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“I think it does just opens it up and... you’re not hiding it anymore”: Trainee Clinical  
Psychologists’ experiences of self-disclosing Mental Health Difficulties

Running title: TRAINEE EXPERIENCES OF SELF-DISCLOSURE

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## Abstract

Self-disclosure of experiences of mental health difficulties is a complex process, particularly within the workplace. Research shows that a significant number of trainee clinical psychologists have lived experience of mental health difficulties and thus face the dilemma of whether to disclose and how to manage self-disclosure during doctoral training. Grounded theory methodology was used to explore trainee experiences of self-disclosure of mental health difficulties during training. Twelve trainee clinical psychologists from accredited doctoral programmes in the UK participated in semi-structured interviews about their experiences of disclosure. Six core categories emerged relating to 'motivations', 'enablers', 'barriers', 'features of disclosure', 'responses' and 'impact', each of which were comprised of several further sub-categories. The model that emerged is largely consistent with research on disclosure in healthcare professions and has implications for training programmes, supervisors, and trainees when engaging in conversations about lived experience.

### Practitioner Message:

- Many trainee clinical psychologists with lived experience of mental health difficulties experience the dilemma of whether to disclose this during training.
- A model of trainee self-disclosure emerged which suggests that there are important enablers and barriers that facilitate and hinder this process.
- Furthermore, self-disclosures of this nature, when managed supportively, can have powerful impacts for trainees and their wider network.

**Keywords:** trainee clinical psychologist; self-disclosure; mental health; lived experience

## Introduction

It is estimated that in the last week, 1 in 6 adults will have experienced mental health difficulties. Half of such difficulties will have developed before the age of 14 (Office for National Statistics, 2016). Trainee clinical psychologists are as likely, if not more likely, to experience mental health difficulties than the general population (Brooks, Holtum & Lavender, 2002; Cushway, 1992; Pakenham & Stafford-Brown, 2012) and individuals with personal experiences of psychological distress may be drawn to such careers (Aina, 2015; Murphy & Halgin, 1995; Smith & Moss, 2009).

There has also been increased recognition in moves towards compassionate leadership and valuing of lived experience in mental health professionals training, with its integration into reflective practice and teaching (HCPC, 2017; In2Gr8MentalHealth, 2020; The Kings Fund, 2017). However, there is more work to do to facilitate its application within the curriculum, research, or clinical competence development.

Although health professionals may recognise the relevance of their lived experience to competence development, many experience a dilemma as to whether or not to disclose information about their personal experiences of distress, and if so, how much to disclose and to whom (Waugh, Lethem, Sherring & Henderson, 2017; Valley, 2018). A model which aims to explain the process of self-disclosure of stigmatized identities as a whole is the Disclosure Processes Model (DPM; Chaudoir & Fisher, 2010). The DPM posits that antecedent goals (either approach-focused, or avoidance-focused) will impact the disclosure event. The disclosure event includes the content of the disclosure and response of the receiver, which in turn has mediating effects (such as changing social support, alleviating inhibition or change perceptions of those involved) which then impact long-term outcomes at individual (psychological, behavioural and health), dyadic (liking, intimacy, trust) and social levels (cultural stigma and norms for disclosure), which in turn impact the likelihood of future disclosures. The DPM is hypothesised to capture a universal process of disclosure. However, some factors require further consideration, for example, the DPM does not account for contextual factors that may facilitate or inhibit disclosures and does not appear

to consider how one's professional identity and values may influence disclosure (Chaudoir & Fischer, 2010).

Research in clinical psychology around self-disclosure in the supervisory relationship has found a number of themes that appear somewhat similar to the DPM that may help explain how self-disclosure happens within this context. For example, Spence, Fox, Golding and Daiches, (2014) used grounded theory methodology to investigate qualified clinical psychologists' self-disclosure in supervision and found four core categories related to 'setting the scene'; 'the supervisory relationship'; 'using self-disclosure'; and 'reviewing outcomes of self-disclosure'. Further research concerning trainee self-disclosure in supervision has also highlighted that a perceived good or trusting supervisory relationship may facilitate disclosures (Mehr, Ladany & Caskie, 2010; Lemoir, 2013; Staples-Bradley, Duda & Gettens, 2019).

