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"Being human": A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees

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Abstract

Objective: Recent research and guidelines recommend that trainers on clinical psychology doctorate training programmes consider disclosing personal experiences of psychological distress to trainees. Disclosure is thought to promote cultures of openness, validate and normalise trainee distress, encourage trainee disclosure and help-seeking and challenge stigmatising narratives. However, little is known about how trainers decide whether, what or how to disclose. This study aims to address that gap by exploring the processes and factors involved in trainers deciding whether or not to disclose personal experiences of psychological distress to trainees, generating findings of relevance across counselling, psychotherapy and psychology training courses.

Methods: In-depth interviews were conducted with nine trainers on UK clinical psychology doctorate programmes from around the country and analysed in accordance with constructivist grounded theory methods.

Results: Findings indicated that participants valued disclosure personally and professionally but were wary of the dangers of disclosure. Disclosure decisions were made by judging the context against internally held criteria. If criteria were not met, then disclosures were not made. Outcomes, whether positive or negative, served to reinforce the value of disclosure and the importance of managing risks, creating a positive feedback loop.

Conclusions: The findings of this study suggest factors that are important for trainers to consider when deciding whether or not to disclose. The six-factor framework developed may be useful for trainers to consider within reflective practice, supervision or during guided self-reflection in order to make safe, helpful and ethical decisions.

KEYWORDS
disclosure, grounded theory, lived experience, mental health difficulties, psychologist training, psychology

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1 | INTRODUCTION

Clinical psychology, counselling and psychotherapy are professions that can place high emotional demands and stresses on practitioners (American Psychological Association: APA, 2010; Health and Care Professions Council: HCPC, 2015). Within clinical psychology, counselling and psychotherapy professional populations, both qualified and trainee, personal experiences of psychological distress may be frequent and common, impacting mental health and job performance (Galvin & Smith, 2017; Grice et al., 2018; Hannigan et al., 2004; Hardiman & Graetz Simmonds, 2013; Rosenberg & Pace, 2006; Simpson et al., 2018; Tay et al., 2018). Health Education England (HEE, 2019, p. 82) recently recommended that, in order to promote mentally healthy workplaces, National Health Service (NHS) employers should "Encourage open conversations about mental health and the support available when employees are struggling … [and] improve disclosure processes". Research suggests that this could be achieved on doctorate in clinical psychology programmes by encouraging trainers to disclose[1] personal experiences of psychological and emotional distress to trainees (Howkins et al., 2018; Willets, 2018). Modelling of this kind has been shown to be effective at breaking down personal stigma (Bos et al., 2009; Yanos et al., 2014). Recent guidelines from the British Psychological Society (Kemp et al., 2020) recommend that trainer disclosure is encouraged in order to normalise, validate and promote the disclosure of mental health difficulties amongst trainees. These findings may generalise to the closely related fields of counselling and psychotherapy training programmes, which have many overlaps in terms of culture and curricula.

Research into disclosure processes in people living with concealable stigmatised identities (such as mental health difficulties) indicates factors that may be important in trainers' decision-making. When people with concealable stigmatised identities disclose, they risk negative outcomes such as social exclusion or discrimination (Pachankis, 2007; Quinn, 2006; Quinn & Chaudoir, 2009). However, concealing stigmatised identities has been found to be psychologically and emotionally stressful and to negatively impact personal and professional relationships (Major & Gramzow, 1999; Pachankis, 2007; Smart & Wegner, 1999, 2000). Ragins' (2008) model of disclosure processes in this population identified three central factors: internal factors (including the centrality of stigmatised identity to self-concept); anticipated consequences of disclosure; and environmental factors (including the presence of similar others and supportive relationships). Chaudoir and Fisher's (2010) model similarly points to the importance of perceived stigma, avoiding negative outcomes and pursuing positive outcomes in decisions to disclose. It also emphasises the importance of how the disclosure is received by the confidant in how helpful or unhelpful the outcome of disclosing will be.

The literature on disclosure of mental health difficulties in the workplace suggests further factors and processes which may impact trainers' decision-making. Toth and Dewa's (2014) model found that fear of stigma meant that employees adopted a default position of nondisclosure. Disclosures were only made if there was a triggering incident and a "good" reason. Even then, the benefits and risks of disclosure were carefully weighed. Outcomes of disclosure decisions supported the default position. A literature review identified seven reasons for workplace disclosure: role modelling; gaining adjustments; positive disclosure experiences; gaining support; being honest; explaining behaviour; and finding concealing stressful (Brohan et al., 2012).

