Concerns around confidentiality	Being concerned about confidentiality within the interview
		Choosing not to disclose due to fears about confidentiality
		Confidentiality not being a deciding factor in disclosure
		Considering confidentiality

Relational safety	Disclosing only when confidentiality was assured
	Disclosures being shared with other colleagues without consent
	Disclosures not remaining confidential
	Information being shared among other psychologists
	Not feeling concerned about confidentiality in a supportive team
	Sensitive information about LE being shared among organisation
	Sensitive information being shared without your knowledge
	Being 'psychologised' by supervisor feeling patronising and unhelpful
	Boundaries between personal reflection in supervision and therapy being difficult to navigate
	Bringing MH difficulties to supervision - does this blur the boundary with personal therapy
	Concern about blurring roles between supervisor and therapist
	Discussing practical mental health needs with supervisor
	Feeling safe in a supervisory relationship facilitating disclosure
	Inverse relationship between hostility of team and safety of positive relationship (e.g. supervisor)
	Self-doubt making it difficult to know how much is okay to share (in supervision)
	Supervisor being supportive and caring
	Supervisor pragmatism feeling supportive in response to disclosure
	Supervisors lack of self-reflection as a barrier to disclosure
	Supervisors not wanting to listen to disclosure
	Supportive relationship with supervisor facilitating disclosure
	Supportive supervisor leading to a positive disclosure experience
	Wanting boundaries in supervisory relationships
	Being hardest to disclose to other psychologists, as see them as more competent
	Difficult to disclose in a group
	Difficult to disclose with management present
	Disclosing in smaller groups
	Disclosing more to clients than colleagues

Disclosing to peers (of a same level) in order to elicit disclosures from them
Feeling easier to disclose to non-psychologists
Feeling easier to disclose to other psychologists (peers)
Feeling safe in a supervisory relationship facilitating disclosure
Feeling safer to disclose to peers
Harder to disclose to managers
Manager being human facilitates disclosure
not disclosing in team meetings
Not disclosing to clients
Recipient's profession being less important than personal relationship with them
Supportive relationship with supervisor facilitating disclosure
Contrast between team hostility and safety with supervisor
Culture is not supportive
Feeling possible to be vulnerable in psychologically safe environment
Feeling safe in a supervisory relationship facilitating disclosure
Feeling safer to disclose to peers
Feeling supported by colleagues
Feeling supported in a small team
Feeling supported to disclose by manager
Inverse relationship between hostility of team and safety of positive relationship (e.g. supervisor)
NHS culture feeling unsafe
NHS culture is not safe enough to be authentic
NHS workplace culture not feeling safe
Not feeling concerned about confidentiality in a supportive team
Positive relationships with colleagues facilitating disclosure
Psychological safety facilitating conversations around disclosure
Psychological safety facilitating vulnerability
Regular check-ins feeling supportive
Safety facilitating disclosure

		Spending time together as a team feeling supportive
		Supervisor being supportive and caring
		Supportive relationship with supervisor facilitating disclosure
		Supportive supervisor leading to a positive disclosure experience
		Supportive team being facilitative for disclosure
		Team context influencing sense of psychological safety
		Where you sit in the hierarchy affecting safety of disclosure
Feedback loop		Previous experiences of disclosure affecting decision making around workplace self-disclosure
		Seeing how peer workers are treated, and choosing not to disclose LE
Fear of consequences	Experiences of FTP processes	Feeling 'done to' in FTP
		Feeling powerless in FTP
		Feeling scrutinised by fitness to practice procedure
		Fitness to practice procedures being held 'about you, without you'
		Fitness to practice procedures having negative impact on MH
		HCPC sharing fitness to practice bulletins regularly
	Experiences of Occupational Health processes	Encountering difficulties with Occupational Health
		Feeling exposed by Occupational Health procedures
		Questioning use of resources in Occupational Health
	Permanence of disclosure	'You can't put the genie back in the bottle'
		A disclosure remaining 'on your record' throughout career
		Disclosure being permanent, indelible
		Once a disclosure is made, it having a lasting impact on career and perceptions of you
Team factors & dynamics	Relationships with colleagues	Being 'mothered' by colleagues
		Being harder to integrate with team when you're WFH or out of the office
		Being more vulnerable with some colleagues than others

		Being selective about to whom to disclose - choosing people who might understand
		Colleagues 'looking out for one another'
		Disclosure bringing you closer to colleagues
		Disclosure having an impact on relationships with colleagues
		Feeling like you don't know your colleagues is isolating
		Feeling lucky to have colleagues one can be vulnerable with
		Feeling socially distressed trying to talk to colleagues
		Feeling supported by colleagues
		Getting to know colleagues better face-to-face
		Getting to know colleagues requires effort
		Having raw emotional experiences with colleagues who you don't know personally
		Needing a reason to talk to colleagues
		Not knowing colleagues leads you to not like the team
		Not socialising with colleagues
		Positive relationships with colleagues facilitating disclosure
		Providing support to colleagues
		Working very closely with colleagues but not knowing them personally
	Effect of individual differences in manager	Experiences mediated by individual differences in manager
		Attitudes differing between teams – led by management
		Less compassionate, more target-driven managers getting promoted
		Management style affecting team work style (i.e. individualistic vs. collaborative)
		Manager being human facilitates disclosure
		Managers being flexible about working arrangements feels supportive
		Pressure on managers leading to toxic team dynamics
		Team culture changing with new management
		Unsupportive managers reducing team morale
Stigma	Self-stigma	Concerns (stigma) being internally generated
		Feeling ashamed to be a psychologist with LE
		Feeling shame around your mental health diagnosis
		Hearing horror stories contributing to self-stigma and fear

	Internal expectations of 'professional identity' leading to self-stigma
	Noticing internal stigma
	Perfectionism causing feelings of shame
	Questioning competence and career
	Questioning competence with SUs if can't 'fix' self
	Reflecting on concerns about self-stigma, how MH might be perceived by others
	Reflecting with surprise that disclosure has never been a problem (despite self-stigma)
Societal stigma	Acceptability of mental health diagnoses being on a sliding scale
	Decreasing stigma in wider society
	Reflecting on impact of societal stigma and labels
	Societal stigma impacting culture of working in MH
Stigma from colleagues	Associating stigma or 'bitching' with being human
	Avoiding stigmatising teams by disclosing at job application
	Being exposed to stigmatising jokes (when colleagues don't know you have LE)
	Choosing not to disclose based on colleagues' judgements about service users
	Colleagues believing MH has an impact on competence or fitness to practice
	Colleagues joking about the power they hold over SUs
	Colleagues making assumptions about you due to LE
	Colleagues moderating their language or humour around you (due to your LE)
	Colleagues perceiving you negatively due to MH difficulties
	Colleagues' cultures and attitudes influencing decision to self-disclose
	Concern about colleagues' perception of own competence
	Cultural make-up of colleagues in team affecting decision making
	Desensitisation leading to stigmatising comments about MH
	Fearing being 'othered' by colleagues
	Fearing that colleagues would 'look at me differently'
	Feeling judged by colleagues
	Feeling stigmatised by colleagues
	Hearing rumours or gossip about other colleagues' mental health

		NHS staff holding stigmatising views on MH
		Othering of colleagues with MH needs
		Resentment about colleague taking time off leading to stigma among team
		Staff being cruel about colleagues who weren't 'coping'
		Stigma within staff team making it difficult to be open about our own MH
		Working in peer-led services reducing stigma
Identity	Perfectionism	Competition to enter profession requiring 'perfect' presentation
		LE of MH meaning 'imperfect'
		Not having room to be anything but perfect
		Perfectionism causing feelings of shame
		Perfectionism linking to MH difficulties
		Perfectionism making disclosure more difficult
		Perfectionism mediating relationship between psychology and MH difficulties
		Pretending to be 'perfect' to get into competitive profession
		Psychology being perfectionistic
		Psychology having a culture of perfectionism
		Putting pressure on ourselves unnecessarily (to be perfect, excellent)
		The 'perfect psychologist' doesn't have LE of MH
	Clinical psychologist identity	'It feels quite hard to raise the idea of a psychologist struggling'
		'Not knowing where you stand' (as a psychologist who uses services)
		Anti-psychiatry training as a psychologist
		Being 'marmite' as a psychologist with LE
		Being considered 'interesting' as a psychologist with vulnerabilities
		Being hard to admit your flaws as a psychologist
		Being hardest to disclose to other psychologists, as see them as more competent
		Being more open to talk about MH as a psychologist
		Comparing professional 'freedom' with psychologist role
		Defining role of psychologist
		Distancing from 'psychologist' role
		Distancing from perception of what a psychologist 'should' be

Feeling ashamed to be a psychologist with LE
Feeling easier to disclose to other psychologists (peers)
Feeling erased as a psychologist with LE
Feeling that your skills as a psychologist are in question
Having 'a little touch of MH' is creative and interesting in a psychologist
Holding self to high standards as a psychologist
Identifying with professional identity as a psychologist
Identity as a psychologist (and sense that you should be able to do something about it) adding to mental distress
Identity as psychologist makes you vulnerable
Identity determined by which came first - psychologist or PWLE
Imposter syndrome - feeling different from other psychologists
Internalising a sense that a psychologist should be able to heal themselves
Media depictions of psychologists influencing expectations
Needing 'a reason' to be a psychologist
NHS culture amplifying sense that psychologists should be able to heal themselves
Not identifying as a 'psychologist with lived experience'
Not knowing how to align oneself - psychologist or PWLE - mutually exclusive
Noticing inconsistency between values (as a psychologist) and behaviour at work
Perception of psychologist identity making disclosure difficult
Perception of psychologists as 'magical' or 'mind readers' - superhuman
Presence of MH problems in psychologist is threatening for 'psychologist' identity
Presenting an image of a psychologist
Psychologists advocating for co-production
Psychologists as invulnerable or immune
Psychologists being driven
Psychologists being expected to be unemotional
Psychologists being expected to have it all together
Psychologists being expected to support team wellbeing
Psychologists being relatively well paid