A recent survey by Summers, et al., (2020) shows that psychological practitioners may be an at-risk group for experiencing low well-being in the workplace. Indeed, research has found 92% of the psychological practitioner workforce found their job stressful at least some of the time, with up to approximately half reporting recent feelings of depression (Dosanjh & Bhutani, 2017). Hughes et al., (2016) argues rates of psychological distress among healthcare staff are increasing; however, stigma, anxiety over confidentiality, and fear of negative impact may prevent staff disclosing. In clinical psychology, it is estimated that 62.7% of clinical psychologists have experience of mental health problems (Tay, Alcock & Scior, 2018). Furthermore, the main reasons for non-disclosure were concerns of negative judgement, having a negative impact on career and self-image, and feelings of shame. In partial support of this, research has found that 67% of trainee clinical psychologists reported past or current experience of mental health difficulties (Grice, et al., 2018). Stigma was a concern, but findings suggested that trainees may weigh disclosure based on perceived value and need. The current study thus aimed to investigate the process of self-disclosure of lived experience of mental health difficulties of trainees.

## Methods

### Participants

Twelve trainee clinical psychologists were recruited from accredited Doctoral Programmes in Clinical Psychology throughout the UK. Participants were recruited and interviewed consecutively.

### *Inclusion and Exclusion Criteria*

Inclusion criteria were that participants were: (1) clinical psychology trainees on accredited DClinPsy courses in the UK; (2) not currently experiencing significant difficulties with their mental health impacting social, personal or occupational functioning; plus had (3) experience of disclosing information about their lived experience of mental health difficulties to peers, supervisors or tutors during training; and (4) could describe the process of disclosure of a mental health difficulty that was either historic or ongoing. Significant difficulties with mental health were operationalised as current interruption of studies, and difficulties such as current self-harm and/or suicidal ideation.

### Measures

#### *Demographic Information*

A short demographics questionnaire was used to gain participant information to situate the sample. Questions captured both course and participant characteristics including the nature of lived experience, type of mental health difficulty/difficulties and its onset and current status and significance (such as resolved, recovered, ongoing, managed etc.)

#### *Interview Schedule*

An interview schedule informed by the literature on self-disclosure of hidden identities was designed to investigate how and why the disclosure took place and what mediated the

disclosure. The DPM (Chadoir & Fischer, 2010) informed the questions to some extent in order to examine elements of the process.

### *Well-being*

The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) was applied after the interviews as a measure of well-being in order to situate the sample and screen the current well-being of those taking part. In line with ethics and good practice, the SWEMWBS was also used for quality assurance, to inform debriefing and screen participants' well-being status.. The SWEMWBS has been shown to be validated in general and psychiatric populations, with good psychometric properties (Fat, Scholes, Boniface, Mindell & Stewart-Brown, 2017; Vaingankar et al., 2017).

### Design

The current study utilised a qualitative research design. A series of semi-structured interviews were conducted via Skype. Interviews were conducted until new themes ceased to emerge, indicating theoretical saturation. The interview schedule was designed to elicit perceptions of disclosing mental health difficulties to peers, supervisors, and tutors while on training, including how and why such disclosures arose and how they were managed. Interviews were recorded, transcribed, and analysed by the author. A grounded theory method (Charmaz, 2000; 2006) was used to develop a theory about how trainees approach and manage disclosures and of those factors which might precipitate or inhibit disclosure of lived experience to psychology colleagues during training.

### Procedure

#### *Pilot*

To refine the procedure and materials a qualified clinical psychologist with experience of disclosing mental health difficulties during training gave feedback on the consent form,

participant information sheet, poster advert and the interview schedule. Minor amendments to question delivery and content were made based on feedback.

### *Recruitment*

A recruitment email (which included ethics approval information) was sent to consenting courses which contained a poster advert inviting interested individuals to email the researcher. Social media was also utilised to disseminate the poster advert. Those who enquired about the project were sent an email with the participant information sheet and consent form. On return of the consent form, a time suitable for interview was scheduled. The drop-out rate between enquiry and participation was approximately 57%.

### *Interviews*

Interviews were conducted via Skype, following guidance to ensure quality of qualitative interviews online (Seitz, 2016). Interviews began with explaining the study again and reminding participants of confidentiality, consent conditions and safeguards. On obtaining consent, basic demographic information was elicited, audio recording began, and the interview commenced. The researcher used the interview schedule and prompts as required. At interview conclusion participants were given the opportunity to ask any other questions and the audio recorder was stopped. The researcher then invited participant feedback and checked well-being both verbally and through the application of the SWEMWBS. A debrief form was emailed to participants after interview.

### *Ethical Issues*

Ethical approval was granted by Cardiff University School of Psychology Ethics Committee. Confidentiality was ensured by storing participant identifiable information separately to raw data. All electronic data was stored securely using password protection, and hard copies of data were kept in locked storage. Identifiable information was omitted from audio



recordings at the point of transcription, and gender-neutral pseudonyms were allocated to participant interviews.

