A Narrative Exploration of Lived Experiences of Mental Health Difficulties in Trainee Mental Health Practitioners

being a thesis submitted in partial fulfilment of the requirements for the degree of

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By

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Values Statement

This thesis portfolio aims to witness and welcome each person's individual journey with mental health, with an emphasis on respecting and amplifying the power of shared experiences. It is essential to acknowledge the prevalence of lived experience of mental health difficulties, given the challenges presented within mental health professions. The authors wish to present a clear statement remonstrating any deprecation of individuals with lived experience of mental health difficulties or distress.

As the focus surrounds individuals' lived experiences of mental health difficulties, the decision has been made to abbreviate this term to 'lived experience(s)' throughout. The abbreviation 'LE' will not be used, so as to not diminish the lived experiences of those who participated within the research encompassed within the present thesis portfolio, either indirectly through the systematic literature review or directly via the empirical research paper.

Throughout this thesis portfolio the term 'mental health difficulties' is used to describe lived experience and intends to acknowledge psychosocial causal factors, context and uniqueness of individual experiences of distress, in line with guidance from the British Psychological Society (2020).

Reference:

British Psychological Society (2020). *Supporting and valuing lived experience of mental health difficulties in clinical psychology training.* https://www.ucl.ac.uk/clinical-psychology-doctorate/sites/clinical_psychology_doctorate/files/section_32_appendix_1_supporting_and_valuing_lived_experience_of_mental_health_difficulties_in_clinical_psychology_training.pdf.

Overview

This thesis portfolio comprises three parts and considers the experiences of trainee mental health practitioners' lived experiences of mental health difficulties.

Part One: Systematic Literature Review

Part one contains a systematic literature review exploring help-seeking and sharing among mental health professionals in training with lived experiences of mental health difficulties. A systematic search of five databases identified eight suitable papers, of which the findings are demonstrated using a narrative synthesis. Five central factors and themes emerged. Conclusions and clinical implications are discussed.

Part Two: Empirical Paper

Part two is a qualitative empirical study which explores trainee clinical psychologists' lived experiences of mental health difficulties and the meanings made from these experiences, by hearing their stories. A narrative analysis applied two perspectives to consider the stories' content and form. Conclusions and implications for practice are reflected.

Part Three: Appendices

Part three consists of the appendices supporting parts one and two and includes a reflective and epistemological statement.

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(including acknowledgements, overview, tables, figures, references and appendices)

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Part One: Systematic Literature Review

Part One - Help-Seeking and Disclosure Among Mental Health Professionals in Training with Lived Experiences of Mental Health Difficulties: A Systematic Literature Review

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Abstract

Existing research suggests that a large proportion of student mental health professionals have experienced mental health difficulties at some point in their lives. The present review aims to systematically evaluate some of the published literature relating to help-seeking and disclosure of lived experiences of mental health difficulties among mental health professionals in training. To do so, five databases were searched in the autumn of 2022. Only studies which were peer-reviewed and utilised quantitative or qualitative data were included for review. Studies which focussed on already qualified mental health professionals, or the general population, were excluded from the review. The quality of the published studies was assessed using the National Institute of Health and Care Excellence (NICE) quality appraisal checklists for quantitative and qualitative studies. The present paper reviews and synthesises data from eight studies with a total of 2807 participants. The approaches of the studies were varied, covering: hypothetical scenario-based data; descriptive surveys; and, qualitative studies into specific lived experiences regarding help-seeking. Using Narrative Synthesis, the review finds five principal themes relating to help-seeking including: stigmatisation; sources of support; facilitators; barriers; and incentive to seek support. According to the reviewed literature, the level of help-seeking per participant differed according to trust, supervisory relationships, and peer-support. This review indicates a need for further research to understand the nuances of help-seeking decisions, and to better develop support services provided by universities.

Keywords

systematic literature review, mental health, help seeking, students, trainee mental health professionals

Introduction

According to recent figures from the United Kingdom (UK), the lifetime prevalence of experiencing a mental health difficulty is around 43.4% (Mental Health Foundation, 2016). Data suggests that over 1 million adults accessed National Health Service (NHS) mental health services in November 2021 (NHS Digital, 2021). However, mental health difficulties may be more prevalent within the UK population than data suggests, as the data does not include adults who sought support privately or those who did not seek help at all. Conclusive prevalence rates are difficult to determine as mental health difficulties often require self-disclosure. Many adults feel resistant to disclosing their lived experiences due to stigma or difficulty accessing help (Salaheddin & Mason, 2016). Disclosure is characterised as contact between two individuals wherein one shares personal information about themselves to the other that would not have been known otherwise (Spence et al., 2012). Henceforth, the terms ‘lived experience’ and ‘mental health difficulties’ will be used interchangeably when discussing the lived experiences of individuals with mental health difficulties.

On a societal level, ongoing experiences of mental health difficulties have the potential to transform into negative long-term economic and social outcomes, for example decreased quality of life on an individual basis, and increased costs to healthcare services more broadly (Knapp & Wong, 2020). Poor mental health is estimated to cost the NHS and other health care services £70-100 billion annually (Bridges, 2014).

Mental Health Stigma

Stigmatisation can be born out of negative judgements from others which amalgamate into an individual’s self-concept, resulting in difficult feelings such as shame and low morale (Allport, 1954; Luckstead & Drapalski, 2015; Ritsher & Phelan, 2004). Attempts to shift public ideas and discourses about mental health difficulties are essential, as some still view individuals with mental health difficulties as dangerous and frightening (Schomerus et al., 2012). These stigmatising ideas can lead to low levels of acceptance from wider communities, the media and within interpersonal relationships (Corrigan et al., 2013; Cullen et al., 2017). Subsequently, external stigma can lead to a reluctance to share lived experiences or seek help from others. As Tucker et al. (2013) found, stigma about the self can influence levels of shame and self-blame in individuals who report living with mental health difficulties, therefore influencing the likelihood of disclosing or seeking help.

Research exploring help-seeking and sharing often conceptualises distress using psychiatric ideas and language, which risks pathologizing human experiences into a series of categories and symptoms. This view may fail to consider the wider influences on a person's distress, such as social, cultural, political, psychological and environmental elements (Johnstone, 2018; Johnstone & Boyle, 2018). Moreover, Foucault (1967) postulated that 'mental illness' is a concept constructed within a particular social system of meaning; therefore, it is essential to consider the viewpoint that ideas about mental health may be understood as social constructions by some, though this is not the dominant discourse in UK healthcare systems.

Dialectics of Disclosure

In addition to experiences of stigma and discrimination, disclosing experiences of mental health difficulties can lead to further negative outcomes, such as poor engagement with interventions (Corrigan, 2004) and poor academic performance (Martin, 2010). It is thought that concealing a mental health difficulty due to fear of stigma can contribute to negative impacts on an individual, including an overwhelming sense of fear and isolation; loss of confidence; poor self-esteem and lowered self-expectations (Corrigan & Watson, 2002).

Individuals who have lived experiences of mental health difficulties may be faced with the decision to seek help and disclose their experiences to others. There may be times where disclosure can be advantageous, as it can enable an individual to seek help (Toth et al., 2022). Research posits that the idea of ‘coming out proud’ about mental health difficulties can serve to empower individuals who have lived experience in sharing their lived experiences (Corrigan & Matthews, 2003). Moreover, Rüsch et al. (2014) found participants reported a decrease in the cognitive appraisal of stigma as a stressor on disclosure-related distress, thus demonstrating how advantageous empowerment can be for individuals who have experiences of mental health difficulties.

Research by Slavin-Spenny et al. (2011) suggests that disclosure may positively affect physical health and mood and can cultivate acceptance and understanding of mental health within wider communities (Corrigan & Matthews, 2003). Conversely, the disclosure of mental health difficulties can eliminate negative impacts of stigma, as it facilitates the introduction of emotional support and positive input from others, which positively impacts individuals’ self-esteem and wellbeing (Martin 2010).

Mental Health Professionals with Lived Experiences and Stigma

The present review aims to examine the experiences of trainee clinical psychologists, however the majority of existing research exploring lived experiences of mental health difficulties and stigma have taken place within the qualified mental health professional population. It was deemed important to focus initially on trainee clinical psychologists as there is a relative absence of literature investigating the mental health of this population specifically. Furthermore, currently there are increasing demands on the profession of clinical psychology, as current government agendas seek to increase numbers of clinical psychologists across the UK.

It is essential to consider the findings of this research in order to ground the review in the current research context, given the lack of research investigating lived experiences and disclosure among the trainee clinical psychologist population.

Ideas pertaining to qualified mental health professionals who have lived experience vary, with research often expressing concern or pessimistic views, as demonstrated by Waugh et al. (2017) who investigated the experiences of, and attitudes towards, mental health and help-seeking within the context of an NHS workplace. Through a qualitative exploration, findings highlighted five key themes, including perceived stigmatising views in other staff members, and support following disclosure was found to be variable. This study demonstrates how stigma is still prevalent not only within society broadly, but within the workplaces of qualified mental health professionals. Stigma continues to exist despite the efforts of several anti-stigma campaigns which promote lived experience in mental health professionals, for example the Time to Change Programme (2011) and In2Gr8 Mental Health (https://www.in2gr8mentalhealth.com).

Notwithstanding the promotion of destigmatisation and backing of disclosure and help-seeking within mental health professions, scholars propose that mental health professionals remain susceptible to stigma (Zartaloudi & Madianos 2010). Both qualified and trainee mental health professionals' decision making around disclosure may be differently affected by stigma than other healthcare professionals due to the professional culture which may 'discourage' professionals to disclose (Boyd et al., 2016). This can impact decision-making surrounding help-seeking and obstruct transparency about mental health needs or lived experiences.

Understanding how disclosure may be advantageous holds clinical importance due to the potential benefits of accessing support and intervention, creating an increase in positive outcomes and reduce the challenges associated with concealment of mental health difficulties, including internalised stigma and further mental health decline (Pachankis, 2007). Furthermore, understanding decision making surrounding disclosure may help areas of existing health care services provide improved support for qualified and trainee mental health professionals alike, particularly those in training as this may help to cultivate a workforce more able to thrive, therefore decreasing the impact of poor mental health in staff. It is essential to understand the experiences and research pertaining to qualified clinical psychologists, in order to set the context for uncovering the experiences of clinical psychologists in training.

Supporting qualified clinical psychologists to consider the impacts of disclosure and to consider when and why it may be advantageous may contribute to a reduction in levels of stigma by dismantling existing discourses both within services and societally, and may contribute to a more ‘normalising’ narrative around mental health disclosure. In their 2018 study, Tay and colleagues explored the impact of stigma on 678 qualified clinical psychologists and found that two thirds of participants reported experiencing mental health difficulties, with many suggesting that concerns about negative consequences and shame prevented them from disclosing and help-seeking. Further research exploring disclosure among qualified mental health professionals found that participants reported themselves less likely to seek support in the workplace and had previous negative experiences of doing so, as the fear of stigma inhibited help-seeking (Zamir et al., 2022).

Scholars state that help-seeking involves a dialectical struggle including weighing up the value and risk of disclosure (Greene et al., 2006). Disclosure-focussed decision making is a multi-faceted process and suggests that disclosing potentially stigmatised identities (i.e. lived experience of mental health difficulties) may be advantageous as it can enable adjustments, support and care (Corrigan et al., 2010; Rüsch et al., 2014; Beukering et al., 2022).

In 2015, Galvin and colleagues found that increased stress due to the demands of training and navigating mental health services as a student can lead to the development of mental health difficulties, suggesting clear implications for the impact of work and training on mental health. If trainees are struggling with their mental health while supporting the mental health of others in their professional role, it is possible that shame, internalised stigma and fears of professional repercussions may be present due to internal and external judgement or concerns about competence as a clinician. In addition, trainees may experience more challenges due to the evaluation processes during training in order to pass the course and register as a qualified clinician.

Disclosure and Help-Seeking in Trainee Clinical Psychologists

Research exploring disclosure and help-seeking among clinical psychology trainees is scarce, yet there is reason to believe that mental health problems are as likely, if not more likely, to develop in this population than in the general population. This is because clinical psychology as a profession is known to place high emotional demands on practitioners, which increase the challenges of working in a mental health setting, including workplace stressors and the challenges of working clinically in a trainee role (Pakenham & Stafford Brown, 2012; Cranage, 2022). Trainees are known to be exposed to a high level of stress during training which may contribute to, or exacerbate existing mental health difficulties.

Previous research investigating stigma and student mental health in higher education indicates that students with lived experience avoid speaking about their difficulties for fear of discrimination during their university studies and in later professional employment, thus demonstrating how stigma influences both the qualified and trainee population (Martin, 2010). This study also highlighted that participants were challenged by staff responses to disclosure of mental health difficulties, suggesting that decisions about disclosure and help-seeking may be influenced by staff approaches to providing support. This research however included students from a range of backgrounds which may limit the applicability to the clinical psychology professions due to potential variation in understandings of mental health difficulties within these academic areas.

Moreover, in Cushway's (1992) study of 287 trainee clinical psychologists, 75% of participants reported being 'moderately' or 'very' stressed, in addition to high levels of lived experience of stress-related burnout. Additionally it found that trainees reported the main stressors were deadlines, poor supervision and the ambiguous nature of clinical work. The study highlighted the value of community support as a predictor of help-seeking, suggesting that if trainees do not feel supported, they are less likely to seek help. A more recent unpublished thesis study reported training stressors for clinical psychology trainees as: placement difficulties; coursework and discrimination, and personal stressors as: relationship difficulties and traumatic experiences (Willets et al., 2018). The role of a trainee involves coping with stressors while simultaneously developing knowledge and skills related to clinical work (Myers et al., 2012). Both studies highlight the challenges faced by trainee clinical psychologists with lived experience of mental health difficulties, and a clear need for improved support to facilitate disclosure and help-seeking in this population. There has been a recent shift in recognition of valuing and supporting lived experiences and challenging stigma among trainees. Several documents are available to guide universities and students in navigating disclosure and supporting those with lived experience (British Psychological Society [BPS], 2020). However, it is unclear how widespread the use of these ideas is within educational institutions, as there has been no research to investigate this.

Further, in 2018 Grice and colleagues used quantitative methods to investigate attitudes towards disclosure among trainee clinical psychologists in the UK. The survey was completed by 348 trainees from 19 training institutions, and their findings showed that 67% of participants reported experiencing at least one current or past mental health difficulty, with anxiety and depression being the most common. In addition, their research suggested that decisions to disclose lived experience were related to anticipated stigma, who the disclosure is made to, and levels of 'maladaptive-perfectionism'. Findings suggest that trainee decisions around disclosure are guided by its perceived value, and a possible motivation to conceal their mental health difficulties due to concerns about stigma; as the study found that trainees were least likely to disclose their difficulties to supervisors, mentors and tutors. The use of quantitative methodology reached a broad scope of participants, though the study may omit richness of data necessary to deeply understand disclosure and help-seeking among this population.

Findings from Willets and colleagues (2018) outline factors associated with disclosing mental health difficulties during clinical psychology training as: having a specific reason to disclose (e.g. seeking support); anticipating negative outcomes (e.g. due to concerns about stigmatising attitudes); feelings of shame and fear, or striving for acceptance and comfort. This research appears to support previous research findings, however this was an unpublished study which may be subject to recall bias, as participants consisted of recently qualified clinical psychologists who were required to reflect on their training experiences.

Despite an increase in recognition of attending to mental health difficulties in individuals in the workplace and undertaking study, including trainee clinical psychologists, limited research exists which examines trainee clinical psychologists' experiences of disclosure and help-seeking, in addition to the assumptions that disclosure decisions are based upon. Research exploring experiences of disclosure and help-seeking in clinical psychology trainees with lived experience has potential to encourage a shift in responses to stories of lived experience and inspire a wider appreciation and acknowledgement of the challenge and impact of sharing or concealing a mental health difficulty.

The aim of the present review is to synthesise and critically appraise current literature, as findings will help to develop an understanding of trainee clinical psychologists' experiences of help-seeking and disclosure surrounding lived experiences of mental health difficulties. Given that existing research predominantly focusses on qualified mental health professionals or clinical psychologists, the findings of the review will have important implications for understanding the attitudes towards help-seeking and disclosure within the trainee clinical psychologist population, and influences within the decision-making processes. From existing research, it is unclear how trainees experience disclosure and help-seeking, therefore this was considered essential to explore as findings may inform future support structures within training programmes. In line with this, the present review aimed to answer the following question:

What are trainee clinical psychologists' experiences of disclosure and help-seeking surrounding lived experience of mental health difficulties?

Method

Search Strategy

Various databases were searched to increase the likelihood of obtaining all relevant articles to answer the review question. The systematic search strategy was applied to five electronic databases, all accessed through EBSCOhost: Academic Search Premier, Psycinfo, MEDLINE, PsycArticles and CINAHL Complete, as these databases were deemed most appropriate to the topic area. This search was initially completed in Autumn 2022 and repeated in December 2022 to ensure the inclusion of recent papers.

Search Terms

Scoping searches of related literature enabled the development of search terms, through reading reviews of comparable subjects and highlighting keywords within the topic area. Search terms were considered within research supervision, where additional synonyms were reviewed and added to the final search terms.

Search terms were set to occur within the ‘title’ of papers, as the previous application to ‘all’ and ‘abstract’ resulted in instances of unrelated research being returned. A limiter of ‘English’ was applied during the search protocol, to ensure papers would be understood by the researcher.

"clinical psycholog*" OR psycholog* OR "psychology, clinical" OR clinpsyd OR dclinpsy

AND

"mental health problem" OR "mental* ill*" OR "mental wellbeing" or "psych* wellbeing" OR "psych* health" OR "psych* distress" OR "emotional distress" OR "lived experienc*” OR depress* OR anxiety OR distress

AND

disclos* or "self-disclos*" or "self disclos*" OR conceal* OR “self-conceal” or “non-disclos*”

AND

trainee* OR training OR student

It is important to note that the decision was made to only include search terms linking to disclosure of mental health difficulties due to an interest in help seeking as a secondary phenomenon to disclosure, therefore only disclosure-focussed search terms were utilised. It is thought that help-seeking is an important factor within the process of disclosure as implicated in previous studies, and an individual’s intention to conceal or disclose lived experience is related to previous or current help-seeking experiences and highlights the process of disclosure and help-seeking as interconnected (Hinson & Swanson, 1993; Kelly & Achter, 1995; Cepeda-Benito & Short, 1998).

Selection Strategy

Duplicate papers were identified and removed during screening. The remaining papers (944) were then screened by Title and Abstract against inclusion and exclusion criteria, outlined in Table 1. Inclusion and exclusion criteria were developed through discussion within research supervision. Afterwards, the full papers (56) were accessed, read and the inclusion and exclusion criteria were applied to establish eligibility and applicability to the focus of the review.

Table 1.