Studies looking at the disclosure of mental health problems by mental health professionals, including clinical psychologists, counsellors, psychotherapists and trainees, support the idea that stigma, identity cohesion and disclosure environment may be factors in whether trainers decide to disclose personal experiences of psychological distress to trainees. For example, Tay et al.'s (2018) survey of clinical psychologists found that the central reasons for nondisclosure were fear of being judged negatively, impact on career, and shame and impact on self-image. Fears around being found incompetent by employers, colleagues and faculty members may also prevent disclosure (Dearing et al., 2005; Gough, 2016; King et al., 2020; Moll et al., 2013; Walsh & Cormack, 1994). Having a personal experience of a mental health problem and being a mental health professional may feel like incompatible identities (Richards et al., 2016). Clinical psychologists, counsellors and psychotherapists may be reluctant to disclose mental health problems for fear of adopting the role of

Implications for practice and policy

- This study found that participants used a six-factor framework based on "being safe" and "considering helpfulness" to make decisions about disclosing to trainees. This framework may be a useful tool for trainers within psychology, counselling and psychotherapy training courses when considering whether or not to disclose personal experiences of psychological distress to trainees.
- Trainers were monitoring the safety and helpfulness of their disclosures based on trainee and colleague responses. More research is needed to understand how trainees and colleagues experience trainer disclosure.
- Another implication relates to the importance of self-reflection, reflective practice and supervision in supporting effective and ethical decision-making. Training course providers could consider providing training around the framework and using it within existing supervision structures.
- A minority of participants did not disclose due to fearing professional consequences or uncertainty about how disclosures would be received by employers. It is recommended that governing bodies require training programmes to make views on disclosure explicit and consider both the benefits and risks of disclosure when making decisions on their ethos in relation to it.

the client and stepping out of their professional "helper" roles, or of failing to live up to a perceived "ideal" of the clinical psychologists as impartial, professional and neutral (Aina, 2015; Charlemagne-Odle et al., 2014).

Conversely, breaking down stigma and "coming out proud" has been cited amongst the reasons that mental health professionals, including clinical psychologists, counsellors and psychotherapists have chosen to disclose (Corrigan et al., 2013; Corrigan & Matthews, 2003; Grant & Barlow, 2016; King et al., 2020; Tay et al., 2018; Waugh et al., 2017). Identity coherence may also be a motivating factor. Coherence between being a mental health professional and a mental health service user can have benefits, including bringing meanings of hope and recovery to personal experiences of psychological distress (Richards et al., 2016).

The processes involved in therapist self-disclosure to clients in therapy suggest further factors that may be relevant to trainers deciding whether or not to disclose. Therapist self-disclosure is broadly defined as any statement that reveals something personal about the therapist and includes both immediacy statements and statements about personal background (Hill & Knox, 2001). There is little consensus within the literature on whether therapist self-disclosure is positive or negative, suggesting an unresolved dilemma (Müller, 2019). Disclosure is seen as both a useful clinical tool, which normalises, validates and promotes therapeutic alliance (Hill & Knox, 2001); and as potentially unethical and dangerous, risking role reversals such as care elicitation, client overwhelm and the focus of therapy shifting to the therapist (Peterson, 2002). Clinician skill in disclosure decision-making and in managing the risk of disclosures may be the intervening factor in whether disclosures are received as helpful and appropriate or unhelpful and inappropriate (Audet & Everall, 2010; Hanson, 2005).

Although disclosure decision-making is a well-researched area, no studies to date have investigated how trainers working on doctorate in clinical psychology programmes decide whether or not to disclose personal experiences of psychological distress to trainees. Little is known about whether the same processes and factors apply to this context. The current study aimed to address this gap by developing a model of the processes and factors involved in trainer disclosure, using constructivist grounded theory methodology (Charmaz, 2014).