### Data Analysis

Audio recordings were transcribed verbatim and a grounded theory approach was used to analyse the data. A constructivist approach was taken (Charmaz, 2000; 2006) as the author aligned with ideas that reality is socially constructed and that the researcher will have a particular position which informs what is found, rather than seeing the data as an objective, observable truth. The researcher began with re-reading each transcript before line-by-line coding, followed by focused, selective coding to find core categories. Memos were used to help the researcher compare data and help make sense of emerging codes and categories. Finally, categories were compared using memos and modelled pictorially to facilitate theoretical coding and build the model. Data was analysed using NVivo version 11 qualitative analysis software.

### Quality and Rigour

Quality assurance was considered through adherence to Yardley's (2000) principles pertaining to 1) sensitivity to context, 2) commitment and rigour, 3) transparency and coherence, and 4) impact and importance. Thus, the researcher engaged in methods that would facilitate these. Reflexive bracketing was used through discussion with other researchers and a reflective journal (Ahern, 1999) to consider personal, socio-cultural, and research contexts (El Hussein, et al., 2017). A personal position statement was created for consideration of sensitivity to context and transparency. The process of analysis was documented, including use of memo writing and excerpts, and direct quotations are provided to demonstrate transparency and evidence themes (Street, et al., 2016). The researcher fully engaged in the data through interview, transcription, and analysis processes, exhibiting commitment. A way to situate the sample was used, and theoretical saturation was felt to have been achieved, both of which help demonstrate rigour. Grounded theory was chosen as the methodology as it was felt to fit well with the questions

posed in the current study, thus exhibiting coherence. Concerning importance and impact, anecdotally several participants commented on the importance of the current study but mainly, this will be determined by the contribution to the research in self-disclosure, and the usefulness to clinical psychology as a profession.

## Results

### Demographic Information

Twelve trainee clinical psychologists took part in interviews (Table 1). Interview lengths ranged from approximately 24-83 minutes (M = 42 minutes).

All participants described difficulties that had onset prior to training including anxiety (generalised, health anxiety, panic, and specific phobia); low mood and depression; emotion regulation difficulties; trauma, complex trauma, and Post-Traumatic Stress Disorder; self-harm; suicidal ideation and behaviour; and bipolar disorder. Individuals described the current nature of difficulties in a variety of ways including ongoing, intermittent, or cyclical; resolved or recovered; managed or well-managed; or 'having made peace with it'.

Results from the SWEMWBS showed that participants' well-being was comparable to that of the general population. No participants exceeded the cut-off for probable depression and anxiety (Shah et al, in press).

### Theoretical Model of Trainee Self-Disclosure

The data from interviews was analysed using Grounded Theory (Charmaz, 2000; 2006). Table 2 describes the six core categories and subcategories that emerged.

## *Motivations*

Trainees reported they were motivated to self-disclose for a variety of inter-related reasons including to gain support or understanding, to discharge a duty or to influence narratives about mental health difficulties, which were captured in the sub-categories 'feeling the struggle and needing support', 'being understood', 'professional values and duty' and 'influencing narratives'.

### *Feeling the struggle and needing support*

Trainees felt the need to disclose because they needed support to manage active difficulties. For example, many trainees spoke of disclosing because they needed to talk, needed additional support, or needed something to change in order to continue with work and training.

*Chris: I didn't want to stop work, but if I wanted to continue the work, it felt like I'd need to, like be able to go in and talk to someone. Tell them about, tell them what was going on kind of, you know having a cathartic conversation, in order for me to kind of get back out there and carry on.*

### *Being understood*

Trainees were also motivated to be better understood by others. Some trainees spoke about feeling disclosure would be helpful for others to see that 'side' of them, to feel better understood and prevent people misattributing difficulties to personality flaws or other negative attributes.

*Rowan: ...obviously I spend a lot of time with the trainees, on teaching days um and socially and things so it felt like they could understand me a little bit better um and just had a bit more knowledge about me and something that was, is an important aspect of myself um, and that being helpful and helpful for me and helpful for them.*

### *Professional values and duty*

Motivation to disclose was also aligned with professional values and duty. For example, participants spoke about disclosure as fitting with values held about being a safe professional and ensuring personal difficulties did not have a negative impact clinical work.

*Jamie: There was only one thing, it was very clear. It was my professional duty to disclose. Because I was dealing with a case that was too close to home, I needed an outsider to help, to guide me through that case. So...that was it.*

### *Influencing narratives*

Motivation to disclose in order to influence conversations and narratives around mental health was also an emergent theme. This often was in relation to peers but sometimes other professionals, supervisors and course staff too.