Inclusion and Exclusion Criteria and Rationale for Papers Included in the Review

Inclusion Criteria	**Rationale**
Peer-Reviewed	To ensure articles had sufficient scientific rigour.
Available in English	Necessary to be read and understood to ensure articles were relevant to the research question. It was not within the remit of the study to translate non-English studies.
Qualitative and Quantitative Methodologies	Both methodologies were considered in order to present a rigorous review of available data.
Exclusion Criteria	**Rationale**

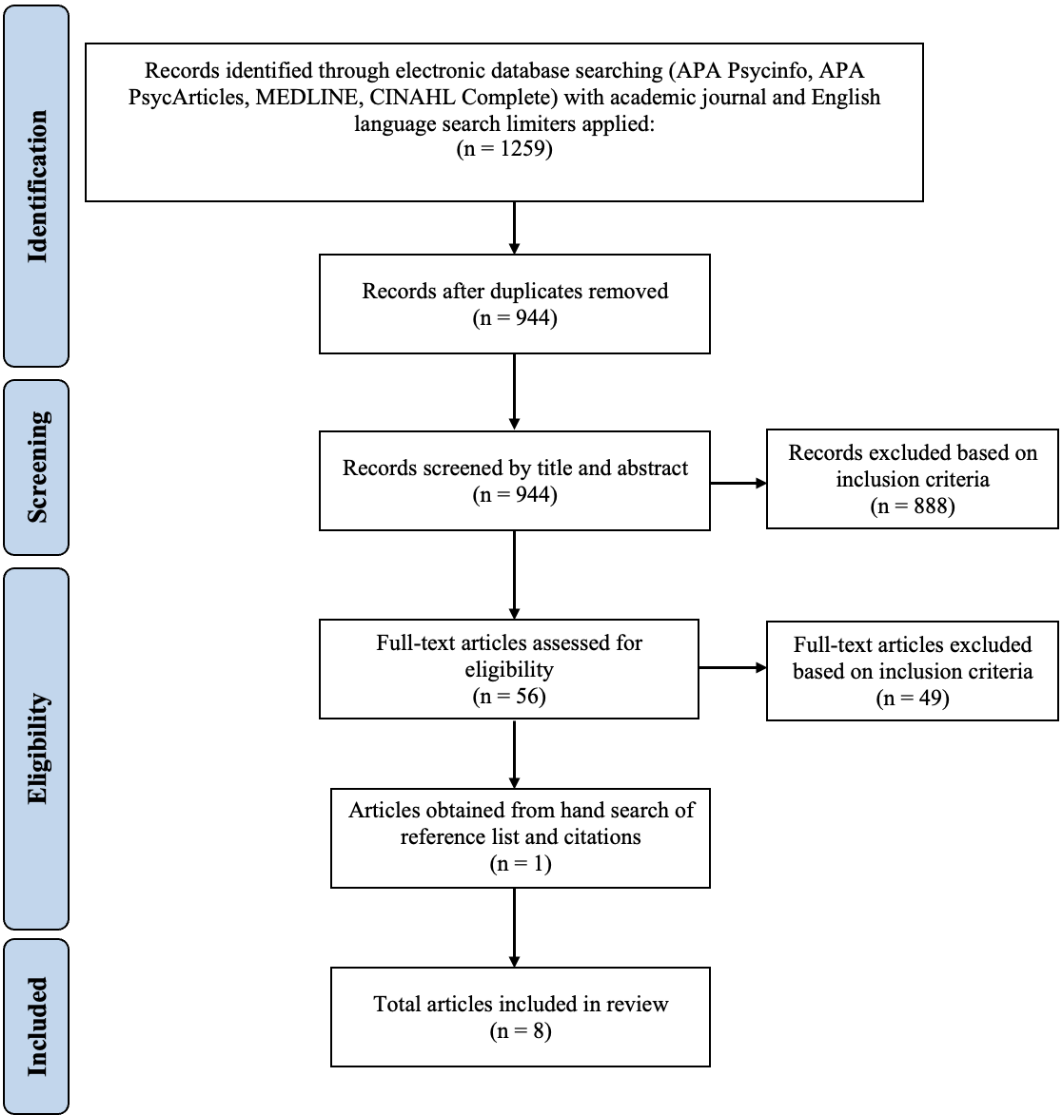
Insufficient focus on help seeking or disclosure of lived experience of mental health difficulties	The review question is focussed specifically on lived experiences of mental health difficulties
Insufficient focus on students within mental health professions	The review question is focussed on the experiences of students within the psychological professions
Conference posters	Posters provide insufficient data to be included in a systematic literature review, and may not be peer-reviewed to ensure quality
Literature review/Correspondence	This review aims to synthesise original, primary research
Not Peer-Reviewed	Cannot ensure study quality

Following initial screening, full text articles were reviewed with inclusion criteria applied. 49 papers were excluded at this stage and a hand search of reference lists was conducted, during which, one additional paper was included. A total of eight papers were included in the present review. Figure 1 outlines the process of paper selection.

Due to the lack of existing literature relating to the trainee clinical psychologist population, it was decided that literature relating to student mental health professionals (including mental health nursing students, counselling trainees, psychology students and nursing students), would be included in the review, as the experiences of this population may mirror the experiences of the trainee clinical psychologist population.

Figure 1.

PRISMA Flow Diagram Demonstrating a Summary of the Article Screening and Selection Process (Moher et al., 2010).



Data Extraction and Quality Assessment

Following article selection, data was extracted from each article, including study aim(s), participant characteristics, design, analysis and key findings as outlined by the study. For full details of data extraction, see Table 2.

Two checklists were utilised to evaluate the quality of included studies. For qualitative studies, the National Institute for Health and Care Excellence appraisal checklist (NICE, 2012a) was employed (see Appendix D). For quantitative studies, the National Institute for Health and Care Excellence (NICE) quality appraisal checklist for quantitative studies reporting correlations and associations was used (NICE, 2012b; see Appendix E). The quantitative checklist contains 14 items, each item is rated and awarded an overall identifier of either ++, +, -, NR (not reported) and NA (not applicable). The qualitative checklist consists of 19 items, all items must be reviewed and awarded a final grade according to ++, +, -. Based on researcher judgement of ‘all/most’, ‘some’, ‘few/none’ of the criteria being met to make the final rating. Additionally, the quantitative measure recommends giving two ‘overall scores’: one for internal validity and one for external validity.

To establish inter-rater reliability, three quantitative studies were randomly selected and rated by another researcher who was blind to the original scores, any differences in quality assessment were discussed until an agreement was met. Minimal differences were found and a percentage agreement of 80% was agreed. Appendices G and H demonstrate the results of quality assessments. Quality assessment was not deemed an appropriate method to exclude studies from the analysis due to the limited amount of studies, however it provided key information explored within the synthesis.

The NICE checklists for both qualitative and quantitative research appraisal were selected and applied because they are robust and established checklists providing sufficient detail of review to consider relevant methodological quality.

Data Synthesis

Data synthesis was conducted using a narrative synthesis approach (Popay et al., 2006). As the review contained quantitative and qualitative studies which utilised varying measures, it was not plausible to conduct a meta-analysis in this instance. Narrative synthesis allows for the analysis of studies with varying methodologies to consider all the available experiences of disclosure in trainee mental health professionals. Moreover, this method is known as a form of storytelling and uncovers relationships within the data, this was deemed important due to the broad focus of the research aims which explores mental health trainees' experiences of disclosure.

Results

Overview of the Included Studies

In total, eight studies were included in the present review (see Table 2 for an overview). Of the included studies, six were quantitative, two were qualitative. Studies recruited participants from the UK, United States, Canada and Australia, across the lifespan and included mental health professionals in training, studying psychology and mental health nursing. The qualitative studies utilised individual interviews and thematic and narrative analyses (Turner et al., 2021; Dayal et al., 2015). The quantitative studies (Victor et al., 2022; Grice et al., 2017; Edwards & Crisp, 2017; Thomas et al., 2014; Mitchell, 2018; Joseph et al., 2022) utilised different methods of analysis. Victor et al. (2022) utilised descriptive statistics and analysis involved group comparisons using one-way analysis of variance (ANOVA). Grice et al. (2018) used exploratory factor analysis and ANOVAs to understand maladaptive perfectionism and anticipated stigma within trainees. For data involving trainees with lived experience, one-way repeated measures ANOVAs were conducted to understand how the likelihood of disclosure was influenced by recipient type. Edwards et al. (2017) employed descriptive statistics to understand the perceived barriers to accessing support for mental health difficulties, and the factors which impede disclosure. Likewise, Mitchell (2018) used analyses in the form of descriptive and inferential statistics through chi-square analyses to understand the rates of anxiety and depression in nursing students. Joseph et al. (2022) used descriptive statistics and analysis involving internal comparisons and chi-square analyses for quantitative data. Similarly, Thomas et al. (2014) utilised chi-square analyses to explore interactions between personal factors which influence disclosure and help seeking behaviours within healthcare students and logistic regression analyses to understand attitudes towards help-seeking and disclosure.

No studies used the same dataset, and several studies explored the experiences of mental health professionals in training, which was deemed to provide rich data including participants from different training backgrounds. All studies focussed on experiences and understandings of mental health professionals in trainings' help-seeking for, or disclosure of mental health difficulties.

Quality of Included Studies

Regarding quantitative studies, most were deemed to be good quality (Joseph et al., 2022; Victor et al., 2022; Grice et al., 2018; Michell 2018) and received a rating of "++" due to representative samples and reliable outcome measures. Two quantitative papers received a lower rating of "+" due to a lack of information and it remained unclear whether these studies had fulfilled items within the checklist. Overall, both qualitative studies were deemed good quality (Turner et al., 2021; Dayal et al., 2015) and were given ratings of "++". Broadly, research designs were robust, analyses were thorough, well-described and studies presented findings which were compelling.

Table 2.
Summary of Studies

Study and Country of Origin	Study Aims	Participant Characteristics	Methodology and Measures	Design and Analysis	Key Findings	Quality Assessment Rating
Dayal, Weaver and Domene (2015) Canada	To explore shame as a barrier to help seeking and the factors which contribute to resilience.	7 counselling trainees who have lived experiences of eating problems	Qualitative; non-directive interviews	Narrative analysis	Stories of shame and resilience recounted by trainees with eating difficulties suggest there is an existing dialectical conflict between protecting shame and prioritising recovery. Shame was defined as layers of failure or weakness for not attaining self-prescribed ideals and not overcoming the eating issue. Themes also included Secrecy; Disconnection from others and the self.	++
Edwards and Crisp (2017) Australia	To conduct a pilot investigation into attitudes towards seeking help and barriers to help-seeking reported by pre- and post-qualified mental health professionals and	31 student mental health professionals (including psychologists, psychiatrists and mental health nurses)	Quantitative; Barriers to Access to Care Evaluation Scale (BACE; Clement et al., 2012)	Chi-square analyses	Barriers were reported as indicated to be: ‘concern about what people at work might think say or do’, ‘difficult taking time off work’, ‘feeling embarrassed or ashamed’.	+

	to investigate different in the reported barriers.		Single item questions were administered to understand participants’ experiences of mental health difficulties, requiring a ‘yes’ or ‘no’ answer.			
Grice, Alcock and Scior (2018) UK	To explore trainee clinical psychologists’ experiences of disclosure of lived experience of mental health difficulties, through understanding factors associated with anticipated disclosure.	348 trainee clinical psychologists	Quantitative; Questionnaires were administered in the form of: Multidimensional Perfectionism Scale (MPS; Frost et al., 1990) Perceived Devaluation and Discrimination Scale (PDD; Link, 1987) Anticipated likelihood of disclosing experiences of mental health difficulties was measured using	Exploratory factor analyses were conducted to determine whether responses to the MPS (Frost et al., 1990) fell into the six factors outlined within the measure and to distinguish between adaptive and maladaptive perfectionism. For hypothetical disclosure scenarios, a multi-level linear analysis investigated contributions to disclosure. For trainees who reported having	Participants reported broad experiences of mental health difficulties. Several participants indicated lived experience of being attracted to a career in mental health, in addition to stress relating to the emotional demands of training. Factors associated with disclosure decision making revealed significant patterns, with anticipated likelihood of disclosure being predicted by recipient type and whether the problem was past or current; levels of anticipated stigma and traits of maladaptive perfectionism.	++

			questions taken from research from Rüsch et al., 2011. Participants were also asked whether they identify as someone who has lived experiences of mental health difficulties.	lived experience, one-way ANOVAs explored help-seeking behaviours by recipient type.		
Joseph, Barnes, Harris and Boyd (2022) Australia	To understand and explore the reasons behind supervisee disclosure of lived experience; and to understand whether supervisors who openly share their lived experience of mental health difficulties experience more disclosures from supervisees.	40 mental health professionals in a supervisory role to trainee health professionals, including psychologists, mental health nursing staff	Quantitative; Questionnaire designed specifically for this study gathering data on reasons for disclosure of lived experience, involving quantitative data with option open text spaces to provide further context.	Descriptive statistics and chi-square analyses	Disclosure of previous lived experiences of mental health difficulties are more likely to occur within a well-established supervisory relationship. The most commonly reported reason for disclosure was ‘a desire for social support’ and ‘stigma reduction’. Findings indicated there is a desire for accessible examples of how other supervisors have navigated trainee disclosures previously, suggesting a need for improved resources relating to supporting supervisees with	++

					lived experiences of mental health difficulties.	
Mitchell (2018) UK	The aims of this study were to understand: The levels of anxiety and depression amongst undergraduate students taking a programme of study. Understand whether the level of anxiety and depression vary with demographics characteristic of the sample? What percentage of students seek psychological help/disclose difficulties? What are the main perceived barriers and facilitators of help seeking?	121 nursing students	Quantitative; Participant experiences of psychological distress – Symptom Check List-90-R (SCL-90-R, Derogatis, 1994) Seeking support questionnaire, made specifically for this study, involving eight items designed to understand participant help-seeking and any potential barriers.	One-way ANOVAs	90% respondents reported anxiety within clinical range, and 84% for experiences of depression, therefore for both sets of experiences, participants reported higher than average scores for anxiety and depression. 34.7% of participants reported seeking help from their GP, 26.4% from university counselling services and 24.8% seeking support from student support and guidance services. 57.8% feared disclosure due to other people’s perceptions of their ability as a health professional (nurse). 55.3% feared disclosure due to the fear that others may be talking about you.	++

Thomas, Caputi and Wilson (2014) Australia	Conduct a pilot study exploring attitudes towards seeking help/disclosing mental health difficulties and the barriers to help seeking. To investigate differences in barriers reported by experienced and inexperienced mental health care professionals, including trainees.	289 psychology students	Quantitative; Questionnaires were utilised to assess: Intention to disclose through the General Help Seeking Questionnaire (GHSQ, Wilson et al., 2005); Disclosure Expectations Scale (DES, Vogel & Wester, 2003); Attitudes Towards Seeking Professionals Psychological Help Scale (ATSPPHS; Fischer and Farina, 1995) to measure general attitudes about help seeking.	Chi-square analyses and logic regression analyses	Two threads of Attitudes were identified; firstly participant scores indicated they would 'seek help from a professional if I believed I were having a breakdown' and 'a person with mental health difficulties is not as likely to solve it alone'.	+
Turner, Moses and Neal (2021) UK	To explore trainee clinical psychologists' experiences of self-disclosing mental health difficulties	12 trainee clinical psychologists	Qualitative; semi-structured interviews	Grounded Theory	Ideas about factors involved in trainees decision to seek help, including motivation (e.g. desire to feel understood), enablers (e.g. trusting	++

					relationships) and barriers (e.g. internalising stigma).	
Victor, Devendorf, Lewis, Rottenberg, Muehlenkamp, Stage and Miller (2022) United States	To examine and understand the prevalence of lived experiences of mental health difficulties within trainees of applied clinical psychological science and explore the factors which influence disclosure and help seeking.	1959 faculty, graduate and post-doctoral trainees affiliated with US and Canadian training programmes in clinical, counselling and school psychology.	Quantitative; Questionnaire designed specifically for this study, involving ‘yes/no’ questions addressing mental health difficulties.	Descriptive statistics and one-way ANOVAs to measure for group comparisons	82.8% of respondents reported having lived experience of mental health difficulties. Findings suggested that cisgender female trainees and trainees from the LGBTQ+ community are more likely to have lived experience.	++

Narrative Synthesis

Narrative synthesis is a process using words to review quantitative or qualitative data, focussing on using findings from studies to 'tell the story' (Popay et al., 2006), this approach was deemed appropriate for the research focus due to its focus on experiences. It was essential to synthesise data using an approach which aligns with the social constructionist epistemological stance, enabling a construction of meaning through interactions and processes within an individual's contexts (Burr, 2015).

Throughout the process, Popay et al.'s (2006) guidelines on conducting a narrative synthesis were utilised, where each paper was reviewed several times and a detailed data extraction method was completed. Following this process, an initial thematic analysis was carried out, whereby the extracted findings across papers were grouped into different themes using an inductive approach. Once findings from the selected papers were synthesised, five different themes were identified: 'stigmatisation', as experiences of shame and secrecy appeared to connect with participants' experiences of internal and external stigma; 'sources of support' due to participant narratives involving seeking help from others); 'facilitators' of and 'barriers to help-seeking' as data highlighted positive attitudes and experiences of help-seeking, in addition to challenges which serve to hinder seeking help when needed; and 'incentives to seek support', this theme highlights motivating influences on participants decisions to disclose and seek help.

Subsequently, an ecomap (Appendix I) was developed by the author to explore the relationship between themes, in addition to contextual themes from the literature. An ecomap was selected as a means to illustrate and explore relationships between the extracted data and further literature in the area, as selected by relevance to the systematic review. Further, the ecomap was thought to consider the context surrounding the data and was used to explore connections among the reported findings, in a similar way to 'ideas webbing' from Popay et al.'s (2006) narrative synthesis guidelines. This method of examining the data aligned with the social constructionist epistemological standpoint of the present review, as the construction of meaning is thought occur within wider contexts. The following section provides a description of the themes and the narrative of the ecomap.

Stigmatisation

The first theme connected with experiences of stigma within help seeking and disclosure of mental health difficulties which were seen across samples. Experiences of emotional distress were thought to relate to help-seeking and disclosure as a means to obtain support, either in hypothetical or real-life situations (Edwards & Crisp, 2017; Dayal et al., 2015; Turner et al., 2021; Grice et al., 2018).

Students reported feeling shame relating to actual or anticipated help-seeking (Dayal et al., 2015; Edwards & Crisp, 2017; Turner et al., 2021) which led to secrecy about lived experience, in turn, impacting decision making surrounding help-seeking and disclosure.

> *"I don't want people to know, because I don't want them to look at me differently. It would change their perception of me as perfect, and pulled together, and everything was wonderful to, "Wow! Oh my god, she's a bit of a mess." It threatens my perceptions of myself and who I am. In a sense it's a way of hiding my true self."*
>
> (Dayal et al., 2015, page 160)

Results suggested that, for some, shame led to minimisation of the problem and reluctance to seek help, thus invalidating lived experiences, leading to isolation and fear of judgement and disconnection from others (Mitchell, 2018). Other emotional reactions include embarrassment (Edwards & Crisp, 2017), or anxiety about disclosing lived experiences of mental health difficulties (Turner et al., 2021):

> *"I guess it was kind of embarrassing as well when you feel like you should not have these sorts of problems if you are a trainee clinical psychologist you kind of feel like um, a bit embarrassed uh to say that you are having these problems."*
>
> (Turner et al., 2021, page 738)

The above quote highlights the influence of concerns surrounding external stigma, which can be internalised in decision making around help-seeking and disclosure. In line with this, some students felt reluctant or less able to share lived experience due to concerns surrounding the need to appear competent within the training context (Victor et al., 2022). Moreover, others felt disclosing difficulties represented behaviour which failed to align with their authentic selves, leading to further secrecy about mental health difficulties and avoidance of disclosure (Dayal et al., 2015). Many students held apprehension about sharing their lived experiences, suggesting that seeking help leads to an increase in scrutiny from others (Mitchell, 2018).