2 | METHOD

2.1 | Study design

The study employed a constructivist grounded theory approach (Charmaz, 2014) to address the research questions. A constructivist rather than a positivist grounded theory approach (Glaser & Strauss, 1967) was used as the study aimed to explore how disclosure decisions were created within the specific social contexts of UK training courses. Constructivist grounded theory starts with an assumption that "social reality is multiple, processual and constructed" (Charmaz, 2014, p. 14), as are the researchers' contributions. This reflective stance is especially important as the researcher worked within the same culture that was being investigated (i.e., was a trainee on a UK training course; Charmaz, 2017).

2.2 | Participants and procedures

Nine participants took part in the study (six women and three men). Participants were required to meet the inclusion criteria of being: (i) currently employed as a trainer on a UK doctorate in clinical psychology programme; (ii) a qualified clinical psychologist. Trainers currently working at the University of East Anglia (UEA) were excluded from the study. Participants did not need to have experienced a mental health problem, used mental health services or received a psychiatric diagnosis to be included. The term psychological distress was used to encompass meanings and understandings based outside medical models of diagnosis. All participants had both teaching and supervisory responsibilities. Time in the trainer role varied from 1 to 20 years ($M = 10.6$). Three participants had 3 years or fewer experience: the remaining six had 9 years plus. Ages ranged from 25–34 to 55–64 years. All participants identified as White (British) or White (other).[2]

The study information sheet was emailed to UK doctorate in clinical psychology programme directors, along with a request to disseminate to trainers working on UK programmes. Later rounds of recruitment included snowballing to informal contacts amongst participants and research team members.

Both purposive and theoretical sampling were used in line with guidance on grounded theory research (Charmaz, 2014). Three rounds of recruitment were conducted. Recruitment was widened after Round 2 to include trainers with either teaching or supervisory responsibilities, rather than both. This achieved variation in participants' ages, gender and experience in the trainer role. However, despite snowballing to find those who were not open to disclosing or did not believe in the value of disclosure, significant variation in the degree of openness was not attained. There was no ethnic diversity within the sample, which was likely to be unrepresentative of the population: Black, Asian and Minority Ethnic individuals represent fewer than 10% of qualified clinical psychologists in England and Wales (Health and Social Care Information Centre, 2013). Theoretical sampling (Charmaz, 2014)—collecting data pertinent to emerging categories—was achieved by modifying the focus of the interview guide as interviews progressed. All participants were interviewed once.

2.2.1 | Data collection

Data were collected in one-to-one semi-structured interviews, lasting an average of 76 min. An interview guide was developed based on a literature review conducted for the topic and in discussion with trainers from the research team. The guide was

reviewed with a clinical psychologist with links to the lead researcher's training programme. The guide was used flexibly and changed over time. A reflective diary was employed, to record these developments.

2.2.2 | Reflexivity

Multiple strategies were employed to increase the awareness and transparency of the researchers' impact on the research process. During the early stages of research, the primary researcher (SD) reflected on her position in relation to the research topic, writing a series of memos (Lempert, 2007). SD reflected that she occupied many unique spaces in relation to the topic. She was currently a trainee herself and had been the recipient of multiple disclosures from trainers, experienced as varying in helpfulness and appropriateness. Prior to commencing doctorate training, SD had worked as a peer support worker. She had received training and supervision in the use of disclosure and gained considerable experience of disclosing, as well as participating in and conducting research into peer support working. When preparing for interviews, SD reflected on the power dynamics between herself and the participants, especially in relation to being both a trainee and the interviewer, and the parallels between the dynamics in the interview and the disclosure context. She noticed worries associated with being a naïve researcher and interviewing trainers with much greater experience than herself, such as being viewed by others as ill-informed or incompetent.

Throughout the research process, the primary researcher and the supervision team held reflective discussions on their assumptions and experiences in relation to the topic and responses to the data. Additionally, SD conducted an interview with an Expert by Experience Lead on a UK training programme, exploring differences and similarities in disclosure processes.

2.2.3 | Data analysis

Iterative data analysis was conducted using a constructivist grounded theory approach (Charmaz, 2014). Analysis began during transcription and took place concurrently with interviews, to allow for interview questions to be adapted and changed to fill emerging knowledge gaps. Iterative data analysis moved forward and backward through the three main processes of initial coding practices, focused coding and theoretical coding as more data were added to the analysis, while memo-writing took place continuously (Charmaz, 2014; Lempert, 2007).