*Morgan: ...sometimes it was just because I guess being open, about where I was coming from felt important to the conversation with others, the other trainees, and maybe lecturers as well. That it changes the story or the conversation that's happening, if you put that in there.*

### *Enablers*

Participants identified several factors that made it easier for trainees to disclose in placement and teaching settings. This included sub-categories of 'trusting relationships', 'feeling safe', and 'having an in-road'.

### *Trusting relationships*

Trainees reported finding it easier to disclose when they perceived they had a good relationship with recipients of the disclosure. For example, participants talked about trusting the recipient to respond helpfully and be empathetic and containing.

Chris: ...trust in my supervisor, that they would be helpful that they would be accepting, that they care, that they wouldn't be dismissive or they wouldn't be concerned, was obviously a big thing. Um my supervisor was great um I never had any doubt that she would respond in the right way...

### *Feeling safe*

How disclosure was enabled depended on how 'safe' the trainee felt, interpersonally and contextually. Often trainees spoke about these being one-on-one spaces like talking to a peer, using supervision, or using personal tutor meetings, but sometimes this included 'safe' groups such in trainee-led spaces.

Ellis: I think probably again with the, having a safe space to do it, so having 1:1 supervision and personal tutor meetings I think um, I can't imagine that I would've done outside of that really, if it was just in the office or with other people around. So I think having that space where it's I don't know I keep wanting to say safe I guess, um...to talk about it and know that actually it's supposed to be kind of private stuff in there as well so it shouldn't be taken anywhere else, that helps.

### *Having an 'in-road'*

Trainees felt more able to disclose because of the disclosure having some relevance to the conversation. For example, the disclosure was enabled because stressors, like academic work or clinical work, could invite discussion of more difficult feelings.

Drew: So it started out as kind of, discussion about more academic work, and it...it sort of became clear as I was talking about it that I would need to explain what was happening, why I was finding it so difficult... And that kind of gave me the in-road to talk about it.

## *Barriers*

This core category describes the factors that reduce the likelihood of trainees feeling able to disclose. This includes the sub-categories 'worrying about the impact on training', 'voicing the unspoken' and 'internalising stigma'.

### *Worrying about the impact on training*

Trainees worried about the consequences of disclosure on themselves, others and on training. Trainees talked about feeling their disclosure would be 'a big deal' and talked about worries of their fitness to practice being questioned, having to stop training, and worrying about failure.

*Taylor: I think I was so afraid of like, what was too much, um and sort of, I don't know like frightening people and people just having this view of she's unsafe, or she needs to deal with some of this stuff before she can do the work...*

### *Voicing the unspoken*

Lived experience was perceived to be a topic not often raised or voiced in training, and in psychology more generally. Trainees felt that because others did not speak about lived experience, they had few models of how to talk about it, and whether talking about it was 'acceptable'.

*Ellis: Yeah, I think the fact that it's not really spoken about on the course, um very much, um...I know other people having similar difficulties that are part of psychology but, we don't really talk about it. I don't know, I don't know what that's about, whether it's just, do we want to present the sort of best versions of ourselves? I don't know but um, I think that probably impacted it as well.*

### *Internalising stigma*

Some trainees acknowledged being hindered in disclosing because of feelings of internalised stigma. For example, trainees talked about feeling embarrassed and anxious to disclose, and worrying about people's perceptions of them changing or their lived experience being seen as a 'weakness', particularly in relation to wanting to be seen as 'a good trainee'.

*Avery: I guess it was kind of embarrassing as well when you feel like you shouldn't have these sorts of problems if you're a trainee clinical psychologist you kind of feel like um, a bit embarrassed uh to say that you're having these problems.*

### *Features of Disclosure*

This core category describes how trainees managed the content and the method of disclosure. This included the sub-categories 'being selective', 'spilling out versus controlled disclosures' and 'testing the waters'.

#### *Being selective*

Although the content and manner of disclosures varied, there were some commonalities in the judgements trainees made. For example, trainees spoke about others still 'not knowing the full story' and having disclosed to people they trusted gradually, with smaller disclosures over time. . Some trainees also spoke of giving a precis of their lived experience, keeping things 'surface-level' or asking themselves what the person 'needed to know' rather than going into more depth..

*Rory: I won't disclose the details and what's happened to me and what kind of treatment but I would disclose kind of, give a little summary and then probably like a little summary about the treatment. Um, for example I've had EMDR and I'm trained in EMDR and I know some people especially on my course think it's like voodoo, so it's kind of like well actually I've had it and I've used it with people and I really like it and this is why... but I don't say well this is the trauma that we worked on or anything like that.*

### *'Spilling out' vs 'controlled disclosures'*

Many trainees acknowledged making quite 'controlled' or planned disclosures that appeared to have been less emotion-laden.. Conversely, a few spoke of more emotion-laden experiences where they had felt it had 'spilled out' or been 'vomited up'.