	Psychologists liking 'interesting histories' but struggling with idea of 'illness'
	Psychologists not being immune to workplace pressure
	Psychologists not being seen as needing support
	Psychologists not following their own advice
	Psychologists perpetuating stereotypes of psychologists
	Reflecting on placing internal pressure to have a 'fix' and wondering if other psychologists feel this way
	Reflecting on psychologist identity, born out of problematic history of profession which promulgated the 'us and them' divide and othered those with MH needs, and difficulty in reconciling professional origins with modern inclusive ideals
	Risk of being 'othered' is higher for a psychologist, often as a minority in a team
	Sharing experiences of challenging career journey with other psychologists
	Shouldn't need medication as a psychologist
	Stereotyping psychologists
	The 'perfect psychologist' doesn't have LE of MH
	Uncertainty within psychologist role
	Working 'as a service user with a psychologist title'
Dual identity	'Not knowing where you stand' (as a psychologist who uses services)
	'Putting a professional stance back on'
	'There's a massive proportion of psychologists that have lived experience'
	'Wounded healer'
	'Your stuff has to be out of the way'
	Being 'marmite' as a psychologist with LE
	Being 'othered' as a clinician in PWLE groups
	Being authentic in the therapy room makes you vulnerable
	Being considered 'interesting' as a psychologist with vulnerabilities
	Being drawn to Psychology due to lived experience
	Being more aligned with service users experiences due to LE of MH
	Being obliged to disclose due to nature of job history (peer support)
	Being successful 'despite' LE

Being treated like a patient by colleagues
Blurring of boundary between 'staff' and 'service user' (i.e. prosumer) is problematic for team identity
Boundaries between personal reflection in supervision and therapy being difficult to navigate
Disclosing to support teaching and training
Dual identity as clinician and PWLE 'clash'
Experience as SU enables you to think critically about service structures
Experience of personal therapy influencing clinical practice
Experiences bringing something intangible (but positive) to clinical practice and relationships
Experiencing service use (i.e. using MH services) as problematic and unhelpful
Feeling ashamed to be a psychologist with LE
Feeling erased as a psychologist with LE
Feeling LE expertise is denied
Feeling unable to use expertise as a service user
Having 'a little touch of MH' is creative and interesting in a psychologist
Having a mental health difficulty as a MH professional is hard
How can I contain other people if I don't feel contained myself
Identity as a psychologist (and sense that you should be able to do something about it) adding to mental distress
Identity determined by which came first - psychologist or PWLE
Internal expectations of 'professional identity' leading to self-stigma
Internalising a sense that a psychologist should be able to heal themselves
Knowing how far you can push it (with an SU)
Lack of visible professional role models with LE
LE being a professional asset
LE facilitating a more casual relationship dynamic
LE facilitating qualitatively different therapeutic relationship with SUs
LE helping to broaden understanding of MH (and therefore enhance competence)

LE making me a more compassionate psychologist
LE valued in peer workers but not in MH professionals
Maintaining a personal boundary at work
Managing dual identity in clinical work and peer work
MH difficulties not being considered in allocation of work
Needing to choose which identity you align to more (clinician or PWLE) - not reconcilable together
Not identifying as a 'psychologist with lived experience'
Not knowing how to align oneself - psychologist or PWLE - mutually exclusive
Once a disclosure is made, it having a lasting impact on career and perceptions of you
Paradox within clinical psychology, 'it's good to talk' vs. narratives around those who do
Perception of psychologist identity making disclosure difficult
Professional knowledge protecting against self-blame for MH problems
Proving to myself that I can be competent even when struggling with MH
Psychologising yourself out of it
Psychologists not being seen as needing support
Questioning competence with SUs if can't 'fix' self
Reflecting on difficulties of co-production (lack of trust between groups)
Reflecting on position as MH provider and having difficulties talking about MH at work
Returning to work following a therapy session
Self-disclosure of MH seen as unprofessional
Special relationship with SUs not understood by other psychologists (without LE)
Taking a non-expert position in therapy
The 'perfect psychologist' doesn't have LE of MH
Understanding a client's position in therapy
Understanding the service user perspective
us and them (staff and service users)

	Using 'overfamiliar' language when describing MH problems
	Using inclusive language as a form of inferred disclosure
	Using inclusive language when talking about MH ('we' rather than 'you')
	Using LE to advocate for a specific approach or treatment plan
	Using LE to advocate for the SU position
	Wanting more recognition that some staff members are also service users
	Who contains the container
	Working in MH makes own difficulties hard to accept
	Feeling conflicted about peer support roles
	LE valued in peer workers but not in MH professionals
	Peer support workers amplifying the gap between staff and SUs
	Peer support workers erasing MH staff with LE
	Peer work holding power within the Trust
	Peer workers feeling empowered to make change at Trust level
	Peer workers having more contact with Board than psychologists
	Seeing how peer workers are treated, and choosing not to disclose LE
	Trust wanting to tick inclusivity boxes but not prepared to deal with consequences of (i.e. employing peer support workers)
Seniority and pay	'You're a consultant now, you need to get a handle on this'
	Being easier to disclose the more senior you are (as this comes with more power and influence)
	Being harder to disclose the more senior you are
	Culture of team mitigating effect of seniority on self-disclosure
	Disclosure being more difficult as a leader
	Getting more difficult to disclose later in career
	Needing to set an example (as a Band 7+)
	Where you sit in the hierarchy affecting safety of disclosure
	Being paid more than MH colleagues increases pressure to be competent and put-together
	Being pushed to take on more responsibility than Band suggests

	Comparing pay scale to colleagues
	Entering NHS workforce linked to values (i.e. not pay)
	Level of pay adding to imposter syndrome
	Material factors impacting on NHS staff MH (too many hours, too little pay)
	Needing to set an example (as a Band 7+)
	Psychologists being relatively well paid
Imposter syndrome	'Could someone else do it better?'
	Imposter syndrome - feeling different from other psychologists
	Imposter syndrome making it difficult to disclose 'weakness'
	Level of pay adding to imposter syndrome
	Seeking reflection of own imposter syndrome from colleagues
Family of origin culture	Family culture affecting decisions around self-disclosure
	Family culture and upbringing affecting attitudes towards disclosure and mental health
Hope for the future	Culture of self-disclosure shifting with newly qualifieds coming through
	Feeling hope for the future of self-disclosure in the NHS
	Research being conducted into psychologists with LE
	Responses to disclosure being more supportive post-COVID

Appendix H – Example transcript with codes

This appendix has been removed from the electronic copy.

Appendix I – Reflexivity statement

As a white, middle-class female psychologist, my demographics represent the vast majority of the clinical psychology profession, and recognise that my experiences, perceptions and views may not represent the more marginalised or minotiritised members of our profession. I'm aware that my interpretations of the data will be based on my experiences (including my privilege), and on the relative privilege of my participants, and are unlikely to capture the diversity of experience within the profession.

Also as an expert-by-experience in this field (a psychologist with lived experience of mental health difficulties), I recognise that I bring my own experiences, perceptions, and beliefs to every aspect of this project, from conception, through data collection and analysis, to interpretation and dissemination. I was particularly aware of this as the grounded theory began to emerge from the data. At one point, I felt like I couldn't see the wood (theory) for the trees (codes). Then, as links and meanings started to emerge, I found that they often really fit with my own experiences. Some didn't, and I have made a conscious effort to value these elements in the same way as the ones that fit. I have found it helpful to be very close to the data, to return to passages and codes multiple times, to be led by the data in my interpretation of meanings – but in this, I acknowledge that I am likely to be biased towards the meanings that 'fit' with my experience. GT does not attempt to elucidate an objective truth, rather one possibility for understanding a social phenomenon, and in this way I feel I can present one possibility to explain the experiences of NHS clinical psychologists with LE of MHD, like me.

This is not a topic which could be meaningfully explored by an 'objective' researcher. My role as an active agent in the shaping of this research feels fitting, especially given my understanding of 'culture' (the Meek definition in the introduction has really helped me with this). The initial process of line-by-line coding really helped me to remain close to the data, and memo-ing throughout the project helped me to build a theory grounded in my participants' data, alongside reflection on my own interpretations, emotions and experiences.

I believe I embarked on this research partly in the hope that my own experiences would be recognised and validated, but I was also very keen to learn from other psychologists with LE about their experiences, and their perceptions of the culture. I have found the most rewarding parts of this work to be when my participants have had different experiences to me, building on my understanding and giving me a richer concept of 'NHS culture' and its effects.

I've also developed a real interest in the 'sparkling moments', the bits of 'NHS culture' that are really very good, kind, compassionate and supportive. I embarked on this project feeling like I hadn't been exposed very much to these. My participants have both shared their own sparkling moments, to enhance my understanding; and have helped me see my own sparkling moments, that I hadn't seen before.

Appendix J – Project summary to participants and to Salomons Ethics Committee

Dear participant,

I'm writing to thank you again for participating in my research project on the experience of 'NHS culture' and its influence on self-disclosure of lived experience of mental health difficulties at work. The project has come to an end now, and I am writing to summarise the project's findings. This is just a brief summary – the full thesis will be available in the future on the Canterbury Christ Church research repository, should you be interested.

The study

Nine NHS clinical psychologists with lived experience of mental health difficulties participated in interviews for the study. I used grounded theory methodology to analyse the interviews, and produce a model grounded in the data. My aim was to explore participants' experiences of 'NHS culture', and its importance in their decision-making around workplace self-disclosure of their lived experience of mental health difficulties.

Results

The findings are very much based on my interpretation of the data – grounded theory does not attempt to find an 'objective' reality, rather one possible explanation for a social phenomenon. Not everything in my findings will be relevant to all participants. Hopefully at least some of the below feels representative of your own experiences. I've included a diagram of the resultant model, at the end of this letter.

The 'core category' defined by the data was titled "*weighing the decision – to disclose or not to disclose?",* and the following categories were seen to be important factors in this decision:

1) NHS Culture

5 sub-categories of 'NHS culture' were identified. 'Responses to distress' included processes such as splitting from service users ('us and them'), stoicism, denial of difficulties, and cultural individualism (including pathologising work-related distress). 'Structure' included hierarchy, and a lack of clarity over management structures; this appeared to lead to a distance from management, and a sense of distrust. 'Resources' described the lack of funding, difficulties with recruitment and retention, ever-increasing demand and seemingly unnecessary bureaucracy. 'Keeping up appearances' relates to an apparent preoccupation with external perceptions of the NHS, resulting in tokenistic or performative concern for staff wellbeing, and a sense that "*they don't practice what they preach"*. 'Public ideas about the NHS' included the 'NHS Heroes' discourse, public dissatisfaction with the NHS, and the objectification of NHS workers.