Throughout the analysis process, steps were taken to ensure the credibility of the theoretical model produced (Yardley, 2017). The quality standards of sensitivity to context, rigour and impact were discussed regularly by the research team (Yardley, 2000). Emerging categories and concepts were cross-checked between members.

TABLE 1 Theoretical categories and subcategories.

Theoretical category	Subcategory
Default position: disclose (if useful and appropriate)	Valuing disclosure
	Wary of risks
Being safe	Being contained and containing
	Stigma and shame
	Professional consequences
Considering helpfulness	Being relevant
	Keeping the trainee central
	Monitoring intent and being purposeful
Outcomes	Receiving positive feedback
	Experiencing a negative outcome
	Identity cohesion and well-being

3 | RESULTS

This study aimed at understanding how trainers decide whether or not to disclose personal experiences of psychological distress to trainees. Four theoretical categories and nine subcategories were constructed during the analysis (Table 1).

3.1 | Narrative summary of the model

The findings of this study indicated that participants adopted a default position of disclosing to trainees. They adopted this position due to a belief in the usefulness of disclosure for trainees and because disclosure aligned with personal and professional values. While valuing disclosure, participants also recognised risks, both to self and to trainees, and were cautious in how, what and when they disclosed. They reported applying a series of criteria to ensure that disclosures were safe and helpful. These criteria were applied flexibly and were dependent on context. If the criteria were not met, then disclosures were not made. Outcomes of disclosure, whether positive or negative, served to reinforce the value of disclosure and the importance of carefully considering how safe and helpful disclosures would be, creating a positive feedback loop. Confidence and perceived skill in disclosing safely and helpfully increased with experience. A visual representation of the model is presented in Figure 1.

3.2 | Theoretical categories and subcategories

3.2.1 | Default position: Disclose

All participants had disclosed personal experiences of distress to trainees. Participants talked about being predisposed to disclose,

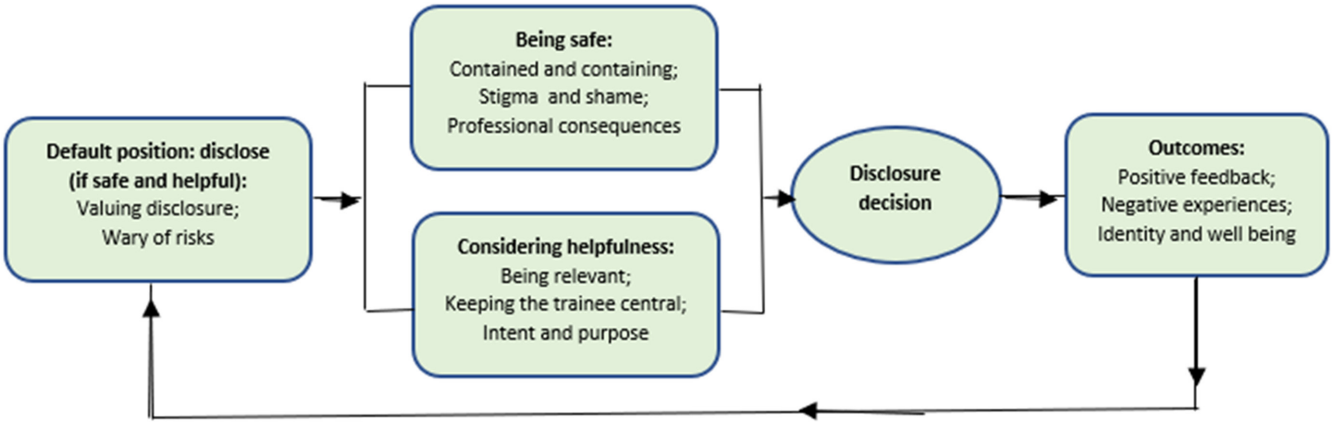

FIGURE 1 Decision-making processes in trainer disclosure of distress to trainees.

as this was in alignment with their personal and professional values and beliefs around "being human" and authentic. Disclosure was perceived to benefit participants through increased identity cohesion and well-being. Disclosure was valued as a way of challenging narratives viewed as stigmatising and debunking myths about clinical psychology. Participants perceived containing trainee distress as central to their professional roles as trainers. Disclosing was conceptualised as a tool to validate and normalise distress and promote disclosures from trainees and as part of modelling professional competencies in managing distress, stress and fitness to practice.