Taylor: *...as soon as she asked me the questions it all just spilled out I think um, and then went away from me.*

### *'Testing the waters'*

Disclosure judgements entailed gauging responses as they disclosed which in turn informed decisions around making further disclosures in the moment, and in future too.

Sam: *...very much based on their reactions, I'm kind of like judging as I go along, giving tiny little bits...so with my last placement supervisor, um as I said I had a really positive experience with her so I shared more. Whereas with my current one um I just kind of got this vibe that she was uncomfortable, and so kind of just kept it very much as like...there might be certain situations I find difficult, or triggering um and then kind of left it as that really.*

### *Responses*

This core category describes the kinds of responses trainees perceived they received during disclosure. It includes 'listening vs jumping to fix' and 'exploring vs lack of curiosity'.

### *Listening vs 'jumping to fix'*

Many trainees spoke of positive experiences where the respondent had listened, been open and accepting to the idea of not needing to 'fix' it (for example, in the case of trainees disclosed without seeking further support). Some trainees however reported feeling the respondent was invalidating or appeared to 'jump' to questions about risk or solutions.

Drew: *They gave me time to talk about it and I suppose to think about it, again without coming up with solutions. But they did also, once I'd had that opportunity to express what*



*was going on, to talk about oh what happens next? Like, what can we do to practically support you? But that was always the uh second part if that makes sense, rather than leaping into, let's sort the problem.*

#### *Exploring vs lack of curiosity*

This category linked to the preceding 'listening' category and reflected trainees' experiences of responders taking time to explore the disclosure with curiosity. Trainees appreciated responders asking questions about experiences and exploring what trainees felt would be most helpful. Conversely, some trainees described experiences where responders had seemed to lack curiosity, possibly due to being unsure how to respond to a disclosure from a peer or colleague.

*Jo: I have had friends here who have been like oh wow ok, thanks for sharing you know I've had this too, and maybe give their own opinions. Or I've never experienced that, what must that have been like? So I guess, I react well when the other person's inquisitive...*

#### *Impact*

This core category describes the impact that disclosing had on trainees as individuals and relationally. It includes the sub-categories 'making it easier to be open', 'growing connections', 'integrating different parts of self', 'finding the right support' and 'clarifying positions'.

#### *Making it 'easier' to be open*

Trainees reflected that it was easier to be open and honest about one's lived experience with others when disclosures were met supportively and that this built their confidence, after initial disclosure, that other responses would be helpful making future disclosure more likely. Some trainees, conversely, felt they would not disclose again in certain places or to certain people because the response they received was not perceived as supportive.

Ellis: *In terms of how it's affected me, I guess I'm more open about disclosing and I haven't disclosed with my cohort but now I would say I'm willing to do that...I would feel a lot more comfortable doing that now, um just being a bit more honest I guess and open about my, my past experiences.*

#### *Growing connections*

Relationships were perceived to change as a result of disclosure. Many trainees felt that their relationship with the responder had become closer or deeper, or more trusting. Others mentioned how disclosing had opened opportunities for relationships with other like-minded people.

Sam: *yeah I think so, I think it's enabled me to really connect with some people who... I might not have before. So I think opening that up as a conversation has meant other people have opened up to me in return.*

#### *Integrating different parts of self*

For some, disclosing was reported to have helped them better understand and integrate components of themselves, and feel more confident with having a dual identity of professional and person with lived experience, including being able to bring the personal side of themselves to clinical and research work in a helpful and reflective way.

Taylor: *I think it's been so huge in a way because um, it's helped me to recognise my boundaries and this position that I take in terms of being a human and being a trainee and having the two together, which I still I feel like I'm still working through but, it's helped me to own it a lot more I think, and own my lived experience and how that helps me as a therapist, as a psychologist. Um, rather than getting in the way of things.*

#### *'Finding the right support'*

Disclosure functioned as a pathway for some trainees to support when needed. Trainees spoke about a variety of practical and emotional supports offered, from extensions for

assignments, adaptations to work through occupational health, accessing personal therapy, to colleagues 'checking up' on them a little more than before. Trainees appeared to have individualised views on what kind of support was helpful or not as helpful, and recommended others in similar positions found the 'right support' for them.