2) Motivation

3 sub-categories of 'motivation for disclosure' were identified. 'Benefits of LE and disclosure' addressed the pride and strength felt by participants regarding their lived experience of mental health difficulties, and the ways in which this could benefit teams, service users, and society more generally. 'Asking for reasonable adjustments' included disclosing in order to request occupational adaptations or sick leave; there appeared to be a particular friction around taking sick leave in the NHS, with concerns around letting clients down, letting the team down, and stigma associated with taking time off for mental health reasons. 'Feeling forced to disclose' related to experiences when disclosures might be unavoidable, either because mental health is sufficiently poor as to necessitate a disclosure, or if there is other non-concealable evidence.

3) Safety

5 sub-categories of safety were identified. 'Stigma' included considerations around self-stigma, stigma and discrimination from colleagues, and societal stigma. 'Confidentiality' related to concerns that disclosures may not remain confidential, especially in the context of stigma. 'Relational safety' included the importance of the supervisory relationship in disclosure decisions, and psychological safety among colleagues (and a sense of not being judged). 'Fear of consequences' relates to the perceived indelibility of a mental health disclosure 'on your record', and experiences of fitness-to-practice and occupational health procedures, which were experienced as pejorative and discouraged future self-disclosure. 'Local factors and dynamics' addressed the importance of individual differences in local management, including a feeling that local managers needed to 'protect' their team from 'the wider culture'.

4) Identity

6 sub-categories of identity were identified. The "clinical psychologist" identity, and the culture of clinical psychology, included stereotypes of psychologists, the 'small world' of psychology, and guilt and shame around experiencing mental health difficulties as a psychologist. 'Perfectionism' was a common trait amongst participants, and this included a difficulty in accepting and admitting a 'flaw' (mental health difficulties were largely conceptualised as 'flaws' in this regard). 'Dual identity' included grappling with identities as both psychologist and service user, the apparent mutual exclusivity of these, and the possible impact of peer support roles on this identity struggle. 'Seniority and pay' included mixed opinions about whether it was easier, or harder, to self-disclose as one moves up the hierarchy, and considerations around the transparency of pay in the NHS (Agenda for Change bandings), comparing banding with other mental health professionals, and a sense of responsibility (and guilt?) for being well-paid. 'Imposter syndrome' was also a common experience among participants, and this too contributed to a reluctance to self-disclose as other psychologists were seen as more competent. 'Family of origin culture' was briefly discussed by some participants, and appeared to include an influence of the way emotions were talked about in childhood.

Conclusions

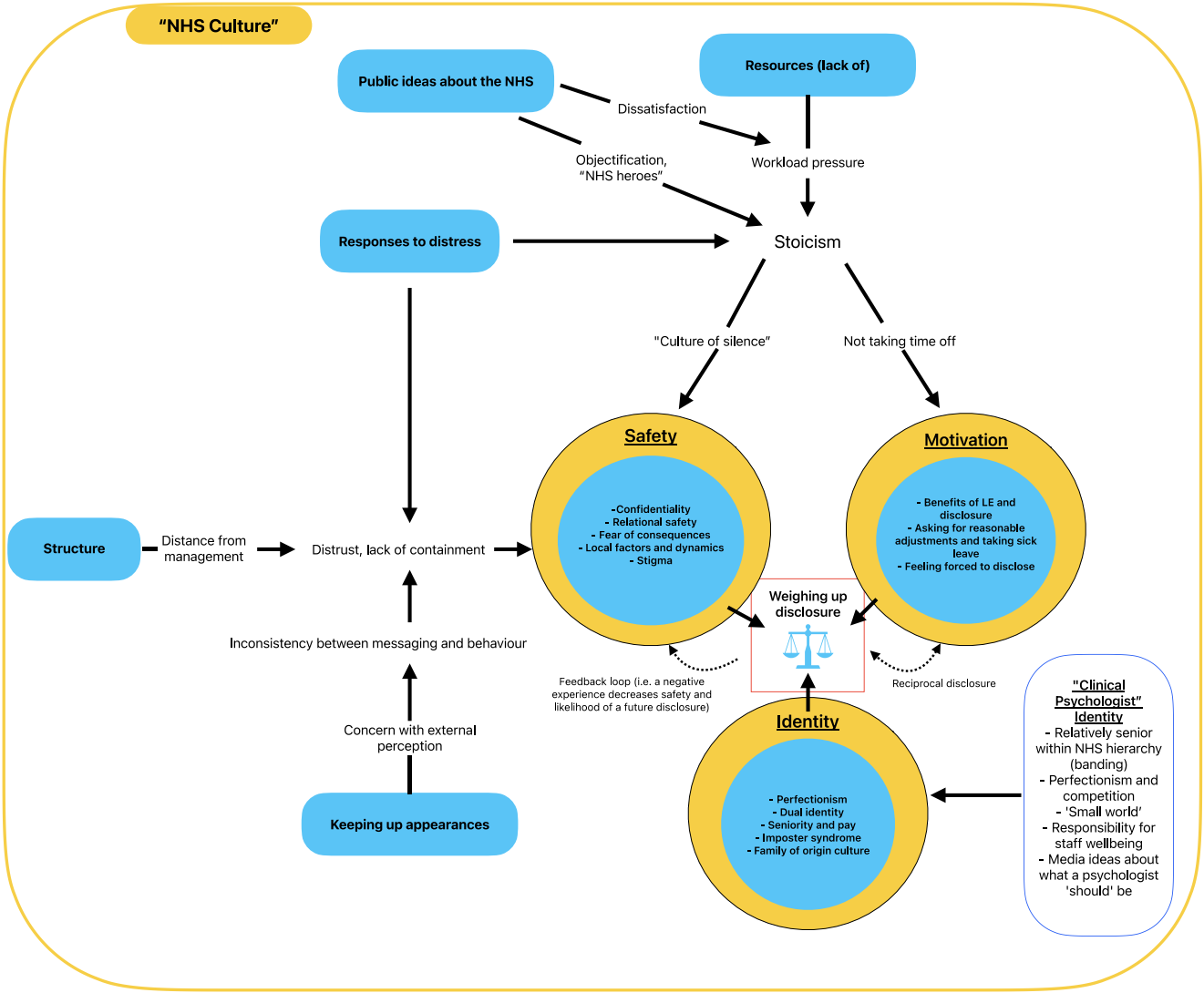
Findings suggest that perceptions of 'NHS culture' play an important role alongside the social and psychological processes involved in psychologists' decision-making around self-disclosure of lived experience of mental health difficulties. Perceptions of 'NHS culture' highlighted in this research are comparable with other recent investigations, including a tool developed by the Kings Fund (www.kingsfund.org.uk/projects/culture) to help NHS trusts identify and address areas of difficulty within their culture. It is hoped that tools and initiatives such as these could help to foster a supportive, non-judgemental culture in which to self-disclose. Further integration of LE into clinical training could also be beneficial.

I would like to take this opportunity to thank you once again for your contribution to this research. It has been invaluable to hear your insights and experiences.

Yours sincerely,

Vita Bowman, Trainee Clinical Psychologist
Salomons Institute for Applied Psychology

Core category: Weighing up the decision - to disclose or not to disclose?



Appendix K – Example quotations

Category	Sub-category	Theme	Example quotations
NHS Culture	Responses to distress	Individualism	*Having an opportunity to think together makes it easier to connect with [colleagues] about other things as well I guess, and that a lot of that comes down to the manager and making time for that sort of work, rather than just bashing away at your own individual caseload, actually bringing some heads together and spending time in a room together and thinking about stuff, which is really important clinical work. But I think is quite easy to sacrifice in the name of waiting list reduction.* Participant 7 *…If you've been off for a period of time – what are you gonna come back to? 1000 emails? And although someone's looked after your caseload for you, they will have just been keeping an eye on it. They won't have had time to do the kind of same kind of level of work that you would have done. So you just got to catch up… I think it can feel a bit like, 'I'm just actually going make things harder for myself'.* Participant 3 *The overarching ideology, or ideological position, is one in which, if you are struggling, it is your fault. It's basically a very hypernormal - as some sociologists call it, I think - you know, almost consumer capitalism gone wild in the NHS, whereby systemic institutional problems are reframed and redescribed as individualised pathological ones. So it's your problem. But it's also to do with your pathology, that you are struggling.* Participant 8 *And that's a way, of course, of deflecting from the systemic problems as an NHS culture at large, so a way of deflecting from 'we haven't got enough money, we haven't got enough money because we've been underfunded', and one way of disavowing that information is to say these people who are struggling, it's their*

	problem, rather than - as if they're struggling for a systemic problem, then you have to obviously look at the systemic problem. Participant 8
Intergenerational hazing	*I wonder sometimes whether there's some kind of narrative from… people that have worked for longer within psychology. "It's just kind of what we did, and we got on with it"… And with very, very little recognition of that, about what's being asked of people and, you know and almost a bit of a sense of… you know, particularly from maybe older generations… Was kind of like, well, we had to do it, so sort of, get on with it.* Participant 5
	This old manager… would pass the problem down, she didn't share the problem as much… 'you've got a high caseload, kind of, suck it up, that's the job'. I feel like she used to say that quite a lot when people would complain… she used to say things like 'well, when I was a nurse, I used to have a caseload of 60, get on with it', kinda thing. So she was - she was just generally less compassionate. I think less able to see other people's points of view. Participant 3
Manic defense	*They've [*The Kings Fund*] shown very clearly that these transformations, these organisational changes, don't save money. In fact, they cost money. But there's this manic quality where the reality is just denied. The reality is just, I'd say, disavowed. You know, it's known in some sense, but then it's turned away from. So that… Things are kind of redescribed as working when clearly they're not.* Participant 8
	There was absolute, like, absolute disbelief almost, that people didn't think it was a good place to work. And that's what I mean. It's like this disconnect of kind of like what the reality is, almost, with what, kind of, more senior people think has been going on. And actually staff have been treated really badly and you know, my understanding is that they had no awareness of that, but they seemed to kind of feign absolute surprise… Participant 5