> acknowledging that you are human and that part of being a person is having difficult feelings, difficult experiences, conflicts, stress, as well as all the good stuff.[3]

Disclosure content included the following: distress related to anxiety, depression, work stress, relationships, parenting, childhood adversity, including neglect and abuse, and physical health conditions. However, every participant also spoke about choosing to keep some experiences private and choosing the timings of disclosures carefully.

Participants talked about applying a set of "criteria" or a "rule of thumb" to ensure that they were disclosing safely and helpfully. Participants also described being cautious, conscious, and controlled in their decision-making. Maintaining awareness of their own responses and of the responses of recipients was central to this.

> It is a conscious decision about bringing that material into the teaching room or the supervision room.

3.2.2 | Being safe

All participants spoke about the importance of disclosures being safe, both for trainees and for themselves.

Three subcategories were constructed relating to disclosing safely: being contained and containing; stigma and shame; and professional consequences.

3.3 | Being contained and containing

By being contained and containing, participants saw themselves as being authentic to the relationship or "honouring the contract" with trainees. Participants identified that being able to contain and control their own distress was important to disclosing safely and in avoiding professional boundary violations, such as role reversals, overwhelming others and care elicitation.

> I wouldn't want that to be something that anybody felt like they had to hold for me. So I [...] share it in a way that demonstrates that I've got it.

Participants spoke about needing to feel they could manage the emotional impact of a disclosure on themselves. Unresolved and ongoing distress was often identified as not safe or "too hot, too current" to share and was "taken elsewhere." Having other spaces in which to process distress—therapy, supervision, with peers, colleagues and friends and partners—was seen as an important part of disclosing safely.

> it needs to be safe for me. That I feel comfortable with what I've shared and how I'm going to feel afterwards.

The ability to be containing was construed as dependent on having knowledge and control over the disclosure environment. Participants were more cautious when they had less knowledge (i.e., when disclosing to a group; when online; to an individual they knew less well) and when there were fewer opportunities to adjust how the disclosure was received.

> I think there's something about the control over how people are hearing it, especially in an online world. Maybe in the classroom it's a little bit different, but

> online, you can't really see people, you don't know how people are hearing it.

3.4 | Stigma and shame

Some participants identified a dilemma, whereby they simultaneously wanted to disclose to break down stigma, but also felt unsafe to disclose, due to stigma and discrimination. This resulted in certain experiences being kept private, especially distress which participants thought they "should" not experience as psychologists, such as parenting difficulties, abusive relationships and self-harm. Participants identified some of this stigma as internalised as well as externally perceived.

> I think especially being a psychologist, there's almost this duality of 'I'm supposed to be able to manage this better,' so sometimes there's a fear or a sense of shame coming from if I am having a really difficult time.

3.5 | Professional consequences

Participants spoke about needing to be free from negative professional consequences to feel safe disclosing. Participants spoke about how cultures that were explicitly open and supportive, with shared views and values, enabled them to feel safe to disclose. Participants identified that open supportive cultures were created both "bottom-up" through trainee recruitment processes and "top-down" from the values of senior leadership.

> Being part of a culture that you know there aren't going to be negative consequences to what you disclose, or that's how I feel [...] Knowing that people will support it, won't judge you for it.

Where participants feared professional consequences, either through implicit stigma or from explicitly being told not to share personal experiences, they did not disclose.

> for me it feels quite a dangerous area to get into actually, in that team, [...] when I have tried to push us in that direction it's not, it really hasn't met with much... support.

3.5.1 | Considering helpfulness

All participants considered helpfulness as a key criterion for sharing appropriately.

> That's the basic question, 'is my sharing going to help them?'

Three subcategories were identified: being relevant; keeping the trainee central; monitoring intent and being purposeful.

3.6 | Being relevant

Participants spoke about how being relevant was an important part of a disclosure being helpful or useful for trainees. Relevant disclosures were constructed as those that responded to communications from trainees, such as "I feel on my own with this"; were related to common difficulties for trainees; or were embedded in/related to teaching or reflective practice. Being relevant was evident in what participants chose to disclose (i.e., distress related to academic failures) and in what they chose not to disclose (i.e., managerial conflict).