Sources of Support

Several aspects influence who students sought help from. It is clear that deciding the source of support is a process unique to the individual, and decision making around disclosure is an intricate process with varying factors at play (Grice et al., 2018).

Supervisory relationships influence the likelihood of help-seeking (Puig et al., 2012). Students reported a higher likelihood of disclosing lived experience with clinical supervisors as opposed to someone in a different role, such as an educational trainer (Joseph et al., 2022). Additionally, students are thought to be more likely to seek help from university staff if they are experiencing mental health difficulties in the here and now; with the aim to obtain practical support and are more likely to do so, if their experiences align with anxiety or low mood (Grice et al., 2018). Some students reported feeling reluctant about seeking help from clinical supervisors, suggesting a dialectical struggle or duality encapsulating both a supportive supervisory relationship, and notions that supervisors will not be able to help. Conversely, participants may be more willing to disclose their lived experience or feel that some supervisors are more supportive than others:

> *"there's nothing they could do about it, and there's a dual role, so there's no point in telling them,"*
>
> *"it's not something they ask about and it's not something I'm willing to volunteer."*
>
> (Dayal et al., 2015, page 159)

There is a high prevalence of help-seeking within non-professional contexts, including friends, family and peers. Students may prefer to seek help from family or friends, which may discourage help-seeking from other sources, possibly due to the nature of their lived experience (Edwards & Crisp, 2017). Grice et al. (2018) support this finding, reporting that students anticipated being more likely to disclose a specific phobia to friends than to a professional.

Connection with others was considered essential for positive experiences of disclosure and help-seeking. Dayal et al. (2015) supports the notion that connecting with peers who have similar experience cultivated feelings of "relief from shame" when met with unconditional acceptance within a peer-support setting. There is clear value in feeling safe to disclose a problem, which influences the likelihood of help-seeking and disclosure. Notably one-to-one spaces are reported to be most valued as a safe-space to share, most papers report a higher likelihood of disclosure to peers within this context, with some reporting a supervisor as an equally safe-person to disclose to (Turner et al., 2021).

Facilitators of Help-Seeking

Several papers commented on factors that facilitate help-seeking within students (Thomas et al., 2014; Mitchell, 2018; Victor et al., 2022; Turner et al., 2021). Help-seeking in university students is clearly linked to positive attitudes about future help-seeking (Thomas et al., 2014). Furthermore, supportive responses to disclosure of lived experience enables students to integrate personal and professional aspects of their identity, thus facilitating a positive experience of help-seeking (Turner et al., 2021):

> *"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."*
>
> (Turner et al., 2021, page 739)

Several papers commented on the power of being 'out' about lived experience as a facilitator of help-seeking. There is a higher likelihood of disclosure to a clinical supervisor when it is known that the supervisor has personal experiences of mental health difficulties (Joseph et al., 2022; Dayal et al., 2015). Research suggests that students have a responsibility to pioneer openness about mental health as a means to reduce societal stigma, even in times where this might feel uncomfortable (Grice et al., 2018). This finding highlights that disclosure or help-seeking can be motivated by the hope that the action will prevent others from ascribing difficulties to negative personal attributes (Turner, et al., 2021).

Furthermore, a strong relationship exists between help-seeking and creating a culture of openness about difficulties. Students reflected that help-seeking decisions were influenced by a desire to actively change narratives surrounding mental health. For example, in one study, emphasis was placed on the importance of open conversations around mental health, not only with peers, but with other professionals, supervisors and course staff (Turner et al., 2021).

Barriers to Help-Seeking

A key barrier to help-seeking is the notion that many university programmes do not address personal wellbeing, as Thomas and colleagues found in their 2014 study, psychology students reported a recognition of the need for help-seeking when experiencing distress. Therefore the integration of information about support-seeking for mental health difficulties into course materials and the wider culture of university programmes has potential to increase the likelihood of help-seeking within student populations (Joseph et al., 2022; Mitchell, 2018).

Students described a key barrier to help-seeking as a lack of clarity around support sources, with many reporting they would not seek support due to not knowing what is available (Edwards & Crisp, 2017). This links with findings from Joseph et al. (2022) which demonstrated a lack of resources or training materials pertaining to navigating disclosure from both student and supervisor perspectives, highlighting that 33% of students disclosed mental health difficulties in order to obtain support with finding recommendations for interventions.

Many individuals reported feeling a pressure to be self-sufficient, rather than to seek help for their difficulties due to worries about others’ perceptions of them changing, for example the worry that others may view their mental health difficulties as a ‘weakness’ or wanting others to see them as a ‘good trainee’ (Turner et al., 2021). A further barrier to disclosure and help-seeking is thought to be students’ worries that concerns may be raised by their course about their fitness to practice (Mitchell, 2018).

Research found that trainees often do not engage in help-seeking during training, and in psychology more broadly due to a lack of ‘outness’ from other professionals within the psychology world whereby lived experience narratives are spoken about in an open and non-judgemental way (Turner et al., 2021):

> *“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 do not really talk about it. I do not know, I do not know what that's about, whether it's just, do we want to present the sort of best versions of ourselves?”*
>
> (Turner et al., 2021, page 738)

The importance of sharing a hidden need was further emphasised by findings that students disclosed in order for others to see ‘that side’ of them and to feel better understood by others (Edwards & Crisp, 2017; Turner et al., 2021).

Incentives to Seek Help

Findings suggest that students may disclose lived experiences as a means to encourage destigmatisation and facilitate conversation about lived experience in an attempt to normalise this phenomenon within the trainee population (Joseph et al., 2022; Turner et al., 2021).

The anticipated ‘value’ of disclosure is deemed a key motivation behind help-seeking, within which decisions are guided by how impactful disclosure will be, while fear of stigmatisation can also serve as a motivator for disclosure if it is deemed ‘valuable’ (Grice et al., 2018). Students reported a higher likelihood of exploring help-seeking options only when their distress levels were moderate to high, suggesting that disclosure of distress is something that is not considered unless their situation had escalated (Edwards & Crisp, 2017). This supports the idea that many students will cope alone and avoid seeking help, as a means to reduce anticipated stigma (Mitchell, 2018; Dayal et al., 2015; Turner et al., 2021).

There was a strong relationship between disclosure, help-seeking and hope for change, with decisions to disclose to others occurring as a means to create change in their circumstances (Turner et al., 2021):

> *"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."*
>
> (Turner et al., 2021, page 737)

Another notable influence in disclosure among students was seeking support from others (i.e. family, friends, supervisors) helped to move towards help seeking and, as a result, facilitated resilience and a reduction in shame (Dayal et al., 2015).

Discussion

Overview of Findings

The aim of this review was to explore and synthesise existing research exploring the prevalence and choices linked to disclosure of lived experiences of mental health difficulties among mental health professionals in training, as studies included undergraduate students, mental health nurses in training and clinical psychologists in training. The narrative synthesis indicated five themes across studies, illuminating distinctive aspects of trainee mental health professionals' experiences and understandings. The different components and themes were compiled into an ecomap (Hartman, 1978), as a means to illustrate the authors interpretation of the emerging relationships and interactions between the factors (Appendix I), as ecomaps are deemed a tool which consider groups within their social, cultural and political contexts. With this in mind, the development of the ecomap considered ideas taken from previous research in addition to data included in the present review, therefore findings from both were utilised to inform the creation of the final ecomap.

The present review revealed studies of varying quality. It could be argued that existing literature lacks nuanced understanding of the complex processes involved in decision making around help-seeking and disclosure, and does not consider ideas taken from psychological theory (e.g. consideration of shame, guilt and the inter-relation between these). Both shame and guilt involve self-blame, closely linking to perceptions of the self (Tangney & Dearing, 2002). The presence of shame or guilt correlates with levels of perceived self-efficacy (Baldwin et al., 2006). Findings of previous research suggest that experiencing shame or guilt influences decision making surrounding disclosure, yet limited studies discussed this process, despite stigma being found a key factor in decision making around disclosure (Dayal et al., 2015; Mitchell, 2018; Edwards & Crisp, 2017; Grice et al., 2018; Turner et al., 2021). It would be advantageous if studies linked existing psychological theories and ideas to explore help-seeking behaviours within the trainee mental health professional population.

The majority of quantitative studies within the present review utilised surveys to obtain data, this methodology can reduce the contextual information around help-seeking and disclosure, including facilitating and barriers to disclosure and help-seeking. Additionally, while the two qualitative studies did discuss findings within context, they did not explore how author bias influenced study results and interpretation. Several studies focussed on hypothetical ideas relating to help-seeking and disclosure, although this is valuable evidence, it is unclear whether findings outline real-life experiences and choices of mental health professionals in training. With this in mind, findings within the papers using hypothetical data may be influenced by researcher bias and conscious or unconscious assumptions about how mental health professionals in training would approach help-seeking and disclosure.

The present review highlighted that lived experiences among mental health professionals in training are prevalent, yet this finding could be attributed to self-selection bias within participants, as those who feel more able to speak about experiences of help-seeking may be more likely to contribute to research investigating such topics. In keeping with earlier research (e.g. Klein et al., 2023), the present findings highlight that anticipated or perceived stigma, perceptions about the value of disclosure and availability of support appeared to influence many participants' approach to help-seeking. For example, many studies outlined experiences of internalised stigma with participants reporting feelings of embarrassment, shame and viewing lived experience as a 'weakness', which all contributed to barriers to disclosure and help-seeking. This conclusion corresponds with findings from previous research investigating qualified mental health professionals, whereby stigma was most frequently reported as a barrier to disclosure of lived experiences of mental health difficulties (Tay et al., 2018).

Participants with lived experience reported that they were less likely to share their experiences or seek help, due to the fear of being judged negatively or disclosure negatively affecting their career. It could be suggested that this finding indicates a wider systemic 'culture' of stigma within educational and workplace settings, which serves to perpetuate stigmatising ideas about seeking help for, or simply having, lived experiences of mental health difficulties. This has a clear negative impact and addressing this is essential and is an especially important area to address, given the rates of staff turnover and levels of burnout currently within NHS mental health settings (Johnson et al., 2018).

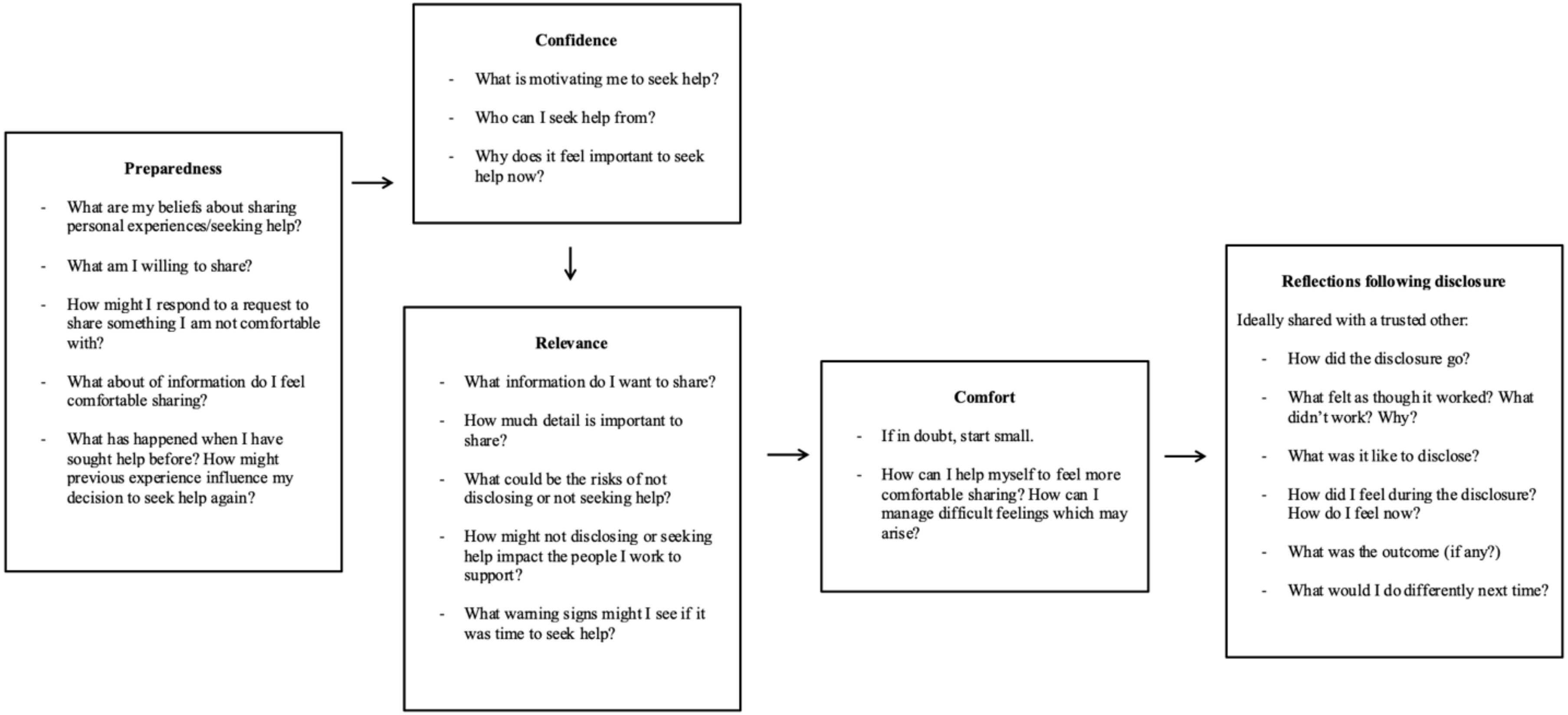
All but one study failed to provide a framework to better facilitate or understand the process of disclosure and help-seeking among mental health professionals in training. This highlights a potential absence in guidance presented to individuals when considering sharing their lived experience or seeking help from support sources.

With this finding in mind, there may be value in addressing the present lack of guidance by using a supporting framework to inform the process of disclosure. At the time of writing, no specific framework had been developed for use within the mental health professional in training population, therefore the author sought to create a disclosure framework for this group by adopting ideas from the Sharing Lived Experiences Framework (SLEF) (Dunlop et al., 2021; Appendix J). The original SLEF provides a structure for sharing lived experiences with others in a clinical setting (i.e. with service users), however the principles of the model could be valuable if adapted for use within psychological or university training settings. Developed for use within social work, the model outlines six areas for reflection including Preparedness, Confidence, Competence, Relevance, Comfort and Supervision, and findings suggest staff felt more able to navigate disclosure following training on this framework. Presently, no formalised research exists which investigates the efficacy of the SLEF as it is a newly devised concept. Therefore the proposed conceptual model outlined in Figure 2 could be suggested for use within the trainee mental health professional population, including trainee clinical psychologists and trainee mental health nurses. Given there is no other existing framework adapted for use within these group, there is a value in the provision of guidance surrounding the sharing of lived experience narratives. The implementation of the author’s proposed conceptual model inspired by the SLEF framework has potential to provide a supportive and empowering structure for student mental health practitioners to share or seek help more readily and feel contained and confident in doing so. The conceptual map devised for the present review mirrors key elements of Dunlop et al. (2021)’s framework and includes headings which align with the original framework. In the conceptual map devised from the present review, headings include:

- ‘Preparedness’ - involving consideration of individual beliefs about sharing lived experience, in addition to details of what feels appropriate to share;
- ‘Confidence’ which encourages reflection on what support would feel beneficial, who is available to seek help from and why is it the right time to seek help now;
- ‘Relevance’ which encourages reflection on details of sharing lived experiences, risk factors of not seeking help;
- ‘Comfort’ which suggests reflection on aspects which may mitigate the challenges of how difficult the process of sharing may be.
- ‘Reflections following disclosure’ which outline ideas for reflections after the interaction, with the aim to consider helpful aspects and whether anything could have been done differently.

Each component of the proposed reflective framework is derived from themes which emerged from the present review, and do not exactly match the original Dunlop et al. (2021) framework. Components include the consideration of potential impact of stigma from self or others through reflection; consideration of available support sources; facilitating factors; barriers or challenges and incentives and the practical value of sharing.

Figure 2.
Proposed conceptual framework for sharing or seeking help for mental health difficulties within the supervisory relationship (adapted from the Sharing Lived Experiences Framework (SLEF).



Preparedness

- What are my beliefs about sharing personal experiences/seeking help?
- What am I willing to share?
- How might I respond to a request to share something I am not comfortable with?
- What about of information do I feel comfortable sharing?
- What has happened when I have sought help before? How might previous experience influence my decision to seek help again?

Confidence

- What is motivating me to seek help?
- Who can I seek help from?
- Why does it feel important to seek help now?

Relevance

- What information do I want to share?
- How much detail is important to share?
- What could be the risks of not disclosing or not seeking help?
- How might not disclosing or seeking help impact the people I work to support?
- What warning signs might I see if it was time to seek help?

Comfort

- If in doubt, start small.
- How can I help myself to feel more comfortable sharing? How can I manage difficult feelings which may arise?

Reflections following disclosure

Ideally shared with a trusted other:

- How did the disclosure go?
- What felt as though it worked? What didn't work? Why?
- What was it like to disclose?
- How did I feel during the disclosure? How do I feel now?
- What was the outcome (if any?)
- What would I do differently next time?

(Dunlop et al., 2022)

When considering ideas pertaining to disclosure and help-seeking, many participants described not knowing where to seek support from, which acted as a barrier to disclosure and help-seeking (Thomas et al., 2014; Edwards & Crisp, 2017; Joseph et al., 2022). Consequently, it is vital to consider how perceived availability of support sources or services impact disclosure decision making and subsequent actions linked to seeking help. Moreover, supervisors described a desire for a clear framework to aid in the navigation of disclosure (Joseph et al., 2022). The lack of such frameworks may serve to perpetuate the lack of conversation surrounding lived experiences between supervisor and trainee, in addition to maintaining the lack of acknowledgement of lived experiences among mental health professionals in training more broadly.

Existing literature demonstrates a focus on mental health diagnoses and disclosure decision making (e.g. Victor et al., 2022), variation in training disciplines may impact ideas surrounding lived experience and as a result influence attitudes towards disclosure and help-seeking (e.g. training in a more medicalised model, with less focus on psychologically-informed ideas). Ideas surrounding stigma may also be present at differing levels within different disciplines, as supported by findings from Boyd and colleagues (2016).

Stigma and barriers to help-seeking are multifaceted processes and with this in mind, the present review revealed an absence of discussion surrounding intersectional identities within disclosure and help-seeking (i.e. consideration of race, or sexuality) and wider social GRACES (Burnham, 2012). Notably, throughout most studies, there were more female participants than male, this could be attributed to the existing gender imbalance within mental health professions currently (Victor et al., 2022; Joseph et al., 2022; Turner et al., 2021; Edwards & Crisp, 2017; Dayal et al., 2015; Mitchell, 2018; Grice et al., 2018; Thomas et al., 2014). No studies emphasised exploration of other contextualising factors which may impact the relative power or marginalisation of participants (e.g. race, disability, class). Investigation of these broader constructs is imperative to help mental health professionals in training understand the processes and decision making behind disclosure, in order to promote help-seeking for lived experiences. Interventions such as the proposed adapted-SLEF framework may serve to shift unhelpful discourses about mental health professionals with lived experience and promote engagement with sources of available support.