	…I think for me that's made me feel really angry because I think like, that's your responsibility. Like, that's your job and you haven't listened. Like it's not because you haven't been told, it's because you haven't listened… My view is, particularly within the NHS… is that they don't want to listen, so there's almost like a culture of kind of silence because… you can raise things or raise concerns, but they either will be ignored, or you will get like a completely different response… It's not very Overt, I don't think. It's quite subtle, but you sort of realise that actually, really, the message you're getting is that things can't kind of be discussed. Participant 5
Stoicism	*There's this idea that we just get on with it. We just, everyone is fine and we do our jobs for people who are not fine. And that's so unrealistic, I know that logically, but yet I still get sucked into it.* Participant 4
	I presented myself as very quiet, compliant, just got on with things, able to cope… and I would not have felt OK to talk about my mental health difficulties at work. I feel like it's very much part of the culture. Participant 5
	Kind of doing your duty for the country at some level, almost a bit like in war times, where it's kind of that, 'we're in this together', it might not be good, but you get on with it and you don't make too much fuss. Participant 6
	I think you're expected to have a very robust coping. And it's an important kind of pressure to maintain that. Yeah, I might be tired, but I still keep going. I might be anxious, but I will still turn up. That kind of stuff is, I think it's quite important within the NHS culture and I think where people don't do that, we very quickly hound them. Participant 6
	There were cultural… local cultural forces, forces of kind of 'get on with things'. There's very many examples of seeing your people in the team talking about, I mean more socially acceptable things, like physical health problems that they have not yet

	gotten checked out or something, and kind of stoically continuing on and finishing the shift... Participant 8
	So that their priority can become around [targets], rather than how the staff might be feeling about – you know, trying to power on through. Participant 2
	So I think there is a sense to which we want to keep working… you know, because we're a public service… You know, I'm a public servant or, you know, I work for the NHS. I need to remain solid… And there's an overall value the NHS puts on, "Come on, we can do this. We're a team, we're helping other people", which I think can sometimes undermine people's sense of being able to disclose sort of mental health difficulties themselves. And if it is, it's not named. Participant 9
	I think at the moment in the NHS culture… Maybe because I've been particularly aware of it in the news recently...That NHS workers are supposed to just put their own needs to one side if… if they even have needs in the first place, that's probably a query isn't it? But, put their own needs to one side in order to meet the needs of service users, which is the kind of dominant narrative, and I always find myself saying 'that makes sense', but it doesn't, because we are human and all NHS workers are humans. But I think we're not always necessarily treated like humans. We're treated a little bit like we just exist to serve other people, and that means that there isn't space for us to have our own difficulties or our own needs. Participant 7
Us and them (splitting from service users)	*So there's a lot of othering goes on anyway, to kind of be very clear about, you know, who's who, which is the group with the problems, which the group that has behaviours that we would never go anywhere near having. But I think that also translates to the mental health… So actually it's, there's a, there's an important distinction as to who's who, who is the other. And all of those things are in the other, and we don't do that in services.* Participant 6

		I think there's also potentially such an othering of people with mental health needs. That it's kind of talked about as if 'that couldn't be us', and any confusion around that boundary is problematic. Participant 6
		And just that, from the language that we use in team meetings and, you know, and I know that the language that service users use as well when they think about professionals, it's very 'us and them'. Us versus them, sometimes, like actually they are the enemy. Participant 7
		…Can be very difficult to hear those views about service users, right? Those views come out in team meetings, don't they, that stigmatising language, those stereotypes… So within that kind of culture, it's difficult to then say, "well, actually, that's me. You're talking about me when you say that". Participant 7
		In those… lived experience groups, I feel like if they knew that I was also a clinical psychologist in mental health services, it would almost be like I was a bit of a traitor. Participant 3
Structure	Hierarchy	*The organisational cultural problems, local institutional service problems, all of that is basically… the buck is passed down, right? The same, I mean, lots of hierarchies work this way, I guess. We're humans, we're very good at projecting our own problems into people. And if you, if you have some power over someone, it's far easier to push your unwanted stuff into them and act it out with them. So I'm sure it happens in all spheres. Problem is that I think the NHS, by virtue of a lot of competing forces, has become such fertile ground for that, for kind of catalysing that process.* Participant 8

Psychologists, relatively speaking, you know… you pop into the NHS as a Band 7, which actually within the - I hate the banding system, but the reality is that's what we use - and you pop out as a relatively senior practitioner. Participant 9

I think we get well paid, really well paid… But I also know, I work all the time with support workers on minimum wage who do stuff that I could just not do. Constantly dealing with clients, and we're saying to them 'be consistent' you know… I could not do it. Who are paid pittance. And that doesn't feel right. And I think for me, that's a massive part, a big part of my impostor syndrome as a psychologist, is that we're really well paid. Participant 4

I think that's the thing in in the trust that I'm in now, the chief executive, although we kind of get lots of emails, they're really inaccessible. He's quite invisible. I hear he's quite good. But I wouldn't know. And I think for me that's really important in an organisation. You need to know who your figurehead is. Participant 5

And it feels like somewhere up the ranks… just thinking about how many, how many layers there are? How many managers there are above… your just kind of normal, in inverted commas, clinical worker… Somewhere up those ranks, you lose touch with what it's like to be on the floor. Participant 7

I feel kind of that there's this ideal, like "this is what our culture should be, this is what we want it to be", and then there's the real life of actually what it is like working in the NHS at the moment, within mental health services, and that's a really big divide… I'm at one extreme end… and I guess comms and other people are at the other extreme end. They're not clinical, they're not working clinically a lot of the time, so it feels like that gap needs bridging. Participant 4

This lack of understanding… this disconnection with higher up management. This sense that really managers, or the senior leadership team, or whoever - the

	Executive Board have no idea what a typical day is like for a clinician on the floor. And you know, that might be because they've never worked clinically and that they've only come up as a manager, or it might be that it's been such a long time since they worked clinically that things have changed, or they've just forgotten what it used to be like. So it might be 15, 20, 25 years since they've worked clinically. Participant 7
Lack of transparency in management structures	*I can see pockets of like really good managers say, that are able to kind of like hold a team and hold the kind of anxieties and things like that within the workplace. But often at real detriment to themselves. Because they aren't then supported kind of above them and feels particularly like there's some kind of like black hole almost before you then get up to sort of like board level or something like that*. Participant 5
	I feel like the Trust are giving the positive message, like the head people are giving positive messages, and my individual managers are giving the negative messages. But I really get the feeling that the team managers personally care much more, and actually at an individual level would really support, but… they're the ones that are being told, they're getting all those difficult meetings they have to go to about justifying all these people that are in beds, and justifying why this person's been on our caseload for eight months, and so they've got a really hard job. So I suppose it's coming from them, but I know not from them really… so it's almost a mismatch, if you know what I mean?... Because actually at an individual level, managers are incredibly supportive. But it's the wider culture that I don't feel necessarily is. Participant 3
	But I think sometimes there's things around like, I think bureaucracy… the paperwork… I'll give you an example is that - which hasn't come from on high, I don't know where it's come from… when I've spoken to the senior management

		they were all like, 'no we wouldn't be recommending that [guidance]'… And I think it's a really interesting discrepancy, because it's not something that is coming from senior management. Participant 1
		You definitely do have power, absolutely, but you don't in the kind of management structure. So I'd don't go to governance type meetings or anything. So I can pass up through my managers things, but I don't feel I have a direct say into the meetings that necessarily make change to service users. Participant 3
		It was also much harder to have influence on a higher level like, even if you looked at the kind of board structure, like, psychology was slightly off to the side, and it felt like actually there were other senior figures that were much more kind of dominant in that. Participant 5
Resources	Lacking resources	*It's been a combination of things. Less staff, higher risk, higher acuity, generally more people accessing mental health services… there's only so much you can do with the resources you have. And that's really demoralising. And that feeling of burnout… feeling burned out and stressed.* Participant 3
		It's like on training… I think you do that with this kind of aspiration of learning about what a good service looks like. And then actually to set-up good services is incredibly difficult. And time-consuming and you need huge capacity to do that well. Participant 6
		It definitely used to be where you felt like you were working with people and they would stay in the team as long as they needed to, until they were able to not need the team anymore. And that could be quite extended periods of time sometimes. Now I don't feel like that. I feel like we always have to justify 'why is this person in this team? Surely there's another service that can suit them'. Participant 3

	What's more important for nursing colleagues, I'd imagine, and I've been told many times it would, you know, regular breaks. Somewhere to have a break. Somewhere to get some hot food at 2:00 in the morning or whatever, that isn't plastic. And not having a kettle, not having you know, all of this, just basic things. Not having… you can read, you read in the papers every week, accounts of junior doctors, you know, horrifying accounts. There's not enough chairs, so they're sitting on sharps bin or something, you know? Participant 8
Staffing and workforce	*And what would actually help, I guess would be to be able to hire more staff. And there's a massive recruitment problem. Or be able to keep staff, there's a massive retention problem. I mean that would help, wouldn't it? If we're thinking about workload and that's what we're talking about, a lot of the time caseload and workload and waiting lists… If we're thinking about that stuff, the only thing that's going to help is hiring more staff.* Participant 7
	If you've got ridiculous waiting list that you can't meet, maybe it suggests to the commissioners that you need more staff? And actually if there's errors coming along, maybe employing more staff might be helpful? Participant 1
Demand	*So yeah there's a lot of, I feel now more than ever, probably related to COVID… and it has… well I think it's affected all services, but has really affected… services are under great demand at the moment. Beds under great demand.* Participant 3
	And the more we have innovation and ideas as to how to help people and a lot of those are time consuming. Umm, the more we can't meet the demand and the more we're creating demand and I think… The perception in the public is that quality of life is always kind of going up, but actually, we can't really manage that. Social inequalities mean that that's not actually a lot of people's experience. And then I think some of those frustrations just get pulled into public services. Participant 6