*Avery: I called the employee support service, so I got an assessment and I got put on a waiting list for CBT. And then, I had two sessions but the situation completed resolved by then so it didn't feel the right timing really... I guess it made me think that I needed a bit of an action plan as to how to manage placements...So I went into my next placement being quite explicit about the fact that I find it hard to get settled in new teams and get to know people uh, and that can sort of play into my anxiety so....um, he, he suggested changing where I was going to sit so I was more within the team*

#### *Clarifying positions*

This category reflects how disclosure can impact trainees' feelings about their position on disclosing and being a professional with mental health difficulties. Many trainees spoke about how to encourage others to disclose safely, to people they trust, because they felt it was more helpful to do so than keep it hidden. Some described reflection clarifying the circumstances under which they would disclose again, such as to whom, and why, and within what boundaries.

*Taylor: It's opened things up and um, and I think...yeah, it's just opened things up and maybe changed the way I disclose, um. In the sense I'll be a bit more thoughtful and won't be vomiting and spilling it all out, but thinking about when I want to do it and how I want to do it and sometimes even choosing not to*

Core categories and subcategories were organised into a model to explain the process of self-disclosure of mental health difficulties by trainees (Figure 1).

## Discussion

### Main Findings and Relationship to Past Research

The current study aimed to explore the process of self-disclosure of mental health difficulties, particularly how and why such disclosures occur during clinical psychology training. The sample of trainees recruited was representative (Leeds Clearing House, 2018), with some features improving participant group homogeneity. It is difficult to speculate why fewer first year trainee participants were recruited. It might have been that they had fewer opportunities to disclose, due to less time to build trusting relationships, and less exposure to other's disclosures, so felt less able to discuss the process. Furthermore, first year trainees may be more worried about appearing competent, being new in the course system. Indeed, this is supported by research concerning self-disclosure during clinical supervision (Hess, et al., 2008). Further research could consider when trainees are more or less likely to disclose lived experience during training and whether reasons for disclosure change over time.

The range of mental health difficulties described by participants was largely consistent with previous research (Tay, et al., 2018), however participants also reported experiences of complex trauma, Adverse Childhood Experiences (ACEs), emotion regulation difficulties, and historical difficulties of self-harm and suicidal ideation. This may be because participants were asked to describe their lived experiences in their own words. Trainees with experiences of psychosis, eating disorders or substance misuse were not represented, perhaps due to perceived stigma (Brohan, 2012; Grice, et al., 2018) but may also be due to how the inclusion criteria were interpreted by individuals.

Results showed that participants' well-being was comparable to that of the general population, despite the inherent demands of training and the start of the COVID-19 outbreak. This finding is somewhat inconsistent with previous literature suggesting high levels of psychological distress in trainees (Cushway, 1992; Pakenham & Stafford-Brown, 2012). This may be due to a self-selecting bias in recruitment but may also suggest trainees

have the resources to manage their well-being, perhaps even more so for those who have lived experience of mental health difficulties.

### *Model of Self-Disclosure of Mental Health difficulties in Trainees*

Several factors emerged which related to why trainees may have been motivated to disclose, and the enablers and barriers that facilitated or hindered disclosure. These factors appear to interact and contribute to whether a disclosure took place. The model incorporates the disclosure event, including features of disclosure and responses received, which appear to influence one another to further guide disclosure content and methods. These core categories appeared to lead to the core category of the impacts of disclosure on trainees individually and relationally, which was also appeared to increase or decrease the likelihood of future disclosures. The relationships between core categories are posited from what the data appeared to suggest – for example, enablers, barriers and motivations all appeared to be factored into the decision-making process; however, it remained unclear how each may have contributed. The model posited is acknowledged to bear similarity to the DPM (Chadoir & Fisher, 2010). Some categories included are comparable, such as motivations to be ‘fully understood’ in the context of one’s personal history, or to educate others; content and depth of disclosure; and alleviation of inhibition (or ‘testing the waters’). The impact of disclosure for trainees is also comparable to those described in the DPM, including changing the likelihood of disclosure, feelings about self and changes to relationships. However, there are some important differences also. Firstly, the trainee model describes factors specific to the trainee context, such as fear of having to stop training, and feelings that lived experience is not voiced in training. It also includes trainee-specific differences between motivations and factors that help and hinder to disclosure, which are not captured by the DPM. Overall, it appears that findings regarding trainee disclosure fit largely with wider literature about disclosure of hidden or stigmatised identities (Follmer, et al., 2019).

The posited model appears to support other previous research in trainee and qualified clinical psychologist mental health (Grice, et al., 2018; Tay, Alcock & Scior, 2018) and also is

consistent with findings from other health care professions that highlights the lack of discussion of lived experience on training as a significant barrier to self-disclosure (Waugh, et al., 2017). It is hoped that as research in this area and discourses in clinical psychology training continue to evolve, this will become less of a barrier. Moreover, some outcomes found in the current study are also consistent with previous research which has found potential advantages to disclosure such as improving relationships; being able to be more authentic; and gaining support (Brouwers et al., 2020).