Few studies outlined favourable outcomes and encouraging experiences of disclosure and help-seeking, there was primarily focus on positive experiences within qualitative literature, suggesting the quantitative research in this topic may not be far-reaching enough to obtain rich information about the valence of experiences. With a predominant focus on stigma, studies failed to highlight incidences of increased resilience, therefore further qualitative exploration of outcomes of disclosure and help-seeking would reveal the functions of disclosure and valence of help-seeking experiences. There is clear demand for further research into existing support structures within educational and placement settings which facilitate help-seeking among student mental health professionals.

It would be advantageous for future research to consider how existing frameworks support disclosure among this population, and how these frameworks could be adapted to bolster support structures for those who decide to disclose or seek help. An existing example is the charity Mind have resources to support students to obtain support for mental health difficulties (Mind, 2023). Additionally, intervention aimed at dismantling stigmatising ideas about sharing mental health difficulties is essential in ensuring that students receive support. Perhaps through training which centres on non-stigmatising understandings of lived experience of mental health difficulties, delivered within educational settings at undergraduate and postgraduate levels.

Assessment of the Strength of the Review

Quality assessment revealed that most studies were of high quality. Studies receiving a lower quality score were impacted by a lack of detail. All studies utilised different participant samples, indicating the findings as representative of the experiences of students from a range of socio-political and cultural backgrounds. Furthermore, some studies focussed on anticipated disclosure and ideas about help-seeking, therefore there may be variance between the ideas and understandings of individuals who have lived experience of disclosure and help-seeking, and those who shared ideas about anticipated experiences based on hypothetical situations.

NICE (2011) demonstrates how researchers can influence data and subsequent conclusions drawn. There was a lack of clarity surrounding reliability of methods, as studies omitted information about the number of researchers involved in data analysis and whether datasets were triangulated, thus generating uncertainty around the effect of researcher bias and any subsequent influence on conclusions. Studies were successful in producing ideas which highlight common attitudes and experiences across samples relating to disclosure and help-seeking.

Wider Implications, Limitations and Future Research

Limitations relate to the focus of the utilised search terms which may be viewed as overly specific which therefore may limit the available papers for review. The original aim of the review was to focus on lived experiences of trainee mental health professionals within clinical psychology training, however due to the lack of available literature investigating the experiences of this population, the review includes literature relating to a wider range of mental health professionals in training.

It is recognised by the researcher that by not including broad search terms in the first and final sets of search terms that there may be some papers which were missed. Similarly, there is potential that including search terms which reflected help seeking rather than solely focussing on disclosure of lived experiences may have produced further papers had the terminology been included in the search. The review focuses broadly on on experiences of mental health professionals in training across different countries rather than solely on the experiences of trainee clinical psychologists. Consideration must be given to the variation in training structures across mental health training contexts which may impact review findings due to studies being carried out across different countries and different educational contexts.

There was a lack of studies from non-English speaking countries, as the search was limited to studies in the English language. Furthermore, only three UK-based studies were included in the review, it is possible that some findings may not be applicable to UK mental health training contexts. Moreover, due to the use of studies from varying countries, variations in the structures of healthcare systems may impact the likelihood of individuals' engagement in disclosure and any subsequent support. This may be due to differing factors, including approachability, affordability and availability (Levesque et al., 2013). Similarly, it is possible that variations in educational structures across the different included countries may have influenced participants' attitudes, ideas and experiences of disclosure and help-seeking, it is unclear how much this may have impacted findings of the present review, therefore further investigation of this area specifically could be advantageous.

The present review may be influenced by author biases, as inferences could be impacted by authors ideas pertaining to this topic, despite efforts to limit this. Additionally, due to the small number of qualitative studies included and the limited number of studies overall, the conclusions drawn may be limited. Nonetheless, the present review has sought to offer understanding and awareness into the strengths and weaknesses of existing research and provided suggestions for progress.

There is a clear need for acknowledgement of broad societal discourses on being a mental health professional in training with lived experience. Societal discourses currently develop and perpetuate stigma, shame and secrecy around sharing of lived experiences, which serve as a barrier to seeking and accessing support and may negatively influence wellbeing. The provision of non-stigmatising education around lived experience on a systemic level (e.g. within universities) has potential to challenge and uproot current negative discourses. Providing non-stigmatising education surrounding lived experiences, in addition to frameworks of support within university settings together with a broad societal level change could dismantle existing harmful discourses which serve to perpetuate stigmatising attitudes towards lived experiences of mental health difficulties among mental health professionals in training.

Conclusions

The present review outlines the strengths and limitations of research and identifies the need for further investigation of the complex processes surrounding disclosure and help-seeking within mental health professionals in training. There are clear barriers to help-seeking within this population, which impact ideas about receiving help. Together with broader ideas relating to identity as a mental health practitioner with lived experience, it is possible this finding relates to self-selection and researcher bias within the reviewed papers. Mental health professionals in training discuss experiences of internal and external stigma which can lead to a reluctance to seek help, in addition to increased isolation and secrecy. Findings are consistent with previous research on disclosure. Education providers have an opportunity to learn from existing disclosure frameworks which promote conversation about lived experience among trainee mental health practitioners.

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Part Two – A Narrative Exploration of Trainee Clinical Psychologists' Lived Experiences of Mental Health Difficulties.

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Abstract

A deficit of qualitative research exploring the lived experience of mental health difficulties of trainee clinical psychologists exists in the literature despite an abundance of quantitative studies which focus on qualified psychologist populations. The present study aims to investigate the lived experience of mental health difficulties of trainee clinical psychologists using non-directive interviews, with a particular focus on the understanding of, and meanings and narratives given to, the lived experience by the trainees themselves. Qualitative data has been obtained from 10 trainee clinical psychologists and understood through narrative analysis. A holistic-form analysis revealed three patterns within the participant narratives, each comprised of five phases appearing in different orders, all of which involving inter- and intra-personal experiences. A categorical content analysis identified six key themes of the data, encompassing: 1) personal meanings; 2) appraisal and understanding from others; 3) navigating training with lived experience; 4) education providers and surrounding systems; 5) holding a lived experience identity; and 6) reflections. Although the accounts of lived experience were all different, similar contextual themes were encountered throughout each of them. The current research shows that a whole-systems approach is helpful in supporting trainees with lived experience. This research supports the holistic consideration of power when bearing witness to narratives of lived experience.

Keywords

trainee clinical psychologists, lived experience, mental health difficulties, clinical psychology, DClinPsy

Introduction

The present study builds on existing research investigating lived experiences of mental health difficulties ('lived experience') among trainee clinical psychologists ('trainees') in the United Kingdom.

Defining Lived Experience

Lived experience can be defined as a "*range of mental health difficulties, regardless of whether the person has received a diagnosis or whether they have used public or private mental health services*" (BPS, 2020 p.7). The present study seeks to acknowledge the fluctuating nature of lived experience across time and contexts, again aligning with BPS DCP guidance which asserts "*Sections of this guidance focus explicitly on current mental distress… other sections are relevant to current and past lived experience*" (BPS, 2020 p.7).

This study uses the term 'mental health difficulties' to describe lived experience and intends to acknowledge the psychosocial causal factors, context and uniqueness of individual experiences of distress (BPS DCP, 2013). Lived experiences make up all human experience, however for mental health professionals (including trainees) there is an apparent 'culture of silence' surrounding support seeking and sharing of lived experience narratives, despite knowledge that mental health professionals are as susceptible to mental health difficulties as the wider population (Turner et al., 2021; Byrne et al., 2022).

Current UK Training Context

The role of a qualified clinical psychologist can be wide-ranging and varied within the NHS, with many individuals undertaking specialised training in specific psychological therapies, supervisory roles, clinical management and clinical academic research.

Clinical psychology training in the UK encompasses research, clinical and academic competencies within a three-year doctoral training programme as an employee of a host trust within the National Health Service (NHS). In 2022, the clinical psychology trainee workforce was comprised of 1155 individuals and numbers have steadily increased over the last three years due to increased funding as part of the NHS Long Term Plan (Clearing House for Postgraduate Courses in Clinical Psychology; CHPCCP, 2022; NHS, 2019). In 2020, intake included 770 trainees and in 2021, 979 trainees – these figures do not wholly represent increases to trainee workforce across all UK courses, as two courses do not require application via Clearing House and therefore are not included in statistics (CHPCCP, 2022).

The rapid increase in trainee numbers nationwide can be attributed to the Psychological Professions Workforce Plan for England (NHS Health Education England, 2021), which plans to expand the psychological professions within 2023/2024. This expansion aims to support the implementation of the NHS Long Term Plan (NHS England, 2019), in increasing numbers in the psychological professions due to a need for a diverse workforce involving quality, evidence-based psychological therapies. These changes have been deemed essential due to increases in demand for psychological intervention across the population as the NHS workforce is under pressure, exacerbated by the COVID-19 pandemic and a lack of resource across health and care systems. Such systemic pressures leave staff at higher risk of compassion fatigue, burnout and sickness thus emphasising the drive to increase numbers within the psychological professions.

Research highlights the prevalence of mental health difficulties among the clinical psychology profession, as Tay et al. (2018) found that of 678 qualified clinical psychologists in the UK, 62.7% reported having experienced a mental health difficulty at some point in their life; with 195 participants reporting experiencing two or more different mental health difficulties. These findings suggest that personal experiences of mental health difficulties are common among qualified clinical psychologists. Moreover, concerns regarding NHS workforce shortages suggest that a decline in staff wellbeing has led to low levels of staff retention (NHS Digital, 2023).

Upon completion of training, trainees meet standards of proficiency for practitioner psychologists set by the Health Care and Professions Council (HCPC; 2022) conferring eligibility for professional registration with the HCPC. Current accreditation standards set by the British Psychological Society (BPS, 2019) encompass the value of a ‘reflective-practitioner’ model which focuses on process over methodology (Schön, 1987). Additionally, trainees develop reflexive skills and strategies to manage the potential emotional impact of clinical training (Hall & Llewelyn, 2006). Consideration centres on self-reflection as a clinician including any impact of therapeutic work on the self and others, which is considered an integral part of professional development (Lavender, 2003).

Training courses focus primarily on providing psychological care to others, and may not emphasise important consideration of the mental health needs of those providing care. The impact of minimising the significance of trainee mental health, training courses risk colluding with the continuation of concealment of lived experiences within trainees thus perpetuating potentially negative outcomes for both trainee and client wellbeing as well as mental health stigma.

Lived Experience within Clinical Training

The structure of clinical psychology doctoral training is unique in that it does not require trainees to undertake mandatory psychological therapy throughout training, unlike other psychological training pathways, such as counselling psychology doctoral training which requires trainees to access a minimum of 40 hours of personal therapy throughout their training. Current prevalence rates of lived experience among the trainee population are unclear, though Grice et al. (2018) reported up to

47% of 648 trainees have had experiences of mental health difficulties. Given their research required self-report measures, it is possible that prevalence rates may be over or under represented within the data, though this is unclear.

The focus of the present research is not on the general experiences of trainees during training, however existing research provides important context around present challenges for trainees (Cushway, 1992; Grice et al., 2018; Higson & Allan, 2019). Consideration of such challenges is essential when exploring the understandings held by trainees about their lived experience during clinical training, as additional stressors attributed to the training context may compound existing difficulties or present new challenges. Cushway (1992) investigated experiences of stress among trainees and revealed significant levels of psychological distress attributed to course structure and work-related stress using a questionnaire and sample within a wide-ranging demographic. Trainees shared experiences impacting on both existing lived experiences and emerging mental health difficulties as a result of clinical psychology doctoral training.

Recently published guidance by the BPS acknowledges the unique and valued contribution of lived experience among the clinical psychology community and accentuates a need to embrace the humanity of mental health professionals in training (BPS, 2020). The guidance emphasises how mental health difficulties are common within psychological professions and highlights the intricacy involved in deciding to share lived experience with colleagues and education providers.

Wider Mental Health Context

Before considering the experiences of mental health difficulties in trainees, it is important to consider the prevalence of mental health difficulties among the wider population. One in six UK adults experience mental health difficulties at some stage of the life span and data illustrates rates of help-seeking within this population as very low (Henderson et al., 2013; McManus et al., 2016).

Relatively little is known about the mental health of those working and training within mental health services, despite reports of a higher prevalence of distress due to emotional manifestations of burnout and vicarious trauma (Rupert & Morgan, 2005). Mental health difficulties among those working in mental health services are thought to be increasing due to system-wide pressures of working in the NHS, accelerated by socio-political changes and the impact of the COVID-19 pandemic (Miu et al., 2022).

Similarly, there is a dearth of research exploring lived experience among trainee clinical psychologists. Some existing research focusses on lived experience among trainee psychotherapists (e.g. Byrne & Shufelt, 2014). Moreover, Kumary and Baker (2008) explored UK trainee counselling psychologists' perspectives and demonstrated high levels of stress and distress among participants in the 'personal and professional development', 'placements' and 'academic' domains of training. With the intention to investigate lived experience in trainee clinical psychologists, one study used quantitative measures to explore personality style, psychological adaptation and expectations of trainees and found lower levels of self-esteem and mood compared to normative means (Brookes et al., 2002). Additionally, 41% of 364 participants reported significant problems on one of more of: anxiety, depression, low self-esteem and work adjustment, though qualitative details of trainees' experiences largely remain unexplored. Similarly, research by Digiuni et al. (2013) investigated attitudes to help-seeking of 462 trainee clinical psychologists across the UK, United States and Argentina using self-reported measure assessing perceptions of stigma relating to accessing therapy and attitudes to help-seeking. The study found that perceived stigma from university staff and the public predicted rates of help-seeking across the sample, with cross-national differences with trainees in the US showing the least positive attitudes towards accessing therapy. This finding suggests significant differences in attitudes to help-seeking across trainee populations, thus emphasising the prevalence of psychological needs and the potential benefit of understanding trainees' lived experiences.

Overall, existing research highlights the existence and prevalence of lived experience among trainees despite a reluctance to share lived experience stories. Further exploration is essential to acknowledge and understand individual narratives, in order to gain a deeper understanding of trainees' experiences and highlight the barriers to facilitating a culture of safety and openness which would normalise lived experience identities among trainees.

Identity and Connection to Lived Experience

Theory suggests that identity is made up of self-concept and self-awareness and embodies an internal and external 'self' (Baumeister, 1997; Gergen, 1971), suggesting that perspectives of the self are reinforced through interactions with others. Moreover, identity is thought to be solidified by larger societal structures and systems, such as occupation and social and cultural dimensions (Gergen, 1971; Phelan & Kinsella, 2009). Professional identity development, lived experience and clinical training are key intersections the meanings made of lived experiences (Schein, 1978; Caza & Creary, 2016). Similarly, Social Identity Theory (Tajfel & Turner, 1979) suggests that identity is defined by in- and out-group connections and affiliation with these groups can influence individual wellbeing; therefore, relating to stigma and lived experience. In turn, theories of professional identity posit that those holding multiple identities can experience positive associations between them; suggesting that developing shared meanings across identities can help to integrate intersecting identities together into one (Burke, 2004).

Throughout clinical psychology doctoral training, individual identities are continually reconstructed as ideas and motivations are reflected upon and consequently re-shaped. Research investigating professional identity development in doctoral level education suggests that, despite being resistant to change, identity can be adapted to a new sense of self when transitioning to a new role (Colbeck, 2008). Therefore, trainees may feel challenged by expectations that come with their role and it is unclear how lived experience influences identity development in this area.

Presently, there is little research exploring the intersectionality of multiple minority experiences (e.g. socio-economic barriers in addition to lived experiences, or LGBTQ+ trainees with lived experience). This is an important gap in research, as stigmatising experiences are likely to impact trainee wellbeing. A study by the Association of Clinical Psychologists (ACP-UK, 2022) explored experiences of minoritized aspiring, trainee and qualified clinical psychologists using semi-structured interviews which considered participants' Social GRACES, namely aspects of social and personal identity which present differing levels of privilege and power (Burnham, 2012). Findings demonstrated that minoritized identities impacted participants' journeys into clinical psychology, as well as current experiences, future hopes and a sense of otherness.

Within the clinical psychology career pathway, some professionals identify as having a dual identity, as both a mental health professional and someone with experience of mental health difficulties. This dual identity can impact training and clinical work in many ways; however, lived experiences can cultivate authenticity, empathy, and increased resilience (Burks & Robbins, 2012; Gilbert & Stickley, 2012). Contrastingly, there may be an increased risk of stress associated with career responsibilities and individuals may find teaching content related to their own experiences difficult (Grice et al., 2018; Higson & Allan, 2019).

Stigma

In the UK, stigmatising beliefs and attitudes continue to be widespread despite the efforts of several campaigns, for example, In2Gr8MentalHealth which aims to destigmatise and support lived experience among mental health professionals (In2Gr8MentalHealth, 2021). Research illustrates how stigma can influence professional decisions to discuss mental health needs, which can impact the level of support received (Dean & Phillips, 2015). Furthermore, the presence of stigma within workplace environments perpetuates a ‘culture of silence’ which further hinders transparency and communication regarding lived experience of mental health (Edwards & Crisp, 2017; Higson & Allan, 2019).

To develop a greater understanding of attitudes surrounding lived experience among mental health practitioners, existing research has focused on the subjective experiences of qualified clinical psychologists. Tay and colleagues (2018) highlighted a reluctance to share lived experience narratives, due to fear of the impact of disclosure, shame, pressure to be self-sufficient and previous experiences of stigma, through the investigation of 678 qualified clinical psychologists. Findings highlighted two thirds of participants held concerns around negative consequences of discussing lived experience of mental health difficulties which led to a reluctance to seek help. Likewise, many psychologists report experiencing shame and fear of being judged negatively by others about having lived experiences. Scior and colleagues (2021) investigated the development of a group intervention designed for mental health professionals with lived experience, Honest Open Proud – Mental Health Professionals (HOP-MHP) was adapted from the original Honest Open Proud programme (HOP), originally designed to support individuals with lived experience but not those who provide mental health support (Scior, Rüsch, White, & Corrigan, 2019). The format of HOP-MHP involves a guided self-help format focussing on benefits and costs of sharing lived experience, as peer-groups were considered inaccessible due to fears of ‘being found out’. Using anonymous surveys of 60 participants, findings showed 84.6% of participants felt ‘satisfied’ or ‘very satisfied’ with the overall intervention. The authors highlight the value of a participatory model and emphasis on empowerment, and suggest that their adaptation requires further development with regards to integrating a peer support element without exposing participants to their fears of stigma. Overall, findings outline that mental health professionals may fear stigma as a direct result of sharing lived experience, highlighting the importance of exploring the impact of stigmatising attitudes and supportive interventions.

It can be concluded that clinicians are affected by internal and external stigma in several ways, including emotional wellbeing, impact on working within teams and clinically as a result of lived experience (Sciberras & Pilkington, 2018). Moreover, concerns relating to stigma can obstruct the sharing of lived experience (Corrigan, 2004), thus reflecting the presence of stigmatising attitudes surrounding mental health difficulties within society more broadly. It is important to note, existing studies investigating lived experiences among trainees did not address actual incidences of lived experience but anticipated responses to hypothetical experiences. Grice et al., (2018) investigated anticipated stigma and anticipated likelihood of disclosure within 348 UK trainees across 19 institutions, finding elevated levels of maladaptive perfectionism associated with anticipated disclosure. It is possible that responses do not reflect how trainees would respond in real-life scenarios, and suggests value in the specific exploration of trainees with lived experience. Therefore the present study is the first to explore meaning making and understanding of trainees’ lived experiences.