	I guess around the kind of rhetoric, and the government, and even the messages that we get as staff. That NHS workers almost just need to work harder, and like we're not doing enough. And there is, there does seem to a culture in the NHS of feeling like you can never do enough. There's always more that you could do. Participant 7
	I think it's a bit of a slog culture. That the… my impression is, is a bit about kind of the endurance of how long you've worked in the NHS, and your ability to withstand the high levels of demand, high levels of need, kind of there's a lot of culture around working when you're tired, that kind of, not taking sick leave, I think it's quite hard. Like appropriate breaks and things like that. I think it's not really encouraged that you have quality breaks. It's kind of that NHS sense of slog would be my impression. Participant 6
	Service-wide demands, and I guess I don't know about it all, I always have to remind myself that you know, I don't know everything that's going on, but yeah there's a huge demand. We can't meet the demand. Participant 4
Bureaucracy	*Innumerable tick- literally, and I don't use this phrase lightly, tick-box exercises in order to apparently reduce risk and with absolutely no evidence… and you can literally find the management consultant emblem on some of them, and they've come up with some risk assessment formed that has no basis in empirical literature and takes valuable time away from clinical practice, that is apparently going to help keep our patients "safer".* Participant 8
	The Choice is the assessment, and actually the Choice itself is like an hour long. The paperwork attached to the Choice probably takes you 2.5-3 hours minimum… really I'm not certain who it [paperwork] benefits, because I actually like, looking at the care plans I have to fill in on the note system, I mean, no young person - who really gives a damn about them? Participant 1

		Don't get me wrong, the paperwork is important because it's the first time the client comes in, so you got to do this, you gotta do that, you've got to do the other, but all the red tape that is needed around it feels quite challenging, and actually kind of, puts people off doing it, which then increases the waiting lists and stuff like that. Participant 1
Keeping up appearances (preoccupation with external perception)	They don't practice what they preach	*I suppose it's often said that, you know, we want staff to take breaks and do all of those other things, but often people are thinking, "but I can't write my notes if I take the break". And actually, "I'm gonna be slammed if I don't manage the basics". So I think it's, it's a dichotomy really as to what goes on.* Participant 6
		You know, the screensavers that you get in the NHS?... It's like I just, I open my laptop and it's like, 'Is this person ready to go home?'. You know, it's just these kind of like, almost commands… But I think, of all the things you could put on there at this point in time… mostly they are quite angry and aggressive, or passive aggressive. So in one Trust I worked in they had it almost like those old wartime kind of posters, where they were like, 'who's listening in to your conversations?'. And it was like, wow, OK, way to increase the paranoia amongst you and your colleagues. Participant 5
		I'm talking about broad stuff, like when you get an email. Like, you know like, that might be like, Trust communications and the way that staff are being spoken to. For example around COVID vaccinations… it didn't sit well with how I might speak to someone, I think… Although Trusts might have different values, they often have common themes, and I don't know whether it completely sung with that… I remember reading what was coming out in the Trust communications, and it was very much like, almost – a bit threatening. That's how it felt… I don't know, it's just, it just didn't sit well with me. Participant 2

Tokenistic/performative concern for staff wellbeing	*I think there's a lot of official messages about self-care and taking time… I think they send official messages about how it's really important that we look after ourselves as we work in a difficult job… however I think then the actual workload that we are given and the targets and the time scales and the lack of staffing that we have, is that in practice the culture is much more… you have to get things done.* Participant 3 *They are offering 'bitesized therapy'. Like what the hell? What the hell is that? What is it, just like, just come off your really intensive shift and have a bite size bit of therapy, and you'll be fine, just carry on? Like what are you doing? I don't know.* Participant 4 *There are resilience sessions where the idea, fundamentally, is that if you are struggling, it is down to you not being something called "resilient".* Participant 8 *If you've got to meet your targets, if you've got to see a certain number of people during the day, if you've got to, you know, just work on that waiting list… When are you going to have time to spend an hour, I don't know, doing a telephone counselling session or going to a reflective group, even, or going, you know, doing some wellbeing training or what-whatever it is that the trust are setting up? And then I think the problem with that is that they set these things up, and nobody has time to go to them, so nobody goes. And then the Trust turn around and say, "Oh well, obviously nobody's interested in our well-being initiatives because no one's going. Hmm. Must be that actually nobody needs that support. Everyone's fine. We'll stop doing them". And it's almost like a bit of a… and then the staff cry out "No, we need that stuff"…. And the trust kind of say well, "You didn't go to it last time, so..".* Participant 7 *And like there's lots of things that I feel like - for example sometimes around… things that I think get forgotten about or sometimes are quite tokenistic, like staff*

	wellbeing for example… Like sometimes there might be like, some initiative around it, and then it just falls by the wayside, or… staff aren't given any time to do whatever it is that they offer… and then it's like, well it's kind of pointless really then. Participant 2
	And the CQC came along and suddenly like, the day before, they instituted a working from home policy, where we all had to like sign in. CQC disappeared and so did the policy. Participant 1
Participants' perceptions of public ideas about the NHS	*I think a lot of it comes from the idea that it's nationalised and it's free for all… and it's always under stretch and it's always under pressure and it will always be available. But it will never be sufficiently resourced, and it can only ever get thinner effectively. So I think there's a whole public awareness of it. But also I just think where it sits within our culture, the way it's set up. The really good things about the NHS are also what make it difficult to work in.* Participant 6
	The perception in the public is that quality of life is always kind of going up, but actually, we can't really manage that. Social inequalities mean that that's not actually a lot of people's experience. And then I think some of those frustrations just get pulled into public services. Participant 6
	I think it's partly the sort of wider societal discourse… around the NHS… It's swung very sharply, I think, from NHS workers, being kind of lauded during the pandemic… this kind of discourse around NHS workers being heroes… It's very quickly just become quite sort of vitriolic towards NHS workers again, because the quality of care just isn't - it isn't good enough and the waiting lists are too long. And people are really angry about that, understandably… there's this kind of overarching societal discourse about the NHS. And the culture around that and the culture that the current Tory government have created, which really undervalues the NHS. You know, we don't deserve a proper pay rise. NHS waiting lists are too long. These are

		the messages… that the public are getting all the time, that make people think that NHS workers are lazy or greedy or… So there's that kind of wider societal culture. Participant 7
Motivation	Benefits of LE and disclosure	*I think it's given me a bit more insight into that side of things. Hopefully adding to that compassion and understanding… It's really valuable for me as a therapist to kind of know more about what it's like… and that's why I share it, because actually I think it's just enhanced my experiences.* Participant 3 *Because as a psychologist with lived experience of mental health problems, actually I do have more of a chance of understanding what my service uses have been through.* Participant 7 *I seemed to have quite qualitatively different relationships with people I work with, that [supervisors] can't quite put into words… I think there's probably an element of having been a service user and being a peer support worker that means I've probably got a bit of an idea as to how far I can push it… I think probably the service user side of me comes through, yeah, indirectly but directly, that probably creates the different relationship and a different connection, but it's quite difficult to put it into words and quantify what it is.* Participant 1 *In the team that I work with, when we're talking about [therapy] as a possibility I will sometimes share, you know, that I've had [therapy], that I found it really helpful, and the reasons why… Anything I can do to promote, you know, 'actually let's not just give them loads of meds, let's think about the therapies that can help', I want to do. And using my personal experience is part of that*. Participant 3 *I think I'm going to be doing some teaching on like risk and self-harm, and that's something I've got experience of, and I'll bring in my personal experiences.* Participant 1

Asking for reasonable adjustments	*I guess sometimes there are gonna be times when we don't have a choice about disclosure. If we need to have time off or we need specific adaptations. Umm, you know, you're then faced with the choice of either you quit or you disclose.* Participant 7 *And I think that definitely there's that feeling of – 'I can't take a whole day off for a therapy session. Not when everyone's so busy'. Even though it was kind of beyond my control, because there's no other time the therapist could do it… And I never even asked my manager about that. But that wasn't - that wasn't the supportive manager I've got now. This is the one before, who wasn't as supportive. And thinking back now, I think even now I don't know that I'd ask her.* Participant 3 *It's sort of like a charity that deals with sexual abuse, and I had - I went to read the case files to see whether I thought I could do that project. It was horrific. Again, there was no support to do that. There was no kind of debrief. And I said, you know, this really isn't for me. I'm going to struggle with this. And again, they were kind of 'I don't see what the problem is really'. And that felt really, really difficult then to say, well, I feel like, OK, sounds like it's a problem to me. That and that didn't feel OK. That was like, God, she… 'isn't she difficult' kind of thing.* Participant 5 *I feel like I would have thought that she thought I couldn't - it was, it was just being a bit too over the top… Probably make me - I feel like she would have said no, and she would've made me feel a bit stupid for asking.* Participant 3
Feeling forced to disclose	*So I haven't [disclosed] out of choice. I have, um, where I've kind of been quite unwell and so it's - I've had to kind of share… but otherwise I wouldn't.* Participant 5 *I guess sometimes there are gonna be times when we don't have a choice about disclosure. If we need to have time off or we need specific adaptations. Umm, you*

know, you're then faced with the choice of either you quit or you disclose. Umm. But I think… So even if that culture wouldn't necessarily stop people disclosing in that situation, if they needed to do it for a practical reason, it's gonna affect the way that they feel about the disclosure and the way that there is disclosure is responded to, right? Participant 7

Taking sick leave

Let's face the facts, you don't choose to work full time in the NHS for years and years without some level of dedication. That may not be a political view, may be moral one whatever it is. You don't do that without that level of commitment, and by virtue of that commitment, when you're on, you know your first episode of being signed off for more than a week, or whenever, you feel enormous guilt, obviously. Participant 8

I was kind of like "I'm letting the service down. I'm not supporting my young people that I'm working with. I just need to get back on it again". Participant 9

I feel like I'm letting them down and also know when I get back I'll need to pick it all up again, plus the waiting list will be longer. Because referrals are not going to stop just because I'm off. So it's more of a personal sense of, 'if I go off I'm going to pay for it'. Participant 3

There's a lot of culture around working when you're tired, that kind of, not taking sick leave, I think it's quite hard. Participant 6

There was an issue of that, 'if someone's off sick we don't cover them' which I think is often true in a lot of trusts. And I think that's a real issue, because I think then people feel… well for me it just feels like it leads to burnout. Because you get someone off sick, then someone else has to do double work, who then possibly goes off sick themselves. Participant 4