### Strengths and Limitations

This study is one of the first to explore trainee experiences of self-disclosure during training. Previous unpublished work (Willets, 2018) focused on the decision of disclosure rather than the process as a whole. Thus, it adds to the evidence base concerning disclosure in mental health professions and workplaces. Secondly, the use of grounded theory methodology means that the findings provide a framework of how trainee disclosures of mental health difficulties occur and are managed, thus it improves awareness of factors that may be particularly relevant for trainees and potential receivers of disclosures. For these reasons, it can be argued that the model posited is a useful addition to the literature, although this remains to be explored in real world situations. Thirdly, as no new patterns appeared to emerge it can be argued that theoretical saturation was reached, and thus the validity and quality of the data gathered is arguably high.

Considering limitations of the current study, interviews relied on participant self-report and recollections of disclosure experiences and thus are subject to bias and error (Jobe and Mingay, 1991). Participants also were self-selecting volunteers and thus may have had particular interest and motivations for participating. It is also recognised that use of Skype interview may have limited richness of data to some extent (Seitz, 2016), although participants reported feeling comfortable with this medium. These factors may limit the trustworthiness of the findings. Also, although the methodology used provides a useful way to explore data and build a model, it does not aim to provide generalisability or transferability of findings. Also, it provides a limited understanding of how the variables

interact. Thus, further research is needed to test the directions of relationships between factors.

## Implications

Firstly, this study shows that disclosure conversations occur within the context of training and these conversations are relational in nature. This study provides a framework for trainees, supervisors and training programmes to consider when approaching such conversations. Trainees with lived experience of mental health difficulties could use this model to scaffold their own position on disclosing, and when and where it would feel helpful and safe to do so, including considering fitness to practice (Grice, et al., 2018).

Training programmes and supervisors also should consider engineering spaces designed for trainees to reflect on lived experiences safely (Valley, 2019). This could include protected clinical supervision, reflective practice, personal therapy, and peer-led groups. Such self-disclosures during training could also help address implicit biases that professionals may hold, and their impact on practice (Sukhera & Watling, 2018).

This model also suggests that lived experience may not be discussed openly on course programmes, which acts as a barrier to disclosure, as in other workplaces (Waugh et al., 2017). Thus, programmes should consider making lived experience conversations part of the curriculum, for individuals to participate in or not as they wish. Worries around questions of fitness to practice may be a barrier, particularly considering the HCPC as an external non-psychological organisation regulates such decisions for clinical psychology. Programmes could improve transparency of such processes to help trainees better understand these (Winter, 2017). Furthermore this model, when viewed alongside the Job Demands-Resource model (Demerouti, et al., 2001), could help training programmes reduce sources of stress for trainees and help address things such as management support; trainee feelings of control; and psychological demands; thus, making training more protective and sustainable.

Overall, this model suggests that trainees disclose for a variety of reasons disclosure and receipt of supportive responses can have a positive impact for trainees (Brouwers, et al., 2019), including creating more meaningful working relationships and gaining appropriate support. Furthermore, it appears that disclosure improves integration of personal and professional identities, possibly through reduction of internalised stigma. For example, one trainee stated “I think it does just opens it up and...you’re not hiding it anymore” suggesting through disclosing they no longer felt the need to ‘hide’ that part of themselves within their profession. This could be significant for competence development, as it may reduce unhelpful rumination and improve one’s sense of coherence (Marin & Rotondo, 2017), facilitating reflection and learning (Szczygiel, 2019).

#### Future Research

Future research could examine how motivations, barriers and enablers interact together to help develop a better understanding of this decision-making process. Research could also explore the experiences of receivers of disclosure to better understand the factors that drive responses and the impact on the receiver, and also explore self-disclosure for qualified clinical psychologists and course trainers, for whom different factors may exert influence. Finally, this study suggests that mental health difficulties may be relevant in the development of professional identity. Thus, future research could investigate this to better understand the role of mental health and trauma in professional identity and practice.