> I went quite kind of targeted. I'm saying this, I'm disclosing this because I wonder if it might help this particular person right now.

3.7 | Keeping the trainee central

Keeping the trainee central was constructed as important when considering helpfulness.

> I do think there is a line where you can talk about yourself too much. So, there is something about the trainee's always at the centre of it.

Part of keeping the trainee central was to make disclosures short, general and without much detail and to move on to modelling coping rapidly.

3.8 | Monitoring intent and being purposeful

Participants monitored their intentions closely, to ensure that they were trying to be helpful to trainees and were not motivated by their own needs. Monitoring intent was tied to being purposeful: participants would not disclose unless they felt there was a good reason to. Reasons to disclose included normalising and validating, fostering trainee disclosure, increasing connection and alliance, debunking myths about clinical psychology and challenging stigmatising narratives.

> that's my intention. Just to be helpful to the trainees, to their learning and development.

3.8.1 | Outcomes

Outcomes of disclosure and nondisclosure, whether positive or negative, served to reinforce participants' default position of disclosing if safe and helpful. Three subcategories were constructed: receiving positive feedback; experiencing a negative outcome; and identity cohesion and well-being.

3.9 | Receiving positive feedback

All participants spoke about receiving positive feedback about disclosures from trainees; a minority also received positive feedback from colleagues. Feedback confirmed and validated the participants' intentions when disclosing and reinforced beliefs in the value of openness. Feedback also helped confirm to participants that they were disclosing safely, as trainees reported feeling safe and contained.

> the feedback I get from trainees is that [...] they feel that I can be approached, and if I self-disclosed it or shared experiences in teaching, it's always positively fed back.

3.10 | Experiencing a negative outcome

Participants talked about being adversely affected by disclosures. Negative experiences served to reinforce the importance of thinking carefully about safety before disclosing and about the importance of supervision and reflective spaces.

> I remember after it, just being, I don't know how to describe it... a little bit off balance. Like I remember getting back in touch with the counsellor and saying 'I need to talk through some stuff', because it felt like a load of stuff had just come back to the surface.

3.11 | Identity cohesion and well-being

Many participants identified increased identity cohesion and authenticity as an outcome of disclosure. They associated this with increased well-being, both personally and professionally.

> I'm in a much, much better place that I've ever been, both professionally and personally, and I think a lot of that is due to sharing who I am more fully.

When participants did not disclose due to fears around professional consequences, they felt like they lacked authenticity and were acting in opposition to their values of openness. They felt as though they were letting trainees down, as they were not teaching them as effectively as they might do.

> the times I have probably been most miserable in my own working life, is when I've felt the least authentic in what I am doing.

4 | DISCUSSION

This study aimed at exploring the processes and factors involved in trainers deciding whether or not to disclose personal experiences of psychological distress to trainees. Participants were found to adopt a default position of disclosing if safe and helpful, due to their belief in the value of disclosure and their awareness of the potential risks. Participants applied a set of criteria to disclosing in order to maximise benefits and minimise risks. Outcomes of disclosure and nondisclosure, whether positive or negative, served to reinforce the default position, creating a positive feedback loop.

Within grounded theory research, there is a tension between staying true to the origins of the methodology, ensuring that theory is "grounded" in the data, and more pragmatic approaches that allow the influence of pre-existing models and concerns within the research topic area (Barbour, 2001). The current study used the later variant, adding value by identifying new themes from the data alongside those from the existing literature (Melia, 1997), drawing on models of mental health disclosure in the workplace (Toth & Dewa, 2014), concealable stigmatised identity disclosure (Chaudoir & Fisher, 2010) and therapist self-disclosure (Müller, 2019). In common with models of mental health disclosure in the workplace and of concealable stigmatised identities, themes of personal support, safety and meaning were prevalent. In line with studies of therapist self-disclosure, there was a focus on the other and on ensuring that disclosures were safe, useful and helpful.