		You hear it in the office when someone's 'off with stress', as it's said. I think because someone being off then means that, their cases… that has to be shared out between the rest of them… You know, and then that turns into a bit of negative about, you know, stigma… so I think people definitely feel that, and also from the individual perspective themselves, the feeling of 'I know if I go off sick I'm going to make my colleagues work harder'. And I feel that. Participant 3 *If you have to be away for some time because you're depressed… what might that mean, in terms of how people perceive your ability to be available for them [the team]?* Participant 9 *…Ended up taking two weeks off of work and I think possibly what then saved me is, I then, I think I basically took myself back to work again and it kind of wasn't ever really spoken about again.* Participant 9 *I'm actually just making it harder for someone else who's already got a really tough job. Because there's just no stretch in the system, there's just no leeway. Everybody – it feels like everybody is at capacity. Drop anyone down, you're just stretching everybody else… And unfortunately when someone goes off, that can lead - it can automatically lead to some kind of ill feeling or judgement maybe about the person that's gone off.* Participant 3
Safety	Confidentiality	*[The supervisor] had talked to the course without telling me, because they perceived me as being quite anxious and they had contacted my clinical tutor without telling me that they were concerned.* Participant 9 *I did have a manager at the time as well, who wasn't confidential, so I like… I knew everyone else's business. I knew who was going for IVF. Who was doing this, who was doing that. Like, you know… it was just really inappropriate. So there's no way I*

	would have told her because I might as well have just stood with the microphone in the car park. Participant 5
	I've also had experiences with supervisors or managers or colleagues who I one hundred percent would never have told that I was struggling… because they would have not kept it to themselves. Participant 7
	No, it [confidentiality] hasn't [been a concern]. I guess that's probably testament to feeling supported, in a supportive team most of the time wherever I'm working. Participant 4
Relational safety	*I felt really safe with my supervisor, so every time he asked me how I was, it was like all of the pressure and hostility and cruelty and this horribleness from the rest of the working week I've been holding in, because I couldn't let it show that I was struggling, came out.* Participant 7
	I felt they treated me like a patient… I could readily identify, almost to the point of techniques, or you know, reframing or different sorts of interventions in our discussion… Which was, just to make it obvious if this doesn't come across on the text, extremely unhelpful, not to mention patronising. Participant 8
	He [supervisor] was really really nice and supportive. And he is really involved in staff support, like part of his job is doing this staff therapy clinic… so I don't know if that did bother me, almost I felt like I'll be going into the - I'd be blurring the boundaries between our clinical supervision and his other role which is where he gave - he provided therapy for staff. Participant 3
	I've always been really conscious of that how much can you talk - and obviously I want to talk about it and I encourage people to talk about the emotions of how clients make them feel, and how to work through that… when that triggers

difficulties that are linked to your mental health difficulties, I think I've struggled a bit with how much is okay to share. Participant 3

I think I wouldn't probably disclose to - I think I find it harder to disclose to people who – well, used to find it harder to disclose to people who were in a position of managing me, I guess. Participant 4

You are at similar points, you might be at same band, or whatever… because that's helpful I think, when… other people around you are also psychologists… particularly if you've got to know each other quite well… Those are settings I think I feel a bit more comfortable as well. Like on a, more of a peer level, I think. Participant 2

It's hardest for me in a way to disclose to other psychologists, because I would see them as being more competent than me when I'm feeling at my worst. Participant 4

Feeling safe, I think. Like, that feeling, feeling safe, feeling like you're not going to be judged, all that stuff… d'you know what I mean?... just feeling safe I think is a big one. Participant 2

…Quite quickly it became evident that there was a culture of psychological safety that made that quite possible to have that conversation around [disclosure]… Whereas I've been in teams before where I might know that person very well, but… it doesn't feel safe to have it - and I suppose "safe" being that it's possible to be vulnerable… But also for that to be seen as being… a valued behaviour rather than being worried that it would be seen to be a negative thing. Participant 9

I wouldn't have felt safe, to be honest with you. I would have felt quite vulnerable and quite open to… Yeah, I just wouldn't have felt safe. I didn't feel like we had that kind of relationship. I wouldn't have disclosed to the other psychologists either, 'cause I wouldn't have felt safe. Participant 5

		I wouldn't describe like, within the NHS that it feels very safe, or that they've got your personal interests like, d'you know what I mean? Participant 2
		It's about creating a culture where people feel safe enough to do that [disclose]... And I think that is what I do not get in the NHS… I don't think it feels like a very safe culture, to be honest with you, is it? I would say it is not generally, across the board, a very safe working environment. Participant 5
Feedback loop		*Yeah, I don't feel like I could go to my manager and say I'm having a hard time or I only... and you know, people did find that hard when I did disclose it and, yeah, well, it was not a good experience.* Participant 5
		I suppose my experience of saying that [disclosure] was, you know, when you can feel like people are having a double look at you. And I thought, I'm not saying that again… it didn't feel comfortable to me, so I did it once and I wouldn't do it again. Participant 6
Fear of consequences	Experiences of FTP processes	*They wanted to have [meetings] without me and then just feedback to me… I didn't really feel like that was OK… If I raised any questions around that, I was perceived as being quite critical of the process… It was horrible, to be honest with you… and I encountered quite problematic things along the way… on reflection, it made my mental health worse. It did. And then I ended up on kind of like formal fitness to practice procedures and going through a fitness to practice hearing, which was horrific… So I felt very voiceless. I felt powerless. I felt like I didn't have a say in the process. I felt kind of done-to, and I felt like I couldn't object really, so disclosure felt like a very painful and tricky process.* Participant 5
		…I haven't had to do that [fitness-to-practice proceedings], thankfully, because it sounds hellish. But that is, that is also something that's in the back of your mind all

	the time, isn't it? You just don't know when someone's going to misunderstand you or make an assumption that you're not fit to do your job. So that's also obviously a concern. Participant 7
	People have their concerns around how vulnerable, exposing… How it might be responded to… Things around fitness-to-practice with the caring professions, d'you know, when you share things like that… it's a very tricky position isn't it? Participant 2
	I think there was a worry that people would think I wasn't fit to do the job. I think fitness-to-practice was on my mind at times. That yeah, people would think that I wasn't. Participant 3
Experiences of Occupational Health processes	*There's all sorts of proceedings where parties from HR or whoever… are involved, and one has to have meetings with these parties… where people that they've never met, who they were never introduced to, whose role is ambiguous at best - are sitting in a room with all these parties, and told to go into great detail how, you know, [personal tragedy] affected them, the symptoms… one is asked to give more and more personal - pressure to give more and more personal detail.* Participant 8
	To ask the pragmatic question - a purely utilitarian NHS point of view - is it a good use of money for several parties to be involved in trying to explicate the nuances of someone's distress? Participant 8
Permanence of disclosure	*Once you've uncorked that conversation, you can't put the genie back in the bottle again. It's like, "God, I'm forever gonna be, you know, seen as being not capable"… So I think what would happen, there was the part of "Oh God, I can never think about disclosing"… because if I did, I'd kind of be, you know, marked.* Participant 9

		And it's not on my record… Every time you have to go to occy health, would you have to kind of go 'Oh, yeah, actually, I've had a diagnosis of…'? I don't want that. Participant 6
Local factors and dynamics	Relationships with colleagues	*I've got some [colleagues] who have made me feel… so cared for, so supported… I'm talking about my relational, my interactions with them and them just being wonderful human beings… I definitely feel it's about having a good relationship with the person, and the quality of that relationship.* Participant 2
		He's very, very, very like, just a really nice man, who's very supportive, very caring… So it was actually, that [disclosure] was a very positive experience. Participant 7
		I speak to people who I think might understand it, people I'm friends with. Participant 4
		There were some team members I really got on well with, and actually it was interesting, it [disclosure] brought me closer to them. Participant 4
		I… didn't know anybody in the team, and the team really didn't make an effort to get to know you, you know?... It would be a pretty isolating experience, and I suppose I didn't really like those teams… People were just really really busy, and so if you didn't have a reason to talk to them, often they wouldn't talk to you. Participant 1
		What I find really interesting is that you can have really, sometimes really raw conversations with colleagues, because of perhaps something that's happened within a session or… and yet actually you might not know much about their home life… you might never socialise with that person outside of the work…. I think one of the really interesting aspects of working the NHS… is that you simultaneously know a lot about people but also not a lot about people. Participant 9

Individual differences in manager	*I've worked in teams before where the managers have not been as supportive, and the morale in the team just feels really really low, and there's lots of sickness.* Participant 3
	The team manager… is placed under enormous pressures, to what the culture, I suppose, fosters and what the culture allows and permits. Which then strays into not only the more quotidian aspects of projecting that into those you have power ove… but also into bullying, harassment, sexual abuse. Participant 8
	Having a supportive manager is such a big deal. It can make a real difference, I think, depending on who your manager is, how supported you feel and how willing you are to talk about how you are... I think it really depends on how human your manager is, as to the team culture as well. Participant 7
	In any kind of workplace it might depend on who manages you, or who's around you. But it's just it's one of those odd ironies that… when you specifically work in mental health services, it just always takes me aback, just the difference of experience of how you can talk about mental health is just huge. Participant 9
	I think it comes down to managers… 'cause the same team can be quite different depending on who the manager is. Participant 1
	I think it definitely varies between teams. And I think that's very much to do with the manager… The teams I work in - their well-being is as good as it can be, given the wider culture, because they've both got really supportive managers. Participant 3
	She [manager] was just… I don't know if uncaring is too hard a word. I know other people struggled with her when they were off sick... I knew that other people hadn't been necessarily treated particularly sympathetically by her when they had health

problems… She just felt very… managerial? Like corporate-y? Rather than that she was necessarily on the side of the staff. Participant 3

And that [discriminatory action] wouldn't have been intentional, you know? I mean an intentional thing, it's just probably, the manager is really busy. Participant 2

What are their [managers] options?... What is the stressed ward manager to do? Or the consultant clinical psychologist in the team? They've been told "do this, or else we shut down the department". Participant 8

There does seem to a culture in the NHS of feeling like you can never do enough… I suppose that makes it quite difficult… for maybe your managers to think about your own needs… because they are focused primarily on targets and waiting lists… They're more focused on that stuff than on staff well-being, I think. Participant 7