In summary, the exploration of lived experience narratives, it is important to hold in mind a whole-systems perspective, promoting a culture of openness, compassion and support. This has potential to encourage a shift in responses to stories of lived experience and inspire a system-wide appreciation of the value and impact of these experiences on work with service-users. This will ultimately benefit services and the people they support, as trainees move through their careers feeling more supported and able to speak about their lived experience, if they choose to.

This study aims to investigate how participant experiences have been shaped as trainees with lived experience; to investigate individuals' stories and narratives to develop deeper understandings of lived experiences among trainees. This knowledge has potential to inform support provided by universities and could help to empower trainees to navigate training with their own lived experience. Further, this study aims to contribute a normalising narrative of lived experiences with a view to increase diversity seen in future training cohorts. Findings will provide insight into the context and experiences of current trainees, to inform the development of support provided to trainees and those within the profession of clinical psychology more broadly.

Henceforth, this research aims to establish ideas related to lived experience within trainees, identify barriers to inclusion and openness about lived experience and bear witness to trainees' narratives and understandings of their lived experiences. In addition, to develop recognition and acceptance of lived experience of mental health difficulties among the clinical psychology training community. The research questions are:

1. *What are trainee clinical psychologist's experiences of holding an identity as someone with lived experience of mental health difficulties?*
2. *What does having lived experience of mental health difficulties mean to trainee clinical psychologists?*

Method

Design

The present study utilised qualitative methodology through individual interviews and a narrative approach to explore participants' meanings, experiences and narratives relating to their lived experience within the context of life before and during clinical psychology doctoral training. Narratives are understood within their context, including how they were obtained and how this process could influence the narration of stories and the context surrounding them (Kim, 2016).

This mode of analysis was deemed appropriate for the study as it is considered a useful method for uncovering how individuals interpret their experiences and understand ideologies embedded in stories together with the broad cultural ideas which create these narratives (Stokes, 2003; Rodriguez, 2016). It was essential to utilise an approach which considers *temporality*, i.e. the time of the individual's experiences and how they might influence the future; *sociality,* cultural and personal influences of the experience; and *spatiality*, the environmental surroundings during the experience and their influence on the experience (Haydon & van der Riet, 2017). Given the aim of the present research was to uncover trainees' experiences in order to deeply understand lived experiences among this population, with the aim to contribute to a normalising narrative and move towards a more diverse workforce, these elements were key in interpreting the data. Further, the research questions focus on experiences and meanings made by trainees with lived experience, narrative analysis focuses on how participants' stories are told and unfold, in addition to examining the content of narratives (Bamberg, 2012). Though Interpretative Phenomenological Analysis (IPA; Smith et al., 2021) had potential to appropriately investigate this topic. However, a narrative approach was intentionally selected due to its unstructured interviewing approach, as the researcher's aim was to minimise influence on data collection, therefore a narrative approach was favoured.

The present absence of literature surrounding lived experience among trainees necessitates the use of qualitative methodology (Camic, 2021). By adopting qualitative methodology, knowledge around topics where there is currently less understanding may be broadened and can provide the researcher with deep, rich information (Creely et al., 2020). This methodology emphasises *process* and *meaning* which produces descriptive data situated in the context of the individual (Levitt et al., 2017).

Participants and Recruitment

Ethical approval was obtained from the University of Hull, Faculty of Health Sciences Research Ethics Committee in August 2022 (see Appendix K). Participants were recruited through opportunistic sampling via social media (e.g. Facebook/Twitter) and an email outlining the study was sent to directors of all UK Clinical Psychology Doctorate courses with a request for the study information to be distributed in September 2022.

Participants were undertaking Clinical Psychology doctoral training at a UK university and identified as having lived experience at some point in their life. Individuals self-identified interest in the research and contacted the researcher directly via email. Following initial contact, participants were sent further details about the study via an information sheet (see Appendix L) and offered the opportunity to ask questions about the study. If eligible to participate, participants were contacted via email to ask that they complete and return a consent form (see Appendix M). Following this, a convenient date and time was agreed to meet with the researcher to complete interview via Microsoft Teams, due to the constraints of both time and distance.

The participant inclusion and exclusion criteria are outlined in Table 1.

Table 1.

Participant Inclusion and Exclusion Criteria.

Inclusion criteria	Exclusion Criteria
Trainee clinical psychologists currently undertaking clinical psychology doctoral training in the UK	Trainee clinical psychologists with personal histories of lived experience who are known by the researcher
Self-identification as having lived experience of mental health difficulties at some point in their life	Trainees undertaking clinical psychology doctoral training at the researcher's university
Able to give informed consent to participate	Individuals unable to give informed consent

Recruitment took place from September 2022 to January 2023. While there are no well-defined criteria for determining sample size in narrative analysis and samples are generally small (Creswell, 2007), the present study aimed to recruit 10 participants based on other studies using a holistic-form and categorical-content approach. Overall, 32 individuals expressed an interest in participating. 12 individuals provided informed consent to take part; of the 12 individuals, one was unreachable, one later declined and 10 agreed to participate. Following the completion of data collection, the sample size was deemed appropriate for narrative analysis as the richness of the data is considered more important than the quantity (Lieblich et al., 1998).

~~Participants identified as male (n=1), female (n=8) and non-binary (n=1) and attended universities across the UK. Six participants were in their second year and four were in their third year of doctoral study in clinical psychology, and were aged between 26 and 31 years old, with an average~~

~~age of 28.4. Further participant demographic information has been omitted to ensure participant identities remain anonymous.~~

Procedure

Interviews were arranged directly with participants and held via videocall (Microsoft Teams). Informed consent was obtained from each participant (see Appendix M). Participants were welcomed to share their lived experience narratives, within a non-directive interview with the aim to reduce researcher influence. This aligns with the overarching objective of narrative research, which is to obtain stories in the least obtrusive way possible (Kim, 2016). Research posits that participants can have difficulty initiating telling their story (Clandinin & Caine, 2008), therefore, to assist in the expression of personal stories, participants were told:

"I would like you to tell me about your experiences of mental health difficulties before and during doctoral training in Clinical Psychology as a person with lived experience. I would like you to think about your experience as a story, each story has a beginning, a middle and an end. You are welcomed to start and end your story wherever you would like.".

During the interview process, the researcher held in mind open questions that served to elicit narratives, these include "When did X happen?" and "Can you tell me a little more?", in line with recommendations from Riessman (1993).

The interview process took on average 54 minutes to complete, with the longest at 72 minutes and shortest at 40 minutes. After interview, participants were emailed a sources of support sheet (See Appendix N), should they require emotional support following interview. Interviews were transcribed and anonymised, replacing any given names with numbers.

Analysis

Narrative analysis was completed using the Lieblich and colleagues (1998) model which utilises a four-cell design (see Figure 1). It is recommended that more than one cell is employed during analysis. A holistic-form approach was used to explore participant narratives as a whole by focussing on story structure and how the individual tells the story, as this explores the person's construction of their evolving life experience. Further, a categorical-content approach was employed to analyse the content of participant narratives.

Figure 1.
Lieblich et al. (1998) Four Cell Design

Holistic-Content	Holistic-Form
Categorical-Content	Categorical-Form

Holistic-Form Analysis

The holistic-form analysis was completed as follows (Lieblich et al., 1998): in the initial stage, each interview was listened to numerous times to distinguish key themes and events, together with the tone, expression and emotion of participant stories. This process was essential in the development of each narratives' plot axis.

A guide by Gergen and Gergen (1988) was utilised to aid the identification of plot axes, as the authors suggest characterising stages of:

- Understanding story development from beginning to end
- Identifying significant events and characters that contribute to the end point
- Re-writing the events of the narrative in chronological order
- Developing an understanding of how events are linked

- Identifying demarcation signs to inform an understanding of the narrative, such as how one event finished and another began

The next stage of analysis centred on identifying and understanding the form of the narrative. Once the form and subsequent plot axis were identified, a graph was created for each narrative, using guidelines to inform an understanding of participant narratives. The researcher utilised reflections on interviews and the emotions within the narratives to create plots (Gergen & Gergen, 1988; Lieblich et al., 1998).

Categorical-Content Analysis

The categorical-content analysis was based on Lieblich et al.'s (1998) method wherein the first stage is to outline the relevant subtext; as the interview prompt asked participants to openly reflect on their lived experience before and during training, the whole transcript was used. Transcripts were read openly to ensure categories were not pre-determined, but developed from the transcript. For categories to materialise, the researcher identified key sentences that presented new and significant information. As such, sentences were employed to establish minor categories using an inductive approach and to identify major categories that represented the content of the narratives.

Researcher Influence

The primary researcher (AR) is a 29-year-old, White-British, female trainee clinical psychologist who has personal experience of mental health difficulties which could influence the interpretation of narratives. Following each interview, the researcher made use of a reflective journal to reflect on the process of the interview, any emotive points which stood out and feelings which were evoked. Throughout the research process, the primary researcher had regular supervision with a qualified and research experienced clinical psychologist and attended qualitative research reflective practice sessions. Consideration of socio-cultural, personal and research contexts was cultivated within reflexive bracketing discussion with other researchers and through supervision (Ahern, 1999). Appendix C encompasses a reflective statement with further reflections on the primary researcher's position and influence on the research.

Results

Results have been organised by analytic perspective, and separated into analysis of the content of narratives, in addition to analysis of narrative form. For each analytic perspective, additional supporting quotes are outlined in Appendix Q.

Holistic-Form Analysis

All 10 narratives appeared to move through similar phases in relation to the overall expression and structure of stories. All participants structured their story by beginning in either childhood or teenage years and proceeded through a journey of events in adulthood, ending in the present. The structure and form of each story appeared to move between five phases, defined as experiences, emotions, actions or events (Gergen & Gergen, 1988): Early Struggles, Low Ebb, Turbulent Times, Renewed Hope and Heading into the Optimistic Unknown. To ensure participant anonymity, individual plot graphs have been omitted.

All ten stories had a plot axis involving the individual encountering difficulties relating to lived experience. For five stories, phases appeared in the same order, therefore a prototypical plot graph was created (see Figure 2). For three stories, although the same phase structure remained, it occurred in a different order (see Figure 3). For the remaining two stories, the phase structure remained the same but appeared in a different order again (see Figure 4).

Figure 2.
Prototypical Plot Axis 1 (n=5)

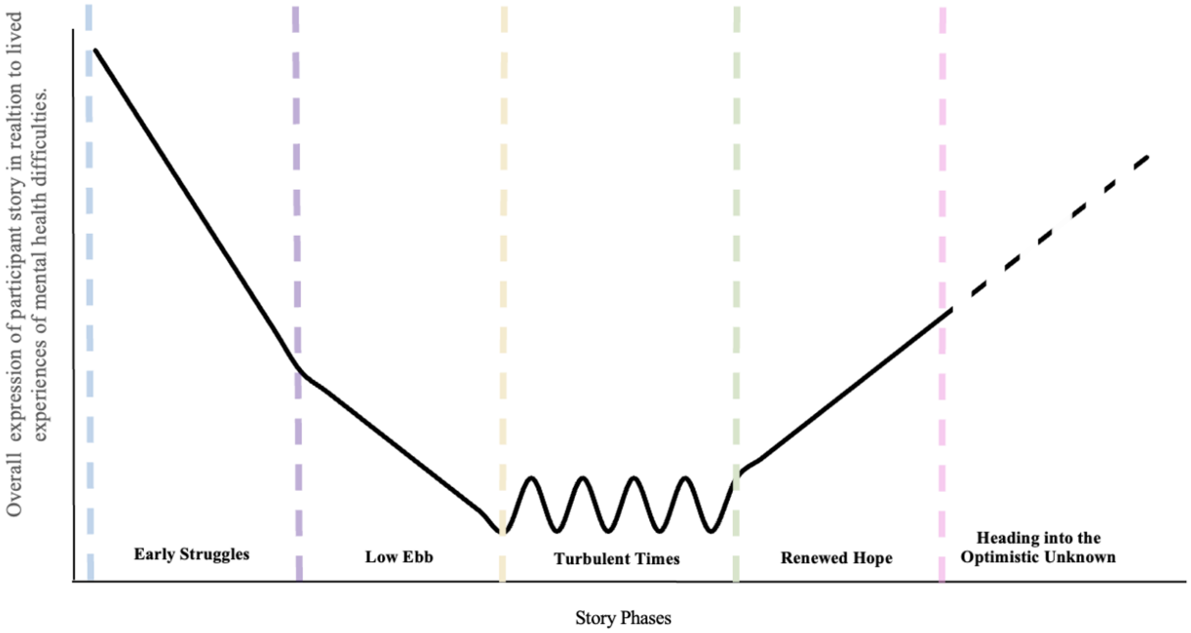


Figure 3.
Prototypical Plot Axis 2 (n=3)

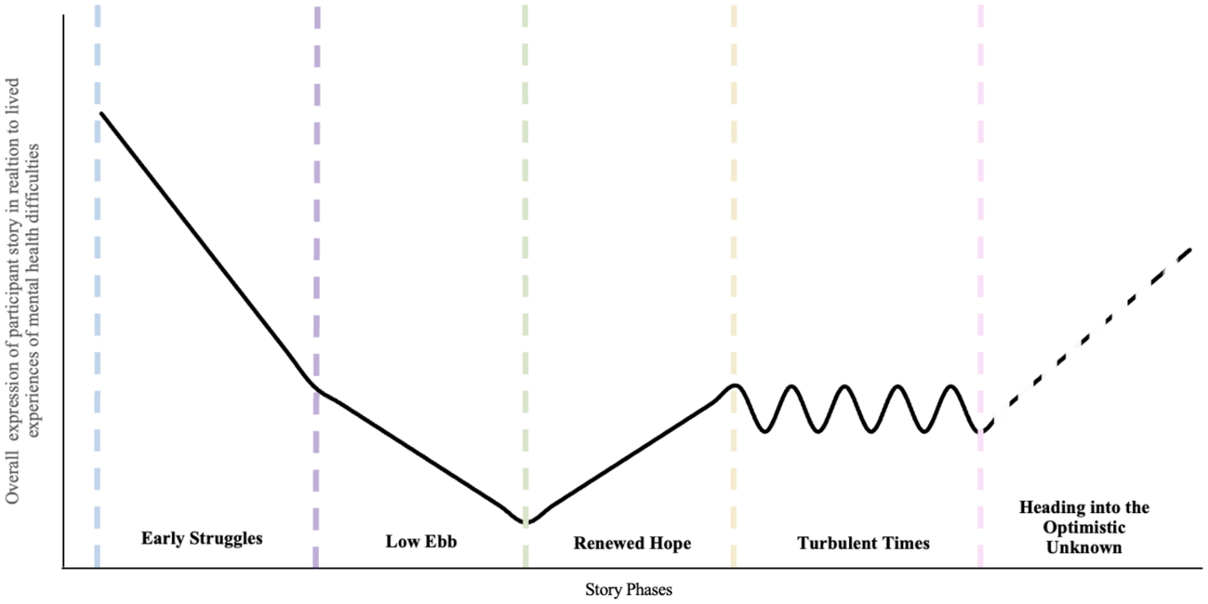
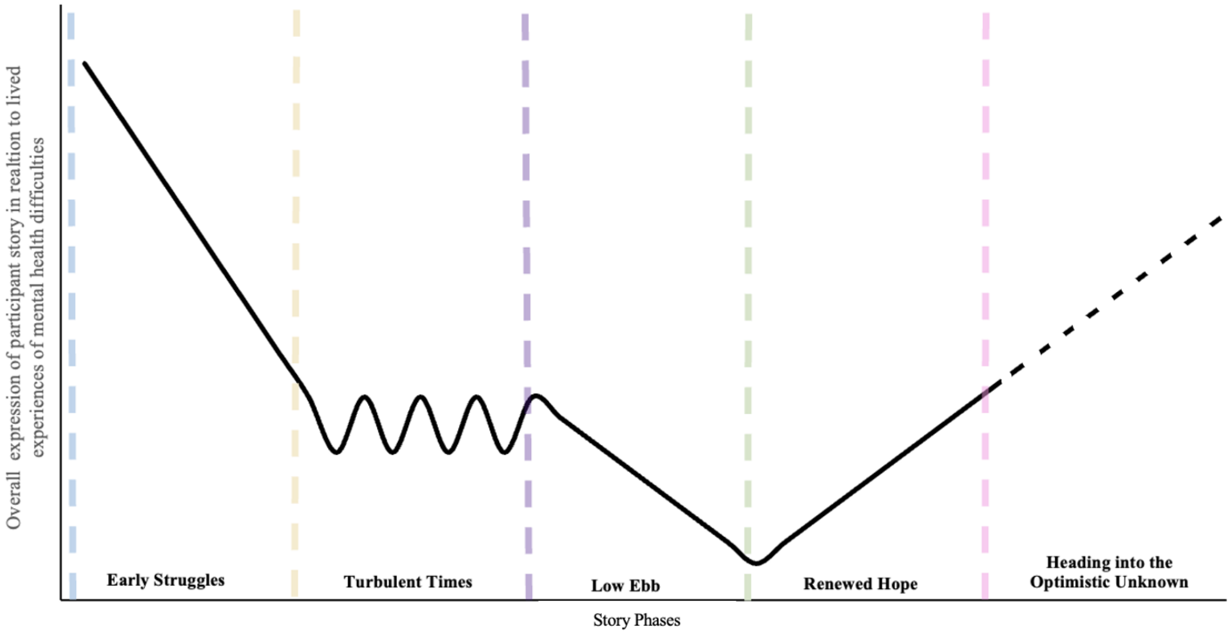


Figure 4.
Prototypical Plot Axis 3 (n=2)



Early Struggles

The first phase showed difficulties emerging in the participant's life, such as bullying, anxiety, panic attacks and the impact of childhood trauma which instigated a decline in their psychological wellbeing.

"…when I was 14 I was diagnosed with an eating disorder…"

(Participant 9, page 1)

"I guess I've had experience of mental distress for most of my life… since the age of, maybe like, 4 or 5."

(Participant 2, page 1)

Turbulent Times

This phase was characterised by ups and downs that participants found difficult to navigate and find an exit from. For some, cycles were impacted by oscillations in their psychological wellbeing. This phase occurred for some participants before clinical training:

> *"Throughout life I've kind of had, like, ups and downs… I've had times where my mental health's been really good and times when it's not been so good."*
>
> (Participant 3, page 3)

Whereas for some participants, this phase presented itself during training and was further perpetuated by the content of training itself:

> *"…there's been times where my mental health has suffered more I think. There's been a couple of traumatic events at work… and sort of, seeing the impact on the staff and the conflicts that ensue from that was really tricky."*
>
> (Participant 8, page 4)

Low Ebb

This phase was characterised by a notable change in participants' experiences, with difficulties emerging leading to a decline in psychological wellbeing, reflected in the declining plot trajectory. Participants reflected on the impact of these events:

> *"…things got really bad and it was the first time I'd had to take time off work for my mental health, yeah things were really bad…"*
>
> (Participant 3, page 4)

Some participants experienced a significant decline in plot trajectory as they were in a positive place prior to difficulties emerging:

"… the low mood was a bit of a shock 'cause I'd not experienced low mood before, so that felt quite different… I'd wake up really tearful on a morning and not wanting to go to placement, worrying about all the academic aspects of the course. I just felt really flat and hopeless and it felt to come on quite quick actually…

(Participant 7, page 6)

At the time of the 'Low Ebb' phase, all participants described seeking help for their difficulties via different sources including: their GP, by accessing psychological services, reaching out to supervisors or seeking support from family.