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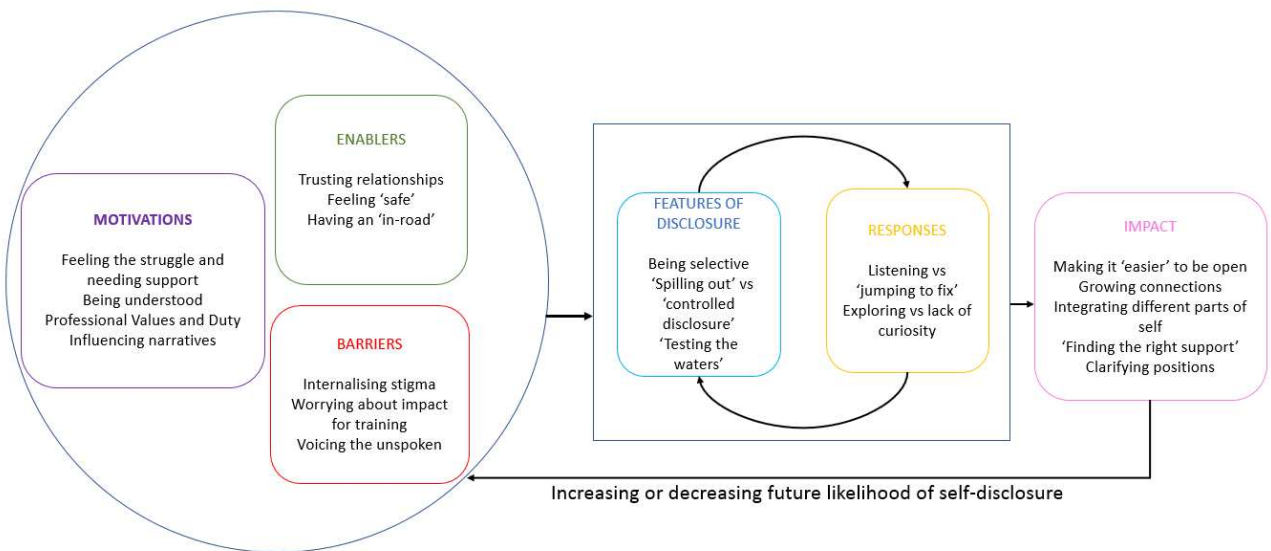


Figure 1. Model of the Process of Trainee Self-Disclosure

Table 1.

*Demographic Information for Participants.*

Demographics	Participants
Gender	
<i>Male</i>	3 (25%)
<i>Female</i>	9 (75%)
Age	
<i>Mean</i>	30.09 years
<i>Standard Deviation</i>	3.47
<i>Range</i>	26-37 years
Location of Doctoral Programme	
<i>North UK</i>	3 (25%)
<i>Mid- UK</i>	4 (33%)
<i>South UK</i>	5 (42%)
Year of Study	
<i>1<sup>st</sup></i>	1 (8%)
<i>2<sup>nd</sup></i>	6 (50%)
<i>3<sup>rd</sup></i>	5 (42%)
Onset of mental health difficulties	
<i>Childhood</i>	8 (67%)
<i>Adolescence</i>	2 (17%)
<i>Adulthood</i>	2 (17%)
Number of mental health difficulties experienced	
<i>One</i>	5 (42%)
<i>Two</i>	3 (25%)
<i>Three or more</i>	4 (33%)
SWEMWBS	
<i>Sample</i>	M = 23.82, SD = 2.75
<i>General Population</i>	M = 23.61, SD = 3.90

Table 2.

*Core categories and subcategories arising from the data.*

Core Category	Sub-categories
<p>Motivations</p> <p><i>Describes trainee motivations for self-disclosure. Motivations, enablers and barriers appeared to all contribute to the occurrence of the disclosure event together.</i></p>	'Feeling the struggle' and needing support
	Being 'understood'
	Professional values and duty
	Influencing narratives
<p>Enablers</p> <p><i>Describes factors that facilitated self-disclosure, alongside motivations and barriers.</i></p>	Trusting relationships
	Feeling 'safe'
	Having an 'in-road'
<p>Barriers</p> <p><i>Describes factors that inhibited self-disclosure, alongside enablers and motivation.</i></p>	Worrying about the impact on training
	Voicing the unspoken
	Internalising stigma
<p>Features of Disclosure</p> <p><i>Describes features (content and methods) of how trainees self-disclosed. Features of disclosure appeared to be in a reciprocal relationship with responses, so that individuals may alter content and methods depending on response received.</i></p>	Being selective
	'Spilling out' vs 'controlled disclosures'
	'Testing the waters'
<p>Responses</p> <p><i>Describes responses of receivers during self-disclosure experience.</i></p>	Listening vs jumping to fix
	Exploring vs lack of curiosity
<p>Impact</p> <p><i>Describes perceived individual, relational and social impacts of self-disclosure. These impacts appeared to exert influence back on motivations, enablers and barriers, influencing future likelihood of disclosures.</i></p>	Making it 'easier' to be open
	Growing connections
	Integrating different parts of self
	'Finding the right support'
	Clarifying positions