Managers feel so overworked that they don't have, like, the capacity to kind of take that on… I get the impression that it's because they don't have the space for it. Participant 5

I can see pockets of like really good managers say, that are able to kind of like hold a team and hold the kind of anxieties and things like that within the workplace. But often at real detriment to themselves. Participant 5

Our team lead for example can be saying 'don't worry about KPIs, don't worry about breach dates', but the wider Trust will be saying to him probably 'you can't breach', so he's having to hold that. Participant 4

Where I've had more positive experience it's been very around, like, specific line managers I've had, who have been amazing… rather than that wider kind of culture as the whole Trust. Participant 2

		My two current managers… definitely feel like they've got a really tough job. I feel a lot of empathy for them, and I feel like they're really wanting to look after their staff, and the messages are definitely coming from kind of chief exec or the board and everything… [Manager] almost like apologetically… I'm not sure if that's the right word, but when like caseloads are going up and when there's a waiting list, she's like '…I'm sorry to share this news', and you feel like she's with the team. Participant 3
		I feel locally, I've got that that license to be the leader that I feel is… needed… whereas at the kind of wider level, I'm being made to feel that I can't be the leader that I want to be. Because it needs to be a certain way of doing things. Participant 9
Stigma	Self-stigma	*I think people have encountered stigma, people have had horrific experiences and I'm not discounting that. But I do wonder how much there is an element of self-stigma that goes alongside.* Participant 1
		I think the resistance to disclosing, the pressure not to. I'm sure stigma plays a huge part of that. Participant 8
		I feel… within the system, there is something still quite marked about… shame involved in disclosing mental health difficulties. I think it happens all the time. Participant 9
	Stigma from colleagues	*There were team members who were quite stigmatising and a bit cruel about colleagues who weren't coping with the workload.* Participant 7
		If people are seen as more stressed by different scenarios, that that is criticised and they're seen as an unreliable team member… it's seen as, that weakens the team. Participant 6

	It might be that some people come from… cultures where… it's much more normal to talk in a very sort of stigmatising way about mental health problems. And… they can bring that with them, right? They can bring that language. They can bring those attitudes about people with mental health problems. Participant 7
	I've worked in teams where there's been quite a lot of black humour used… and you know, some stigmatising comments come out and things like that… I think actually that can make it really really difficult, if that team is completely comprised of that, to… be open about it. Participant 1
	I was sent off to occupational health… And I said '…I haven't had this problem since I was 18… would I be a risk or…?' and she said 'Oh no, it's we just don't want people that are gonna be like the next Beverley Allitt". Participant 5
	I've had experiences with… colleagues who I… would never have told that I was struggling… because they would have thought that meant that I was bad at my job. Or that I couldn't cope with my job. Or that I was a looney. You know, it's kind of stigma- stigmatising language. There's something wrong with me and that I wasn't fit to work. People have very strange ideas about, even things like depression. Participant 7
Societal stigma	*…The kind of societal culture around ideas about mental health and stigma… NHS culture, and our working lives, are within a context of societal stigma around mental health problems.* Participant 7
	I think a lot about the wider, the wider culture of labels and understanding for different difficulties, I think, and the potential shame around some of them… I think it almost feels like there's a sliding scale of acceptance for me, and that affects what people talk about. Participant 4

Identity	'Clinical Psychologist' identity	*I suppose again, part of being a clinical psychologist particularly is the… the competition? The competition to get into the profession is so enormous. You have to be perfect on paper. Being perfect on paper means not disclosing that you have a flaw or a difficulty or a problem, or that you struggle with something. Because if your application has a flaw, which the next 36 applications don't have, you're not going to get through. You're not even going to get an interview.* Participant 7 *I wonder whether or not if as a profession we're quite perfectionist, quite driven, we kind of have to do this, we feel like we have to keep up appearances, we have to keep up standards, and therefore having a flaw can be quite difficult to have.* Participant 1 *I think we're seen as competent and I think there is a pressure to keep up that sense of competence. I think probably more than other professionals, you kind of get trained into the idea that you're gonna be able to hold your head when you're working in scenarios where the whole team is struggling… somehow we're going to walk in and deliver some kind of plan for that team. And I think that relies on the idea that you can maintain your coping more than other professionals. That we will be calm when the teams not.* Participant 6 *I guess there's something about being a psychologist, right?... Other people's ideas about what a psychologist is, what a psychologist should be, what a psychologist can do?... And also that we're supposed to be stoic and unemotional… This idea that we're very calm and put together… Quite blank… Not affected by anything.* Participant 7 *I think psychology is a fairly niche profession, it's quite difficult to get into… A lot of people don't know what clinical psychologists do, or if they do, they think we can read minds.* Participant 1

I think that [psychologists] are generally rewarded for being productive, quiet, compliant and appearing to have it all together. Participant 5

We're kind of like, you're invulnerable or immune to… You know, as though we won't struggle and we'll have all the answers and… Yeah. You know, certainly in my kind of experience, people have said like well, you know, 'you know CBT'… but it is this kind of idea of invulnerability. Almost as though we have it all together… And I think we're very good at presenting in that way, you're kind of like, 'yeah, we're all OK here', but, you know, we're drowning really. Participant 5

So I think in terms of the impact of NHS culture… I think both management and our colleagues look to us as, we are the people to contain. We are the people who help. We're the people that you can go to, and that's brilliant. But I think that that comes with it, this idea that we're kind of untouchable. As though we don't, we don't have our own issues, or if we do have our own issues, we just fix ourselves, because that's what we do... I wonder whether it might be harder for psychologists… than other mental health professionals, potentially? Because we are seen as kind of having all the answers. We are meant to be able to help other people who have these problems. And if we can help other people who have these problems, then we should be able to help ourselves. Participant 7

When COVID kind of hit, they set up this sort of… so the psychologists offered an on-call rota to the rest of the Trust, and I remember saying, well, where do psychologists go then? And it's like, 'yeah, we haven't thought about that'. And they didn't think about it. You know, they just didn't. Participant 5

It's very much seen as the remit of clinical psychologists within a team to look after the rest of the team. And that's kind of placed on them by management I suppose. And I - on the one hand, you know, it absolutely is part of our remit, or it can be. But

it also means that if the clinical psychologists are looking after everybody else, who's looking after the clinical psychologists? Participant 7

I've had people say to me things like, "well, you wouldn't understand because you're a clinical psychologist", as though I would be immune. Participant 5

You should be able to 'psychologist' your way out of this. Participant 9

I feel like I should be able to sort of self-fix it… they said 'oh just CBT yourself out of it'. Participant 4

Professionally as a psychologist… It's almost like I feel a bit ashamed. Participant 5

You can't be a good psychologist if you've got your own difficulties that you can't think your way out of. And that you won't be perceived as being competent at your job generally… That's how I was made to feel… that I should have had a set of skills that would have derailed what I was experiencing into being more manageable. Participant 9

There's an additional barrier, because you feel like if it's your job to do this for other people, it makes me feel like I should be able to do it for myself, but also makes me feel like I'm not good enough at doing it for other people. Participant 4

I think there's this idea that psychologists can't have their own mental health problems. Because if they did, then they couldn't possibly be good at their job helping other people, could they? Participant 7

'Well what if I don't feel contained today? Can I contain people?'. And I think I've proven to myself that I can. Participant 4

Perfectionism	*This career is going to appeal to people who have perfectionistic tendencies, right, because we know that we can, we can do that. We can put that front on at least. But that means that it's very difficult for us in our qualified lives to turn around and say, "well, actually, I do really struggle with this, and I'm not perfect and I'm, you know, I'm probably not the best psychologist in the world, or even in the team". Umm, but you have to almost pretend to be, right, to get onto the course. And it's difficult to shake that off, I think.* Participant 7 *I wonder how much perfection is linked mental health difficulties, so like for example things like anxiety and things like this, which I guess is a fair proportion of what psychologists go through, well if you're feeling quite anxious and… therefore maybe feel embarrassed about how people think about you, and you're a bit perfectionist which means you quite driven, possibly then disclosing… is going to be like 'urgh'.* Participant 1
Dual identity	*I think there's something about the culture of… as a mental health professional, having a mental health diagnosis… I think it's quite hard.* Participant 4 *I think there's something about being a psychologist where you are like, often the container, aren't you? I feel like, you contain a lot of the other stuff so… that's often your role, isn't it? It's holding. Whether that's client or staff or service, or… You do a lot of holding emotional stuff, don't you? So often, your stuff has to be way out of the way… there's not really any room for it when you're carrying everybody else's.* Participant 2 *I always resist from identifying myself in those [social media groups] as either a person with lived experience or as a clinician. Because I feel like they clash. Like I don't know which one I align to more, if that makes sense?* Participant 3

I run a participation group… and basically the agreement is that I will disclose to the young people I work with that I have lived experience… Now I'm working there and obviously there's the kind of clash where some of these people I case manage, might be doing therapy with, things like that… so encountering them in one setting and then kind of having to kind of do more therapeutic work… what would that be like? Participant 1

My mental health difficulties haven't been lifelong or since I was young, so I always feel like I'm a psychologist first. I don't know how much difference that makes for how I identify, whereas I know for other people who had mental health difficulties first and used mental health services, and then have gone on to do the training… they were a person with lived experience first, and that almost motivated them for training. Participant 3

It feels a bit unfair that I have all of this expertise as well, right? The service user expertise I mean. But that's kind of being denied. I suppose maybe I feel a little bit envious that peer support workers are allowed to use their expertise as ex-service users or service users, and I'm not. Participant 7

I think [the peer support movement] does miss the fact that there are already some people working in services who are users of services… There's something about going and asking staff who already work there, who want to identify as and want to share and want to get involved in those kind of things. Because I don't think there have been. Participant 3

I worry… that the peer support movement kind of neglects mental health professionals who are also service users. It kind of denies their existence… Because it's - what a peer support worker is doing… is to say, those people over there, those professionals, cannot and do not understand the service user perspective. Participant 7