"I went through the university GP and they sent me to counselling."

(Participant 1, page 4)

"I accessed support from friends and family and my parents tried their absolute hardest to help in any way thy could whilst also not having any support and direction into how to help me…"

(Participant 9, page 2)

"…my mum helped me get some private therapy…"

(Participant 5, page 2)

"I went to my course tutor cus he's quite approachable and he was really good…"

(Participant 7, page 5)

Within these participants' stories, seven showed variations in trajectory as reflected in the subsequent 'Turbulent Times' phase as a result of their help-seeking experiences.

> *"I went on and off medication and didn't really like it, um, I never got offered any talking therapy at that point… just sort of going through life, enjoying life and it was a good time, yeah, general up and downs but nothing major until I had, a relationship break up…"*
>
> (Participant 3, page 3)

The remaining three participants experienced a decline in wellbeing during the following phase as their experiences of help-seeking served to negatively impact their experiences, as attempts to seek support further compounded their distress.

> *"… looking back it was a little bit traumatising to be honest… at this point I was like I'm never going to get better and professionals keep telling me 'you'll have this for life' and it was really negative... I felt really punished and I felt really like I'd done something wrong."*
>
> (Participant 5, page 3)

Two participants experienced a more linear increase in wellbeing soon after receiving support, reflected by entering into the phase entitled 'Renewed Hope' signifying an upwards trajectory.

> *"So after that [therapeutic intervention], I was able to come off the antidepressants, I didn't need any more therapy and found myself in a much more stable place and I think that's where I've been ever since."*
>
> (Participant 1, page 5)

Renewed Hope

The next phase was symbolised by a sense of renewed hope following support from others, as demonstrated by a shift in participant narratives. This is shown in a positive trajectory and subsequent appraisal of experiences. For most participants, this phase occurred towards the end of their story. Participants attributed the renewed sense of hope to different factors, including crossing paths with an encouraging clinician and receiving support.

"I met a clinical psychologist who said 'why would you not do clinical psychology training as a result of your mental health?... I think you would be really good at it, lived experience and all.'"

(Participant 10, page 2)

"I've learned that actually if I don't tell people how much I'm struggling and if I don't get the help, then I'm going to be off sick again and obviously I don't want that to happen, so yeah, I think that's been helpful and I feel lucky that I've never had any difficult experiences where I felt judged, or anybody's thought of me any differently…"

(Participant 3, page 19)

Heading into the Optimistic Unknown

The final phase signified ideas representing a continued positive trajectory. Some participants spoke positively about their current position, while others shared hopes for their future which aligned with an upwards trajectory.

"…despite there being a lot of stress, I actually think my mental health is in a really good place right now, thanks to the support I've had from supervisors and from the course to change my environment and give me the best chance of feeling well… I think the support that I've had from my

course has helped me thrive instead of just battling through and not being the best version of myself that I can be."

(Participant 3, page 7)

Categorical-Content Analysis

Categorical themes around understanding, experiences, meanings and narratives of being a trainee with lived experience were acquired from participant stories. Table 2 outlines major and minor categories and the overall number of times categorical themes arose across all participant narratives. See Appendix Q for an overview of themes across participants.

Table 2.

Major and Minor Categories Obtained from Categorical-Content Analysis

Major Categories	**Minor Categories**	**Total incidences in category**
Personal Meanings and Understanding of Lived Experience	*Viewing Lived Experience as a Strength and Motivator*	*30*
Others' Appraisal and Understanding of Lived Experience	*Stigmatising Attitudes*	*22*
	Systemic Attitudes and Approach to Lived Experience	*31*
Navigating Clinical Psychology Training as a Person with Lived Experience	*Expectations and Training Culture*	*30*
	Integration of Lived Experience Identity into the Personal and Professional	*60*

Experiences within Education Providers and Surrounding Systems	*Course Experiences*	*38*
	Interactions of Power	*26*
The Impact of Holding a Lived Experience Identity as a Trainee	*Subjugated Narratives of Lived Experience*	*58*
	Experiences of Support/ Help Seeking	*135*
Reflections on Experiences	*Deeper Empathy and Appreciation of Client Experiences*	*27*

See Appendix Q for an overview of themes across participants.

Personal Meanings and Understandings of Lived Experience

Participants shared understandings surrounding lived experience, specifically their own and others' narratives.

Viewing Lived Experience as a Strength and Motivator

Participants shared views on their identity as a trainee with lived experience as a strength. Others suggested that lived experience served as an impetus for pursuing clinical psychology as a career choice.

> *"I really think it is actually more of an advantage than anything else. I don't think it's a deficit."*
>
> (Participant 10, page 11)

"I started to become really curious in terms of how our minds work and I think that's what triggered my interest in clinical psychology."

(Participant 9, page 2)

Others' Appraisal and Understanding of Lived Experience

Stigmatising Attitudes Towards Lived Experience

Participant narratives encompassed others' attitudes relating to their lived experiences, with some reflecting on the stigmatising views of others.

"I found myself really conflicted about whether to talk about my lived experience of mental health, I think I wanted to be open and honest about it… but I found that it wasn't always responded to particularly well."

(Participant 1, page 5)

Participants who experienced stigmatising attitudes from others reported feeling unable to share their lived experience identity as outwardly as they hoped to, due to fear of judgement.

"I think largely it came from earlier experiences where that stigma was there and I had some quite difficult experiences of where talking about that wasn't a done thing… I think that might be why I'm always quite cautious of who I tell going through my career because that was particularly quite aversive."

(Participant 4, page 11)

Systemic Attitudes and Approach to Lived Experience

Participants reflected on the impact of systemic attitudes surrounding lived experience and commented that some attitudes hindered trainee openness, particularly within education providers.

> *"It's all well and good to say on an individual level that we should be sharing our mental health, but if the structured systems around us aren't enabled to support that, then actually that's not a safe place to do it. We need to make sure that the system around us is able to support it and not be stigmatised and be really safe."*
>
> (Participant 5, page 11)

Some participants shared challenges within supervisory relationships which occurred due to negative attitudes to having lived experiences as a mental health professional.

> *"When I've been supervised by people who were significantly older than me, there seems to be more of an attitude of 'it's not acceptable to bring that and actually we don't want to hear about that as your own personal business', whereas I think more recently qualified supervisors that I've had have been much more encouraging of bringing personal that can impact the professional."*
>
> (Participant 8, page 10)

On the other hand, some participants described supervisory experiences involving positive attitudes which enabled them to feel supported and empowered in storying their lived experience.

> *"I've been through a few placements now and the majority of them have been fantastic and had very, very supportive supervisors who have seen lived experience of mental health as an asset, not as a deficit."*
>
> (Participant 10, page 6)

Navigating Clinical Psychology Training as a Person with Lived Experience

Expectations and Training Culture

Most participants reflected on feeling pressure to 'push through' training, a process which involved avoiding or not acknowledging their mental health difficulties at one or more points of training.

> *"There is that very hidden narrative and I think that's really relevant to what I experienced coming onto training and then just trying to navigate how I felt and trying to dampen a lot of that down just to get through, but that just didn't work at all."*
>
> (Participant 6, page 18)

Some described a wider culture within training contexts which serves to perpetuate ideas about needing to 'push through' training. Participants explored the notion that a long-standing rhetoric within the structure of courses maintains the status quo of changing, perhaps due to largely inflexible course structures and funding. It is plausible that narratives were influenced by the competitive nature of obtaining a training place and for some the investment of years of efforts, these elements may lead to further perpetuate a reluctance to change.

> *"I think there's an unhelpful rhetoric within trainees almost, or within some trainees, about managing mental health while you're on the course and a lot of people say things like 'you just need to power through'. I'm like, but at what cost?"*
>
> (Participant 10, page 5)

"It's a narrative I've heard from other trainees, I don't think it's been me alone whose felt like 'I've just got to get through training' and you know, this has bothered me but I won't speak up about it."

(Participant 4, page 36)

Participants reflected on narratives held about expectations as a trainee, and what that means for speaking openly about lived experiences.

"If you do speak openly about how you're feeling… it seems like you're going to break some kind of code, almost, but I've never been able to name it or know what that is."

(Participant 3, page 37)

Several participants reflected on experiences of concern about being a 'good enough' trainee and feeling as though they are an 'imposter' during training.

"I felt like a huge fraud when I had lived experience."

(Participant 1, page 9)

Integration of Lived Experience Identity into the Personal and Professional

Participants spoke about the challenge of navigating several intersections including gender and sexuality, leading to experiences of worry about being 'too much' which contributed to challenges surrounding speaking out about lived experiences.

"I hold quite a few different intersections. It feels like I have to pick which I talk about because I feel like too much otherwise… I always feel like I can't throw all of that at someone at once."

(Participant 2, page 7)

Others suggested that navigating the integration of lived experience identities in personal and professional contexts throughout training is challenging and a varied process for each individual.

"I know in some professions it's like full integration of personal and professional self. I'm not sure if I'll be able to see what that looks like in me until I'm actually finished training and maybe looking back with a bit more hindsight."

(Participant 6, page 16)

Some participants shared a deeper integration of lived experiences into professional identity and described feeling more able to view lived experience as a fundamental part of their identity as a clinician.

"I find it really difficult to separate, because I don't think you can… it's so intertwined because it's your experience and part of who you are as a person, that even trying to think about separating my lived experience from me being [me]… it's just impossible because I'm here now and that's what's happened and that's part of my journey, and that's not gonna go away."

(Participant 9, page 12)

It is important to consider the role of boundaries within the clinical psychology profession more broadly, as boundaries seek to provide a safe structure within clinical work. It is clear that participants held differing relationships with boundaries which raises questions around whether boundaries have a negative impact on trainees with lived experience, as for some it appears challenging to navigate personal and professional identities.

Experiences within Education Providers and Surrounding Systems

Course Experiences

Participants acknowledged different experiences within university that brought about reflection on their lived experiences. Psychological safety within teaching spaces was deemed important to facilitate open conversations about lived experience narratives.

"I was just so dysregulated that day it was absolutely awful, like I was really embarrassed to share. I didn't feel safe sharing that, or my story or even any element of it with my colleagues. I mean it was so early on in training as well."

(Participant 6, page 5)

Other participants reflected on sharing within teaching and feeling empowered due to the facilitation of openness about lived experiences.

"They actually had a session where they talked about lived experience of mental health in, like, the staff and that felt very safe."

(Participant 6, page 3)

"I think I've been really fortunate in that I've built enough trust with my group and with the facilitator to be a little bit more open."

(Participant 3, page 15)

Interactions of Power

Participants considered feeling impacted by the systems surrounding them while undertaking clinical psychology training.

> *"There's something so powerless about the training journey, where you're given your supervisors, you can't leave, you can't take time off on stress to recuperate and regain composure. You just have to keep going in everyday and weathering the storm and hoping it'll get better."*
>
> (Participant 8, page 6)

Some trainees discussed the intricacies of power within help-seeking between themselves and their surrounding systems.

> *"They've [training course staff] been so clear about please come to us with anything and I think they've really tried to do their best to minimise that power however they can, but obviously it's still there. They're marking your assignments, they're observing you in clinical settings, its gunna be there isn't it?"*
>
> (Participant 7, page 10-11)

The Impact of Holding a Lived Experience Identity as a Trainee

Subjugated Narratives of Lived Experience

All participants described concealing their lived experience at some point during training, across different contexts; for some, masking their lived experience identity served as a protective mechanism.

> *"I find there are people who can be really vocal about it and really share their experience and I think that's absolutely brilliant, but I am absolutely not one of those people. I haven't disclosed my mental health to employers or to universities."*
>
> (Participant 3, page 1)

Some participants reflected on feeling isolated and that narratives of lived experiences appeared to be subjugated throughout some clinical psychology training contexts.

> *"In my first year, I was like how can people not understand some of these trauma responses or some of these stress responses? … I didn't understand it, I felt like I was one of few that had experienced what I'd experienced."*
>
> (Participant 6, page 20)

Experiences of Support

Participants described support as individuals (e.g. family members, friends, a therapist) or groups (e.g. therapeutic groups, community groups, peer-support paces) which provided assistance with the aim to improve wellbeing. There was no reported difference in experiences of 'support' and 'intervention', as participants' narrative reflected positive and negative aspects of receiving support.

Some described positive experiences of support, whereby supervisors promoted integration of lived experiences into clinical practice.

> *"I feel like he really heard what I was saying and why it was important and then, like, helping me incorporate that into a way actually for it to be better for the service user and to be better as well, like, for me as part of my training."*
>
> (Participant 5, page 14)

Others reflected on more challenging approaches to seeking support, acknowledging micro and macro level influences of accessibility to support.

"I think I luckily had enough people around me to get things off my chest but it was more the fighting against the systemic pressures and the power imbalance and the criticism and all this stuff that I felt would have made the difference rather than having someone to talk to in a more passive way."

(Participant 1, page 14)

Participants described the value of peer support as positive, helpful and a source of strength within their story, notably when peer support involved shared experiences or stories of lived experience.

"…knowing that they knew, it felt better than trying to hold it all myself, like just knowing that my little group were aware, it was nice."

(Participant 7, page 16)

"I met someone else on the cohort who had lived experience and I feel like that has been fundamental, for me in being able to navigate being a trainee with lived experience is knowing there's someone else there who gets it."

(Participant 2, page 3)

Reflections on Experiences

Deeper Empathy and Appreciation of Client Experiences

Almost all participants described feeling a deeper empathy for clients in the context of clinical work, as a result of their own lived experience. They reflected on a sense of authenticity within clinical work and deeper understanding of clients' experiences.

"It's a double-edged sword isn't it because it's definitely given me a greater ability to be able to sit with people in pain and sit with people who are suffering… I think like when you've suffered yourself, you're more comfortable sitting with suffering."

(Participant 2, page 9)

"I've grown as a person through the experience and that I know how to support people a lot better when I qualify… I think there's something about really feeling that hopelessness and… that's just helped me really get it now when clients are saying the same thing."

(Participant 8, page 14)

Discussion

Overview of Findings

Participants shared understandings, experiences and meaning making as a trainee clinical psychologist with lived experience of mental health difficulties. Results indicate that participants made sense of their lived experiences using a holistic lens, as each narrative involved early life experiences and ended in the here and now. Participants' stories considered personal experiences and highlighted inter- and intra-personal consequences; whereby directional shifts were often instigated by connection with another. Furthermore, participants oscillated between different narrative identity positions which facilitated a deeper understanding of lived experiences.

Within holistic-form analysis, the same phases were present within all stories but appeared in different orders. Participants' difficult life events and experiences influenced the form of stories into ascending and descending trajectories, including experiences of loss, relational trauma and traumatic stress. Narratives emphasised these experiences as key in the development of mental health difficulties which contributed to lived experience narratives. The range of described mental health experiences align with findings of previous research investigating mental health difficulties amongst trainees (Tay et al., 2018; Turner et al., 2020). Participants spoke about significant emotional experiences before encountering a decline in psychological wellbeing, which compounded existing difficulties including barriers to help-seeking and challenges within the university training context. This finding is consistent with literature investigating help-seeking patterns within a university population, indicating that long-lasting mental health problems prevented help-seeking and hindered interaction with educational commitments as a result (Broglia et al., 2021; Hill et al., 2016).

Through categorical-content analysis, themes highlighted participants' personal meaning makings, in addition to others' attitudes and the intrapersonal impact of making sense of lived experiences. Consideration was given to systemic views on lived experience, together with stigmatising attitudes and others' polarised views either that lived experience may hinder progression and success as a trainee, or viewing lived experience as an asset. This finding makes sense in the context of literature investigating stigma within trainees highlighting a reluctance to share lived experience with university staff for fear of stigma (e.g. Grice et al., 2018).

Participants shared narratives about navigating clinical psychology doctoral training while holding a lived experience identity. For some, expectations about clinical psychology training 'culture' compounded challenges faced as a result of lived experience, such as the notion of 'getting through' training. This resulted in subjugated narratives of lived experience and acknowledgement of current mental health needs or lived experience identities. The experience of training as someone with lived experience cultivated difficulties involving power, self-efficacy and self-esteem. Several participants found the challenges of training served to maintain emotional difficulties, alongside feeling like an 'imposter'. This finding is in keeping with Jones and Thompson (2017) who investigated stress and well-being in trainees and illustrated reports of fear of being 'found out as someone not capable' by the course. Notwithstanding, several narratives reflected on the integration of personal and professional identities which was deemed an essential part of trainee identity formation. This finding indicates a sense of dualism, and multiplicity for some, thus demonstrating the value of reflection upon identity development during the process of training (Higson & Allan, 2019). As identity can be conceptualised as a social construction (Foucault, 1980), born of internal and external dialogue and situated within wider social context, it could be argued that ideas about the self and subsequent development of professional identity can be understood as relational, contextual and constructed through societal discourses (Gergen, 2011). Moreover, current findings align with existing research postulating that trainees within subjugated groups encounter increased challenges within identity formation (Schubert et al., 2023; Wood et al., 2013).

Participants’ narratives explored the effect of education providers’ and surrounding systemic influences on teaching, placement and research experiences. Several participants recounted the role of power within meaning making as someone with lived experience, with some reflecting on systemic power imbalances perpetuating challenges presented to them. Key ideas from the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) were highlighted within participant narratives of how power operates within their experiences. In line with PTMF, participants considered their experiences as ‘What has happened to you?’, and the subsequent impact and sense-making as ‘How did it affect you?’ ‘What sense did you make of it?’. Participants shared understanding of how their lived experience impacts themselves, and interconnection with their professional and clinical worlds.

Participant stories expressed a profound sense of empathy and appreciation of the experiences of clients, which led to a more holistic understanding of client experiences. Several participants suggested that receiving psychological support themselves facilitated a new sense of understanding of the therapeutic relationship, in addition to implementing psychological models. Participants emphasised the importance of ‘walking alongside’ individuals receiving support, and shared an appreciation of the uniqueness of every person's individual story as a result of experiencing their own mental health challenges.

Participants described experiences of support seeking within the context of clinical psychology training and beyond, via private and NHS-funded support and demonstrated varied experiences spanning from helpful to harmful. Using PTMF (Johnstone & Boyle, 2018), individual construction of meaning about help-seeking experiences align with the notion of 'what did you have to do to survive?'. Seeking support represents a threat-focussed response as the process was reported as helpful for some trainees, and less so for others. Consideration of surrounding systems and wider context is essential; therefore the Ecological Systems model (Bronfenbrenner, 1979) encapsulates how systems and social structures influence trainee experiences. For example, wider societal and cultural ideas within the macrosystem and exosystem. See Appendix S for a detailed overview.