4.1 | Adopting a default position: Being predisposed to disclose

Participants in the current study spoke about being predisposed to disclose. They valued disclosureas an extension of personal and professional beliefs in "being human," authentic and open. Acting authentically was perceived as bringing personal and professional selves into alignment and having benefits for well-being. Richards et al. (2016) similarly found that cohesion between professional identities and lived experience identities was reported as a motivation for disclosure. In this study, being open about difficulties was valued as a way to challenge narratives perceived as stigmatising and to debunk myths about clinical psychology. This finding is supported by research which found that breaking down stigma and "coming out proud" has been cited amongst the reasons that mental health professionals, including clinical psychologists, have chosen to disclose (Corrigan et al., 2013; Corrigan & Matthews, 2003; Grant & Barlow, 2016; Tay et al., 2018; Waugh et al., 2017). Where this study extends the literature is in the finding that participants valued

disclosure as a professional tool, useful for validating and normalising distress, promoting disclosure from trainees and in bringing teaching to life. Participants spoke about drawing on psychological models, including systemic, third-wave and pedagogic approaches, to inform their use of disclosure as a tool for benefiting trainees.

4.2 | Applying a framework to disclosure

This study found that participants applied the criteria of "helpful-and-safe" to all their disclosure decisions. Being helpful was constructed as being relevant; keeping the trainee central; and monitoring intent and being purposeful. Being safe was constructed as being contained and containing; not experiencing stigma and shame; and experiencing no negative professional consequences. These factors acted as a series of prompts or reflective questions that can be seen as forming a framework for disclosure decision-making. By reflecting on the factors within the framework, participants felt more confident in making conscious, considered decisions that would be safe and helpful. These findings support and extend the wider literature related to disclosure decision-making. Drawing on the ethical principles of psychologists' code of conduct (APA, 2002), the literature on therapist self-disclosure considers the most salient factors to be benefice and nonmaleficence (Barnett, 2011; Gutheil, 2010; Müller, 2019). Sadighim (2014) further recommends that therapists reflect on a series of questions when deciding whether or not to disclose, in order to ensure that decisions are ethical and useful to clients. The Sharing Lived Experiences Framework (Dunlop et al., 2021) was recently developed to support mental health professionals in making conscious, reflective and considered decisions about disclosures and has many commonalities with the framework developed in the current study. This supports the idea that the findings of this study may generalise to other environments, especially counselling and psychotherapy training programmes, where there are many cultural and curricula similarities to clinical psychology doctorates.

4.2.1 | Considering helpfulness

"Considering helpfulness" was constructed as being relevant; keeping the trainee central; and monitoring intent and being purposeful. These factors and processes map onto the areas found to be clinically important in therapist self-disclosure: therapist intent; keeping the client central; and client need and preference, supporting the importance of these considerations when making disclosures (Barnett, 2011; Gutheil, 2010; Müller, 2019). The current study extends the literature on therapist self-disclosure in the emphasis placed on being relevant and purposeful by participants. Participants reported that they looked for signals from trainees before making disclosures and tied disclosures very tightly to the content of teaching or reflective practice. They drew on their own experience and knowledge of the training environment to predict and respond to unmet needs among trainees. Being relevant and purposeful was constructed as essential to disclosures being received as helpful and appropriate.

4.2.2 | Being safe

Being safe was constructed as being contained and containing; considering stigma and shame; and freedom from professional consequences. Participants talked about tensions between wanting to disclose, in order to challenge stigma, and feeling stigmatised, especially around experiences of distress they felt they "shouldn't" have as psychologists. These findings support and extend the literature on concealable stigmatised identities and mental health disclosure in the workplace, including clinical psychologists and trainees. Fear of stigma, discrimination and being judged as incompetent have been found to prevent disclosures (Chaudoir & Fisher, 2010; Ragins, 2008; Toth & Dewa, 2014; Willets, 2018). Self-stigma, shame and perceptions that "good" clinical psychologists do not struggle with distress were also found to deter clinical psychologists and trainees from disclosing mental health difficulties (Aina, 2015; Charlemagne-Odle et al., 2014; Tay et al., 2018; Willets, 2018). In the current study, the culture of the training programme was found to be instrumental in how safe participants felt to disclose. The finding that open, supportive environments encouraged disclosure, while uncertainty about how disclosures would be received or actively discriminatory environments deterred discloses, is supported in the wider literature (Charlemagne-Odle et al., 2014; Chaudoir & Fisher, 2010; Toth & Dewa, 2014; Willets, 2018). This has implications for all training programmes within counselling and psychotherapy, as well as within clinical psychology.