	I think there's also potentially such an othering of people with mental health needs. That it's kind of talked about as if 'that couldn't be us', and any confusion around that boundary is problematic. Participant 6
Seniority and pay	*Now I'm in a more senior role in my team, I feel more confident in my role in the team… I have more power in the team. I feel that's a good position to share that I've had therapy and actually found it really useful.* Participant 3
	I think also the further you go into your career… the kind of seniority that you get to, that you're at, can have an impact… on how safe it feels to disclose… There's a certain ethos that… when you are up the chain… there isn't very many people you can have these conversations around. Because there's this kind of idea where… you're a consultant now… you basically need to get a handle on this. Participant 9
	I think I would find it really difficult to disclose further on, if I hadn't disclosed at the beginning [of my career]… I think it becomes a much bigger thing to disclose. Participant 1
	I think because you're higher-banded member of staff you do carry a bit more of a position of power. Participant 2
	A big part of my impostor syndrome as a psychologist, is that we're really well-paid. Participant 4
	For me, there's often a sense of guilt that you're earning a lot of money in the NHS, you're on a high band, you're kind of being given a relatively high income from the NHS. Participant 6

	[Disclosure led to] sort of questioning my professional competence, but also it raised a doubt in my mind because of course, no matter what band you are, you are human. Participant 8
Imposter syndrome	*To become a psychologist is not a straight-forward profession, and therefore once you're there… they talk about imposter syndrome… so any form of weakness becomes difficult.* Participant 1
	[Disclosure] triggered all of these underlying feelings of… 'what am I doing in this job?' and you know, 'another psychologist would be doing this so much better'. Which you know, is a totally normal feeling, I think this job is right for imposter syndrome. But it made it unbearable. Participant 4
	I work all the time with support workers on minimum wage who do stuff that I could just not do. Constantly dealing with clients, and we're saying to them 'be consistent' you know… just I could not do it. Who are paid pittance. And that doesn't feel right. And I think for me, that's a massive part, a big part of my impostor syndrome as a psychologist, is that we're really well paid. Participant 4
Family of origin culture	*I guess in terms of culture around that, I think it's your own personal kind of family culture, of what it's like talking about your personal experiences, and self-disclosure, and your own mental health.* Participant 4
	I suppose everybody in the NHS, including me, and including my managers and my colleagues and my supervisors, we all come with cultures, don't we? We all come with, um, kind of potentially ethnic or religious cultures? And we all come with family cultures, and the way that we were brought up… I've got colleagues who grew up never talking about their emotions, ever, like it… it just wasn't something that came up at all at home… And that's a very different culture to have been brought up in. Participant 7

	Your individual cultures are gonna play a part, aren't they?... In terms of like, I don't know, your family experiences, and how that's been promoted when you've been growing up, whether it's OK to talk about lived experiences. Participant 2
Hope for the future	*I hope that it changes… I think in psychology like, there is a recognition like - this will be why you're doing the study - like that there is a big proportion of psychologists that… you know what I mean? And I think it is trying to be promoted through training, so maybe that will filter through into psychology generally. But that it's a bit more promoted that it's OK to talk about that stuff.* Participant 2 *I would not have felt OK to talk about my mental health difficulties at work. I feel like it's very much part almost of the culture, though I think that is shifting. I think that is becoming different with a newer wave of people coming through, but certainly I feel like when I trained, when I qualified, there was no scope to kind of think about any of those things.* Participant 5 *It's more and more talked about on DClinPsy programs these days. There's, people are doing research on it.* Participant 8 *I think generally there is more spoken about it. Like in kind of my age group, for example, my kind of wider community outside work… I'm on kind of Twitter and things, and I think that can be really really compassionate, kind of honest, open… really normalising of that.* Participant 3

Appendix L – Excerpts from research diary

January 2021
Really helpful project meeting with Sue (Holttum) this morning as a potential supervisor. She has an interest in the topic and has supervised similar projects before. Had loads of ideas that I have tried to jot down. Very excited.

January 2021
Sue has said she can't take my project on. Back to the drawing board.
Fergal has offered me a supervision slot. Trying to decide if this is sensible – Fergal doesn't have any background in the topic, but will be very knowledgeable about the research methods (which, at the end of the day, is the thing I know least about). It may be my only option. Can I embark on this project with a supervisor who doesn't have an interest in my topic?

February 2021
Trying to find an external supervisor with more interest in the topic. Natalie Kemp (In2Gr8) unfortunately not able to provide supervision/consultation as there is no fee. I'm now looking at doing this project with no external supervision. I've got a lot of reading ahead of me.

March 2021
Writing my proposal. Reading lots about organisational culture – who knew there was so much! Very helpful to have some ideas about how to conceptualise and research 'culture' – it appears to be a *perception* rather than an objective truth which can be measured.

November 2021
Ethics application. Hit a bit of an ethical snag. One of the main concerns for this population is fitness-to-practice – and this is likely to put people off participating, understandably. But it *is* possible that disclosures could be made at interview that flag concerns about fitness-to-practice. So it's important that I include a warning about this in my PIS. But warning about it is going to put people off even more… I don't see any way around it. It basically means I'm excluding any participants who might be concerned about fitness-to-practice. How much am I going to miss by not capturing these experiences!?

December 2021
Trying to cover all my bases by getting Salomons Ethics approval and HRA approval, even though I'm not recruiting via the NHS. Because the project is about 'NHS culture' Fergal felt it might be sensible to get HRA approval just in case. It's a weird situation, and I've been emailing back and forth with analysts at the HRA. They've basically come back and said 'you don't need this, but we can give it to you if you're bothered'. Thankful I don't need REC review.

June 2022
Five interviews down, and trying to get stuck into analysis. Finding it really hard to dip in and out of the data with a half-study day here and there. Spending a good 30-45 minutes every

time reacquainting myself with the data and vocabulary, and to remember what my existing codes are, sometimes with a few weeks in between analysis sessions.
Interviews have largely gone well. I have been collecting further demographics at interview – age, gender identity, ethnicity. Now hoping to get a bit more coding done before tweaking my interview schedule (theoretical sampling) for a further few interviews over the summer. All participants so far are white middle class women in their 30s. Need to try to recruit more diverse sample. Perhaps this speaks to the increasing movement of younger psychologists speaking out about their MH? Where are the older psychologists? Also - recruiting via social media likely to influence target audience. Are there other professional networks I could access older/male/ethnically minoritised psychologists? Will investigate.

August 2022
Carving out a topic for Part A. No one has reviewed workplace self-disclosure among psychologists. I think this is probably because there just isn't enough research out there – maybe 4 or 5 studies? Need to expand this to make it a big enough review. Psychological professionals (this could include counsellors, CBT therapists, family therapists etc…)?

September 2022
Still struggling to recruit a more diverse sample, having contacted BAME psychology networks and having specifically targeted male psychologists. Had a chat with both Fergal and John about recruiting a wider sample. Both had helpful ideas. I think it's likely that it just feels really unsafe for minoritised psychologists to talk about their LE (in an environment which probably already feels really unsafe). Ideally it would be nice to set up an anonymous online survey, but 1) not sure I have time now and 2) other studies which have done this (there are a couple in my Part A) actually couldn't comment on demographic differences either, so what would this add…..? Perhaps this will just be a significant limitation of this research and a future direction.

October 2022
I've discovered the Disclosure Processes Model (Chaudoir & Fisher 2010) in my research for Part A. It's a really helpful way to model self-disclosure, and I think is really applicable to what my participants have been telling me about their disclosures. But it doesn't seem to take environment into account to any great extent. Hopefully my research will be able to shed some light on the processes within the environment which might have an effect on disclosure.

February 2023
Read Menzies-Lyth as it's come up a lot in teaching recently. It's very reminiscent of a lot of the things my participants were telling me about NHS culture, about the pressure, the constant restructuring, the endless initiatives that never seem to achieve anything…

February 2023
I've spent today memo-ing 'NHS culture' (memo: cultures on cultures on cultures). I feel very attached to this diagram. It really feels like it captures the culture(s) my participants were talking about. Now to work out how to also diagram the psychological processes within it…

March 2023
Menzies Lyth stuff coming up again and again. I'm not sure how much to make of it – I imagine all of my participants have read it at some point, and therefore their experiences and perceptions are likely to be shaped by it. Perhaps it's just a shared language rather than an emergent phenomenon.

March 2023
I'm noticing, as I write up my findings, that quotes from Participants 6, 7, 8 & 9 seem to be coming up more frequently than the first 5. At first I thought this was a problem, but actually I wonder whether it just means my theoretical sampling (via adapting the interview schedule) has been helpful... because my questions became more focused on the emerging theory, and therefore their responses were more relevant to my theoretical categories? Perhaps this isn't such a bad thing after all.

March 2023
So much of the richness of the data is lost in trying to condense it into 8000 words. My initial draft of the Findings section was nearly 12,000 words. I've tried to do the data justice by staying as close to it as possible throughout, but so much of it feels lost. I've had to delete really valuable quotations and condense them into 5 or 6 words of prose, which doesn't feel authentic or fair to my participants.

March 2023
I've cut Part B down to 8000 words now. So much is lost. I hope it still makes sense. I've had a similar problem in my dissemination to participants – I want to remain faithful to their experiences, but it's very hard to condense them into 2 sides of A4. I hope they'll understand.

April 2023
Doing a little bit more stream-lining ahead of submission. There's further synthesis that can be done within the model, particularly in the domains of 'safety' and 'identity'. Fergal and I have noticed that some of the sections in my findings are quite a lot shorter than others – perhaps this means they might benefit from further synthesis, maybe with other sub-categories? Categories like 'psychological safety', 'disclosures in supervison' and 'disclosure recipient' all speak to some aspect of the relationship between discloser and recipient. Is this speaking to something about relationship safety? And is this separate from 'local dynamics and team factors?'. I think the latter refers to an overall team culture, whereas 'relationship safety' refers to interpersonal relationships (1:1). Similarly, 'seniority' and 'pay' seem very linked (and are both very short sections). Initially I had them separate, as there seemed to be a difference between seniority (e.g. management positions *within* the profession of psychology) and pay (being well-paid as a psychologist in AfC). Participants didn't talk about the influence of moving up a band *within* psychology – only the banding of psychologists above other MH professionals. But I wonder whether they are both speaking to power and hierarchy, and therefore belong together?

Appendix M – Submission guidelines for the Journal of Clinical Psychology

1. Submission and Peer Review Process

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