Trainees focussed on protective factors as influences on meaning making of lived experiences, including the value of peer support, positive supervisory relationships, expert by experience-led teaching and reflective practice groups. Stories described varied accounts of embedded peer-support structures, course content and committees which support the reflection and consideration of lived experience identities. Trainee narratives encompassed feelings of support and value of sharing stories in a psychologically safe way, in addition to experiences of fear and stigmatising attitudes.

Strengths and Limitations

The present study is the first to investigate meaning making of lived experience of mental health difficulties among UK trainee clinical psychologists. Hearing trainee narratives of lived experience represents a strength of this research. Barriers and challenges presented when sharing narratives of lived experience as a trainee have been encompassed in earlier parts of the discussion and emphasise how the exploration of the voices and stories of trainees within this research is not only unique, but imperative in understanding their lived experiences. The aim of the present study was exploratory through narrative means, this mode of research does not endeavour to produce generalisable data (Adams, 2008). Participants' stories comprised of shared narratives and similarities within form and content, implying collective understandings and experiences within the participant sample.

The recruitment process may have influenced collected narratives, participants were required to self-identify compatibility and may be impacted by self-selection bias. Only second and third year trainees participated, perhaps due to first year trainees showing reluctance to engage in research. In line with Cushway's (1992) finding that trainees in their second and third year of training report higher stress levels than those in their first year, which may influence narratives of lived experience early on in training. Trainees who have lived experience but do not hold salient experiences within the training context may have been less likely to voluntarily participate. Additionally, those who held concerns about storying lived experiences may have been less likely to participate due to concerns about sharing their narratives within a research context.

The present study included consideration of participants whose lived experience related to varied elements of the Social GRACES framework (Burnham, 2012), including gender identity, sexuality, class, ability and geography. The voices of a limited sample of 10 UK trainee clinical psychologists are represented, of which there was limited diversity in terms of cultural background, nationality and ethnicity. Statistics outline the composition of clinical psychology trainees often fails to reflect the population demographics which training courses are located or serve (Turpin & Coleman, 2010). Within applications to enter clinical psychology training in the UK, over 70% of successful candidates identified as white, female (CHPCCP, 2022), therefore, it is possible that the present sample is missing the voices of ethnically minoritised trainees attending UK Clinical Psychology training courses. The provision of demographic information about participants' race would provide insight into the unique experiences of ethnically minoritised groups. Demographic data around race was not collected, as demographic information collected was minimised due to concerns about anonymity. Assumptions cannot be made about the race of participants, nor is it possible to make further assumptions about how the experiences of trainees from ethnically minoritised backgrounds might be impacted.

Given the primary researcher's context and position as a current trainee clinical psychologist who holds a lived experience identity, it is possible the interpretation of data may be influenced by these factors. The researchers sought to minimise researcher influence and bias by utilising regular supervision, use of a reflective journal, reflective bracketing and peer-based reflective groups. The primary researcher's context has potential to cultivate a more rapid acceptance by participants, therefore facilitating an increase in participant openness which can lead to increased depth and breadth to the data gathered (Asselin, 2003; Corbin Dwyer & Buckle, 2009). The notion that insider/outsider status exists within a dichotomy has been challenged within this research, in line with research which suggests the binary of 'insider vs outsider' could be viewed as overly simplistic (Corbin Dwyer & Buckle, 2009). Moreover, an ability to be open, authentic, honest and deeply interested in the experience of research participants' and a commitment to accurately representing their experience is essential to conducting research which may align with ones' own experiences.

Implications for Research and Training

In line with narratives surrounding reflective practice, peer-support groups and lived experience teaching content, further research investigating existing approaches to connecting with lived experience among trainees would be beneficial. This finding supports Cushway (1992) who found that trainees' most frequently reported coping strategy for managing stress was 'talking to trainees'. Therefore, it would be beneficial for clinical psychology doctoral training courses to facilitate peer-led reflective practice groups for trainees with lived experience, in order to further explore meaning making.

The present study undoubtedly presents accounts of high stress and subsequent distress levels resulting from the pressures of clinical psychology doctoral training. This finding naturally confronts the current status of training and uncovers convincing real-life understandings and experiences of trainees. Findings align with previous research (e.g. Kumary & Baker, 2008; Cushway, 1992) in considering the ethical standpoint of encouraging value exploration and reflection on personal experiences while synchronously exposing trainees to incredibly high levels of stress during training. Given the current HCPC standards of proficiency outlining the importance of maintaining wellbeing, it is imperative for courses to consistently uphold their responsibility to support trainees' wellbeing (HCPC, 2022). These standards increase consideration of trainee wellbeing and could subsequently cultivate systemic changes needed to shift existing narratives about 'pushing through' and challenges surrounding support seeking within clinical psychology doctoral training. It could be argued that clinical psychology doctoral training courses are responsible for facilitating support for trainees with lived experience, as it is clear from the present research that for trainees, this can be advantageous.

It would be equally beneficial to investigate how training courses embed support for those with lived experience and how the training environment enables trainees to thrive. Through participant narratives, there are clear variations in UK clinical psychology training course curriculum, suggesting value in the development of set standards and structured ideas for courses to integrate into programme content. Considering the aforementioned HCPC standards of proficiency, it is essential for clinical psychology training programmes to embed acknowledgement of both the value and challenges within lived experience into curriculums consistently across courses.

Conclusions

Overall, the present study outlines that the sample of UK trainee clinical psychologists consider and make sense of their lived experiences of mental health difficulties using a holistic lens. Participants reflected upon the impact of inter- and intra-personal experiences and subsequent events within their stories, in addition to ways of coping. Meaning making of lived experience while undertaking clinical psychology doctoral training can be impacted by the content and pressures ensuing from responsibilities undertaken as a trainee. Additionally, identity formation and development, in addition to the interplay of power influenced participants’ scope to engage with their identity as a trainee with lived experience. This research supports the holistic consideration of power when bearing witness to narratives of lived experience.

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Part Three - Appendices

Appendix A - Author Guidelines for British Journal of Psychology

BJP AUTHOR GUIDELINES

Sections

1. SUBMISSION

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- articles or groups of articles dealing with novel areas, theories or methodologies;
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It enjoys a wide international readership and features reports of empirical studies, critical reviews of the literature and theoretical contributions which aim to further our understanding of psychology.

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Cover letters are not mandatory; however, they may be supplied at the author’s discretion. They should be pasted into the ‘Comments’ box in Editorial Manager.

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The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
- Abstract;
- Keywords;

- Data availability statement (see Data Sharing and Data Accessibility Policy);
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For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

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Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the LaTex Main Document should be uploaded as a “LaTeX Supplementary File.”

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Please check that you have supplied the following files for typesetting post-acceptance:

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

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For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**bjop@wiley.com**) or phone +44 (0) 116 252 9504.

Appendix B – Epistemological Statement

The empirical research aimed to uncover and understand trainee clinical psychologists' lived experiences of mental health difficulties, and how they have made sense of their experiences throughout their journey. Epistemology is foundational to the researcher's approach, methodology and interpretation of data; and is key in understanding knowledge and meaning making (Willig, 2013). This statement aims to highlight the epistemological stance that guides this research.

The researcher completed this research from a social constructionist epistemology, understanding knowledge and meaning as constructed through social interactions and processes between people within historical and cultural contexts (Burr, 2015). The ontological position of this research aligns with a relativist perspective which postulates that there are multiple realities constructed by an individuals' beliefs and context. This perspective aligns with the researcher's views on the existence of multiple truths – harnessing this view enabled the researcher to work with the exploratory aims of the research. Finally, the social constructionist stance acknowledges that each story told by participants are equally valid constructions of events and aligns with the research aims to facilitate reflections on trainees' experiences in order to explore meanings made of lived experience through their personal lens (Mishler, 2004).

The lack of qualitative research investigating lived experience of mental health difficulties among trainee clinical psychologists meant the use of a narrative approach was deemed advantageous. Narrative analysis explores peoples' meaning making of their experiences through the creation of stories (Riessman, 1993), and was selected because the research aimed to learn about trainees' lived experiences of mental health difficulties. In addition to how people constructed experiences into meaningful stories. The nature of the non-directive interview within a narrative approach was thought to be beneficial as it served to enable participants to navigate their stories in their own way without being influenced by a pre-planned interview schedule (Josselson, 2011).

Consideration was key given the role of the interview context and researcher in how narratives are constructed. The researcher reflected on their position as a trainee clinical psychologist, with lived experience of mental health difficulties themselves; interview context was thoroughly considered during study design and a position of openness about personal lived experiences was deemed appropriate in the context of pre-interview conversation. Moreover, the use of bracketing and reflection within research supervision throughout the research process was essential in considering researcher influence on study design.

The systemic underpinning of narrative analysis considers broader societal, social and cultural contexts in which participant stories are formed, and how individuals shape ideas about themselves using narratives and story-making ideas (Silver, 2013). As the research explores stories of lived experiences among clinical psychologists in training, the context of personal and professional identities were encompassed within the narrative framework.

The systematic literature review aimed to explore understandings within current research about help-seeking and sharing stories of lived experience within student mental health professionals. Due to the included studies, encompassing a combination of qualitative and quantitative methods, an epistemological position aligning with pragmatism paradigm was adopted. Pragmatism paradigm posits the use of philosophy and methodology is essential in answering the research question, with a focus on research consequences over methodology.

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Willig, C. *Introducing qualitative research in psychology* (pp 143-153). McGraw-Hill education (UK).

Appendix C – Reflective Statement

At times the research process felt like an odyssey, encompassing a multitude of highs and lows, leaps and stumbles (I realise now, many stumbles were learning opportunities in disguise). In equal amounts I have felt exhausted and empowered as I have continued to climb the metaphorical mountain that is ‘thesis’.

Selecting this research

I remember feeling unsure at the start of this process, as my impression of any research I had completed in undergraduate studies paled in comparison to the idea of completing a doctoral thesis. My potential areas of interest surrounded staff wellbeing within NHS contexts, two areas I remain interested in clinically. My interest in investigating staff wellbeing made sense in the context of a world emerging from the restrictions resulting from the COVID-19 pandemic, and the unknowns surrounding the impact of the pandemic on NHS staff who worked tirelessly to adapt to ever-changing and unpredictable circumstances. Together with an interest in staff wellbeing, came a curiosity to better understand lived experience narratives within clinical psychology.

Early on in training, I remember being introduced to social constructionism and I have found it valuable to hold in mind these ideas; integrating them into my approach to research is something that felt important. For example, challenging the notion that people exist as separate entities, and that our sense of self is constructed within a social and political context. Further, the idea that there is no single unified self, all selves should be considered true selves that are constructed within the context of relationships (Rosenthal, 2004). For me, these ideas served as the catalyst behind my idea to explore lived experiences of mental health difficulties among trainee clinical psychologists. Together with social constructionist ideas, I was motivated by the value of the expert-by-experience movement and had cultivated an interest in lived experience identities within the wider world of clinical psychology.

As a person who has their own story of lived experiences, it felt as though the notion of selecting a research topic in this area was something that may not be possible, despite the sense that it would be an important piece of research to undertake, due to my position as an insider researcher. Through much thought and discussion with my research supervisor and consideration of my position, it became clear that with consistent reflection on my positionality throughout, it would be a feasible, and very exciting research project.

Though I hold privilege in many ways as a white-skinned woman, which means I am faced with less systemic discrimination that other individuals do, it felt incredibly important to explore this research topic in order to recognise, understand and amplify stories of intersectional identities held by trainee clinical psychologists, many of which appeared subjugated in the broader clinical psychology context.

Designing the Study

I knew I wanted to design and undertake a piece of qualitative research and was keen to harness the richness of people's stories in order to develop an understanding of their experiences. My initial idea was to use semi-structured interviews, and a more structured form of analysis (e.g. Interpretative Phenomenological Analysis), however following reflection with other trainees and the research team, it became clear that there was value in exploring narrative approaches to research. Given the minimal investigation into this topic area, it felt important to consider the whole stories of participants and hold in mind how the 'whole is not greater than the sum of its parts'. Moreover, my context as a researcher encouraged me to embrace a mode of analysis that was non-directive, to ensure my influence on focus points during research was kept to a minimum. It felt important to embrace taking a risk with this research, therefore I opted for narrative analyses.

Ethical Approval

Before beginning the process of application for ethical approval, I remember hearing fore-warning narratives from trainees in previous years about the challenges that can ensue. I think these stories embedded into my unconscious, leading me to work hard to ensure I kept putting one foot in front of the other within the application process. When submitting my ethics application, I remember being happily surprised that I did not receive more comments or requests to amend. It is likely that in this instance, my perseverance, hard work and attention to detail had thankfully paid off. I felt grateful that I was able to begin data collection with little delay.

Recruitment and Data Collection

I remember feeling apprehensive about recruitment, and again, I wondered if I had been influenced by hearing the struggles of those in cohorts ahead of me. I felt supported by my supervisor in that he too was sharing the details of the research with other course directors. It felt as though our team approach to recruitment ensured a strong foundation to. I remember feeling incredibly grateful in the following days when over 30 trainees from across the UK came forward with offers to participate, many of which had sent messages sharing how important and overdue this research felt. It was incredibly affirming to know there were many trainees out in the wild who believed in my research and shared the value of uncovering lived experience narratives within clinical psychology doctoral training.

What really sticks in my mind about data collection is how privileged I felt to hear participants share their stories so openly and earnestly. I remember through every interview feeling grateful that each person felt safe enough to ‘go there’ and share stories of their journeys to the present day. I remember being conscious of my own context as a trainee who has lived experience during early interviews, and felt worried that I might inadvertently influence interview content. I soon found my groove, and with each interview I felt more able to lean back into the process of working with whatever the person felt comfortable bringing.

There were times where I felt strong emotions due to the incredibly difficult experiences shared, which was definitely a challenge of researching such an area. I wondered about my own position and whether participants felt more able to share certain things during interviews, as they knew we had some (at least generic) shared experiences as trainees. The times where participant experiences aligned with my own, presented particular challenges. I learned to lean on my reflective journal or go for a mind-balancing walk after interviews if they were particularly tricky. Discussion around this within supervision has been invaluable.

Analysis

I found the process of transcription really interesting. It felt powerful to revisit the narratives shared during interviews and to consider stories on a deeper level. Despite transcription and analysis being time-consuming, I managed to hold on to positivity and continued to feel excited about my potential findings. I’m thankful that I never lost sight of the value of amplifying my participants’ stories, or the potential impact my research might have. My approach to both avenues of analysis (holistic-form and categorical-content) encompassed equal measures of enthusiasm. I found the process of mapping out the data, and emerging themes on paper and discussing these with my peers really enjoyable. The process of cyclical reflection and reconsideration throughout both analyses felt natural as I believe my reflective skills are a strength. There were definitely times I felt challenged by the lack of structure encompassed in narrative analyses, I found it helpful to remind myself of a note I have stuck above my desk – ‘uncertainty is the site of radical transformation’, which helped me recalibrate and focus.

Write up

The last five months have some of my most challenging to say the least. There have been times where I have had to really dig deep to make sure I kept moving forwards with my research, all the while juggling other aspects of the professional and personal. I’ve been struck with how much I have learned about my values both personally and professionally throughout this process. I am proud that I have been able to complete this process to the best of my ability.

Systematic Literature Review

The topic for my literature review was developed through conversations with my supervisor, and ideas initially surrounded help-seeking among trainee clinical psychologists with lived experiences of mental health difficulties, though it transpired there was not enough existing data. I was interested in understanding the relationship between help-seeking, sharing and mental health professionals in training who hold lived experience identities, as I knew little about this and was keen to understand more.

The initial searches showed limited research exclusively in the UK, which consequently led me to reconsider the inclusion criteria. I was initially unsure about widening my scope to include studies from across the globe, as my empirical paper specifically investigates UK trainee clinical psychologists. The decision to include a broader scope of papers was advantageous, as it enabled a deeper understanding of the relationship between mental health professionals in training, help-seeking and sharing lived experiences of mental health difficulties. The process of data analysis was very interesting, as I felt enthusiastic to think deeply about the data I had familiarised myself with through data extraction and quality assessment. I enjoyed immersing myself in the data and connecting with the themes which emerged, and wondered if there was something about the process which aligned with reflectivity which occurs within clinical work.

The journey of completing my literature review has been challenging at times, there were moments where I felt overwhelmed with the sheer volume of information and stepping outside of my comfort zone. However, I am grateful to have learned so much from the process and I feel proud that I was able to create something that aligns with my empirical research and considers the wider context surrounding lived experience narratives.

Choice of Journals

For my literature review, I chose to write for the British Journal of Psychology, as the journal is broad in its scope of published papers and audience and endeavours to inform current research, policy and practice. Again, I chose to write for the British Journal of Psychology for my empirical research, as it is affiliated with the British Psychological Society, and is wide-ranging in the articles it publishes. I am hopeful the findings of my research can inform existing research, policy and practice through publication within this journal.

Final Thoughts

As I take steps towards completing my research, I feel immensely proud of what I have achieved and how I have grown through the process. The journey through this research has been kaleidoscopic, I have learned so much and the process has provided me with insight which I hope to carry with me as I progress further into qualified life as a Clinical Psychologist.