Where the current study extends the literature is in the importance participants placed on being contained and containing, considering both their own safeness and that of trainees. They carefully weighed the impact that disclosures would have, thinking about their ability to manage the emotions associated with the disclosure in the moment and how they would be affected in future. Current and unprocessed distress was taken elsewhere: sharing such distress was viewed as inappropriate and leading to boundary violations such as eliciting care. Participants emphasised the use of self-reflection, reflective practice and supervision in ensuring that they could be both contained and containing. This finding is supported by the wider literature, which recommends such steps as an important part of preparedness for making disclosures (Dunlop et al., 2021; Müller, 2019).

4.3 | Outcomes

Outcomes of disclosure decisions, whether positive or negative, served to reinforce the default position, creating a positive feedback loop. A novel finding of this study was that participants perceived that there were negative outcomes associated with nondisclosure as well as with disclosures: some participants reported feeling as though they were not acting in alignment with their values or

supporting trainees to the best of their abilities when they did not use disclosure within their teaching and supervisory responsibilities.

When disclosures were perceived to have been received badly, or participants felt unsafe sharing, they tended to blame a lack of preparation or knowledge about the disclosure context, including sharing too early in a relationship before trust was established. This reinforced the importance of applying a framework for sharing and the use of self-reflection, reflective practice and supervision to ensure that disclosures were both safe and helpful.

Between the participants, there was nearly 100 years of experience within the training role. Three participants had 3 years or fewer experience in the role, while six had 9 years or more. There was a split between these two groups, with the more experienced trainers feeling more confident in disclosing safely and appropriately and having greater clarity in describing the use of a framework for disclosure. However, despite varying levels of experience, all participants reflected that disclosing was a learning process, with skill and confidence in disclosing increasing over time and with experience in using psychological models that encourage therapist self-disclosure.

4.4 | Strengths and limitations

This study was the first to explore the processes involved in trainers' decisions about whether or not to disclose personal experiences of psychological distress to trainees. One of the strengths of the study was in the methodology that was employed and the richness of data that was generated. The active role of the researchers within a doctorate in clinical psychology training programme was seen as both a strength and a potential limitation. The insider knowledge of the researchers stimulated additional lines of enquiry and was useful in formulating the potential implications of the research (Jones & Bartunek, 2019). However, it is also acknowledged that the researchers will have brought their own assumptions and preconceptions, relationship dynamics and research focus to the process (Galdas, 2017).

Recruitment processes and participant information materials may have limited the range of positions on disclosure that were represented within the sample. All participants both valued disclosure and chose to disclose: the views of those who perceive disclosure as inappropriate or unhelpful were not represented. This has meant that the model may be unrepresentative. Researchers could have conducted a further round of recruitment, with new participant information, in order to collect a broader range of perspectives.

5 | CONCLUSION

This study aimed at understanding the processes and factors involved in trainers on clinical psychology doctorate programmes' decisions about whether or not to disclose personal experiences of psychological distress to clinical psychology trainees. The model shows that participants were predisposed to disclose, due to believing in the value of disclosure, both personally and professionally. They were also wary of the potential risks of disclosure and sought to minimise risk and maximise benefit by applying a six-factor framework to disclosure decisions based on "being safe" and "considering helpfulness." Confidence in using a framework for disclosure and in being free from professional consequences of disclosing enabled participants to choose to disclose, when they thought it would be helpful. The framework and the factors felt to support disclosure have implications not only for clinical psychology doctorates but also within counselling, psychotherapy and other psychology training programmes.

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CONFLICT OF INTEREST STATEMENT

All authors disclose no conflicts of interest.

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ENDNOTES

[1] Some participants in the study preferred the term "share" to disclose, as the term disclose was perceived as inherently stigmatising. Others used the terms interchangeably or preferred to use disclosure. As the literature uses the term disclosure, this has been the term employed here.

[2] Clinical psychology trainers represent a relatively small community, with strong professional and personal links. To preserve participant anonymity, the researchers decided not to provide a table identifying the characteristics of participants, as several participants voiced concerns that they might become identifiable.

[3] The researchers decided not to include participant numbers, in order to preserve anonymity. When quotes from participants were grouped together, it was possible participants might become identifiable, due to the small and close community from which they are drawn.

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