Appendix D – National Institute of Health and Care Excellence (NICE) Quality Appraisal Checklist for Qualitative Studies

Study Identification: Include author title, reference, year of publication		
Guidance topic:		**Key research question/aim:**
Checklist completed by:		
Theoretical approach		
1.Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		

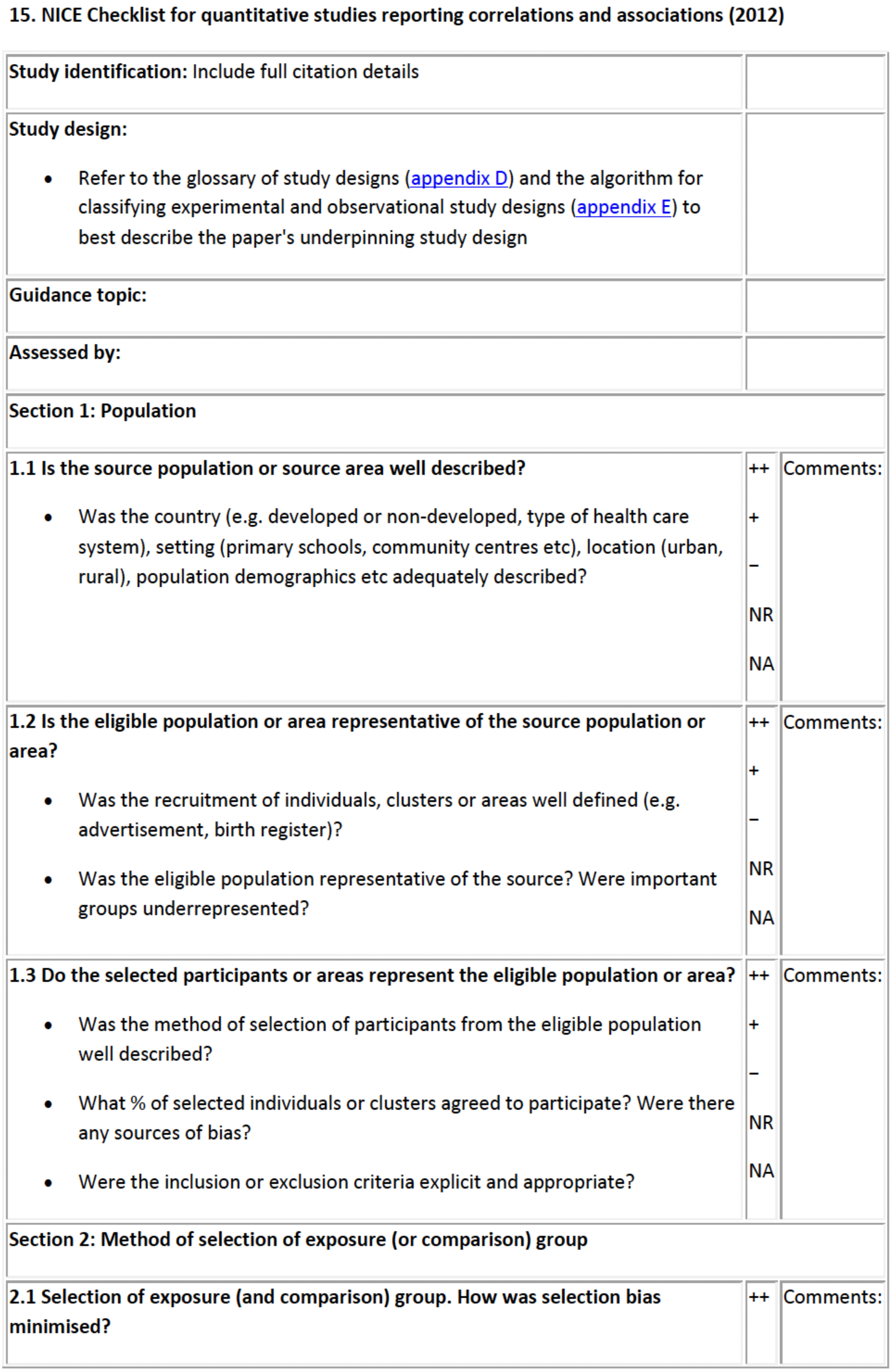
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:

6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances? • Was context bias considered?	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example:	Rich Poor	Comments:

• How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Not sure/not reported	
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions	Adequate	Comments:

For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Inadequate Not sure	
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix E – National Institute of Health and Care Excellence (NICE) Quality Appraisal Checklist for Quantitative Studies



15. NICE Checklist for quantitative studies reporting correlations and associations (2012)

Study identification: Include full citation details		
Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? • Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?	++ + – NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? • Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? • Was the eligible population representative of the source? Were important groups underrepresented?	++ + – NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? • Was the method of selection of participants from the eligible population well described? • What % of selected individuals or clusters agreed to participate? Were there any sources of bias? • Were the inclusion or exclusion criteria explicit and appropriate?	++ + – NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias minimised?	++	Comments:

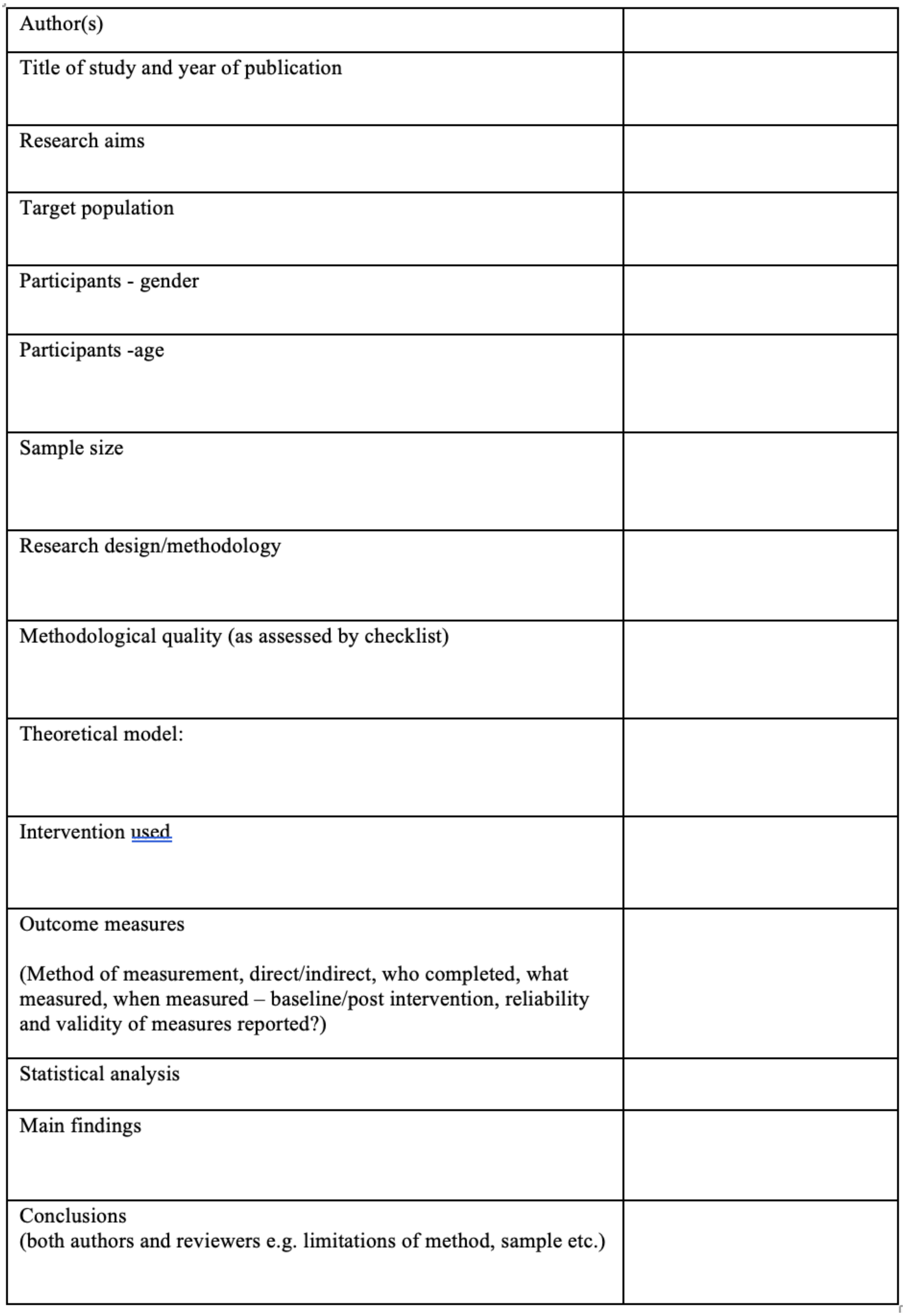
• How was selection bias minimised?	+ – NR NA	
2.2 Was the selection of explanatory variables based on a sound theoretical basis? • How sound was the theoretical basis for selecting the explanatory variables?	++ + – NR NA	Comments:
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + – NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled? • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	++ + – NR NA	Comments:
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + – NR NA	Comments:
Section 3: Outcomes		
3.1 Were the outcome measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically	++	Comments:

validated nicotine levels ++ vs self-reported smoking –)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	+ – NR NA	
3.2 Were the outcome measurements complete? • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	++ + – NR NA	Comments:
3.3 Were all the important outcomes assessed? • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + – NR NA	Comments:
3.5 Was follow-up time meaningful? • Was follow-up long enough to assess long-term benefits and harms? • Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one	++	Comments:

exists)? • A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. • Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	+ – NR NA	
4.2 Were multiple explanatory variables considered in the analyses? • Were there sufficient explanatory variables considered in the analysis?	++ + – NR NA	Comments:
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + – NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? • Are there sufficient details given about the study to determine if the findings are generalisable to the source population?	++ +	Comments:

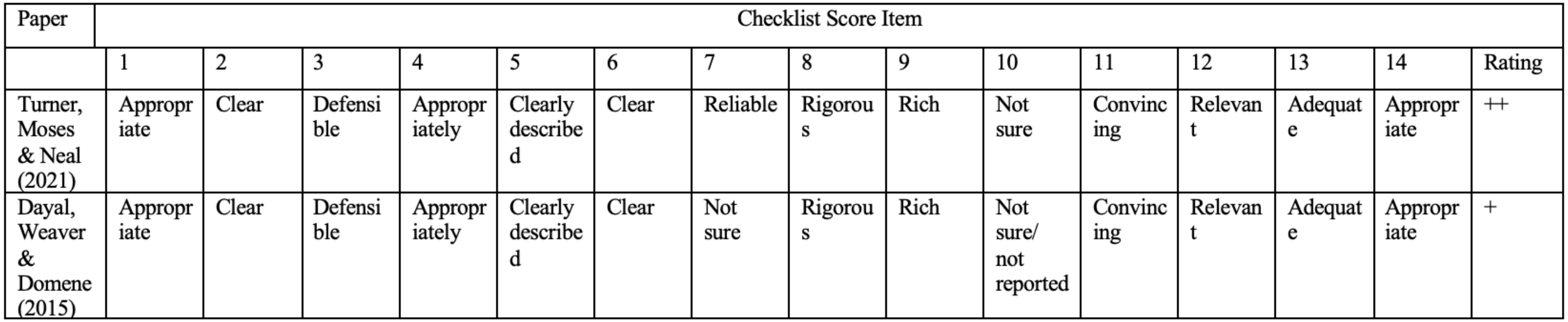
• Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	–	

Appendix F – Blank Data Extraction Proform



Author(s)	
Title of study and year of publication	
Research aims	
Target population	
Participants - gender	
Participants -age	
Sample size	
Research design/methodology	
Methodological quality (as assessed by checklist)	
Theoretical model:	
Intervention used	
Outcome measures (Method of measurement, direct/indirect, who completed, what measured, when measured – baseline/post intervention, reliability and validity of measures reported?)	
Statistical analysis	
Main findings	
Conclusions (both authors and reviewers e.g. limitations of method, sample etc.)	

Appendix G – Quality Assessment of Qualitative Studies

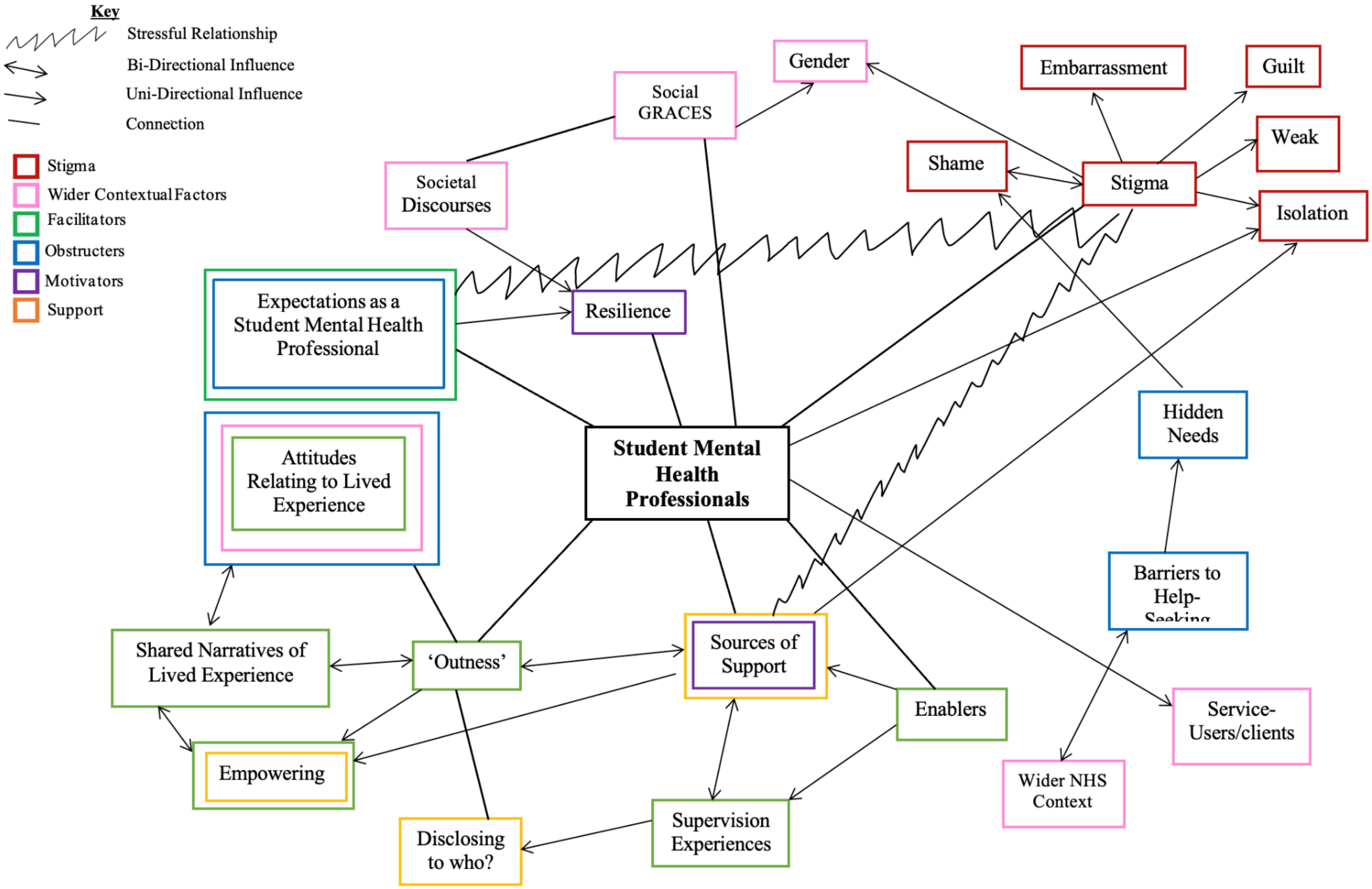


Paper	Checklist Score Item													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Rating
Turner, Moses & Neal (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropriate	++
Dayal, Weaver & Domene (2015)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Not sure	Rigorous	Rich	Not sure/ not reported	Convincing	Relevant	Adequate	Appropriate	+

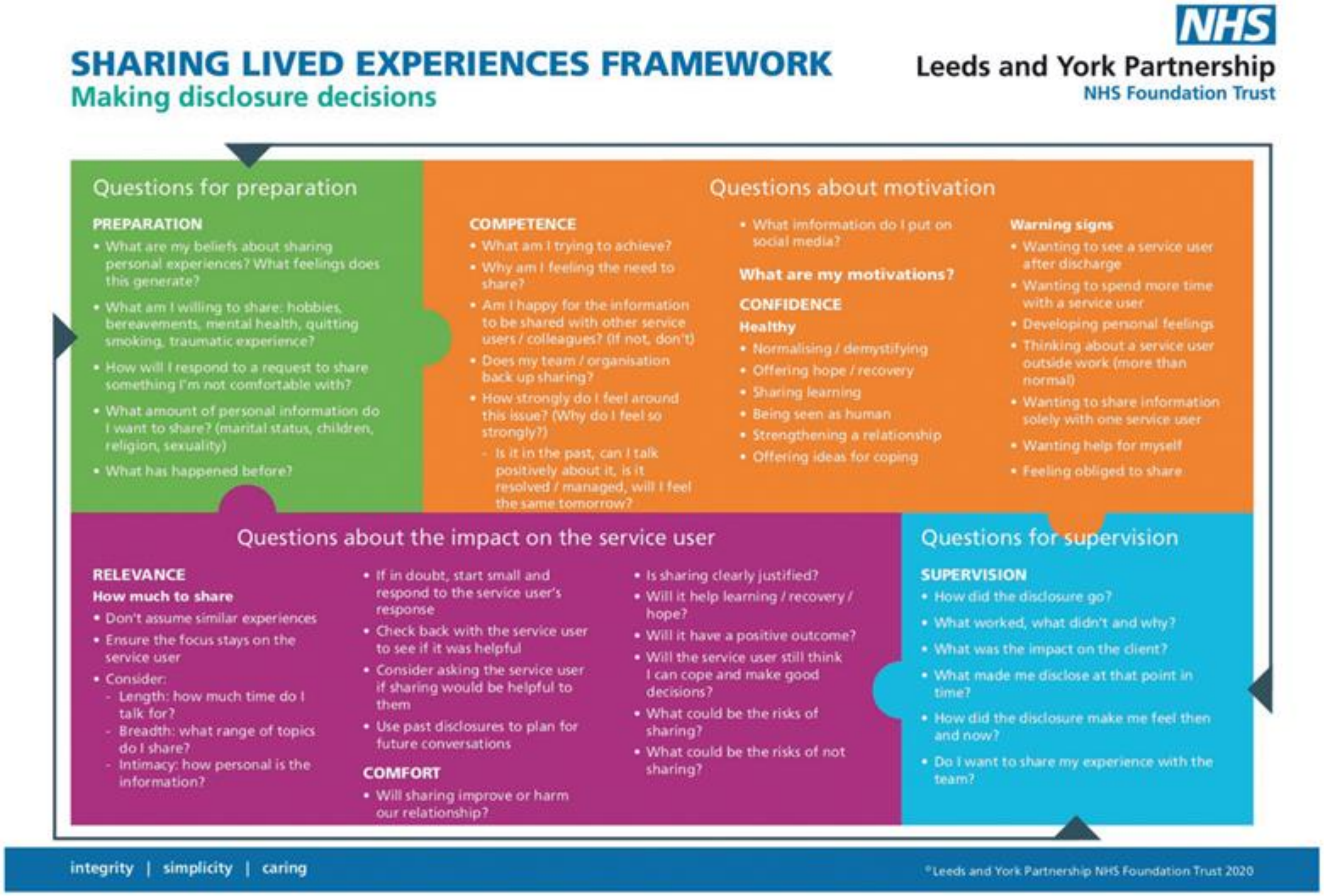
Appendix H – Quality Assessment of Quantitative Studies

Checklist Item Score																														
Paper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	Overall Rating	Internal Validity	External Validity
Grice, Alcock & Scior (2017)	++	++	NR	NA	++	NA	NA	NA	NA	NA	NA	++	NA	++	++	NR	++	NA	NA	NR	NR	NR	NR	+	++	++	++	++	++	++
Mitchell (2018)	++	++	+	NR	NA	NA	NA	NA	NA	NA	+	NR	++	++	++	NR	+	NA	NA	NA	NR	++	+	++	++	+	+	+	+	++
Thomas et al (2013)	++	+	NA	NA	++	NA	NA	NA	NA	NA	NR	NR	NA	++	++	NR	++	NA	NA	NR	NR	NA	NR	++	++	+	++	+	+	+
Edwards & Crisp (2017)	++	++	NR	NA	++	NA	NA	NA	NA	NA	+	-	NA	++	+	+	++	NA	NA	NA	NR	NR	NR	NR	NA	++	+	++	+	++
Joseph, Barnes, Harris & Boyd (2022)	+	++	+	NA	+	NA	NA	NA	NA	NA	-	NA	NA	+	++	++	++	NA	NA	++	+	++	-	++	++	++	++	++	+	++
Victor et al (2022)	++	++	++	++	++	NA	NA	NA	NA	++	++	+	++	+	++	+	NA	NA	NA	NA	NA	NR	NR	++	++	+	+	++	++	++

Appendix I – Ecomap of Themes Identified within Narrative Synthesis



Appendix J - Sharing Lived Experiences Framework



SHARING LIVED EXPERIENCES FRAMEWORK
Making disclosure decisions

NHS
Leeds and York Partnership
NHS Foundation Trust

Questions for preparation

PREPARATION
- What are my beliefs about sharing personal experiences? What feelings does this generate?
- What am I willing to share: hobbies, bereavements, mental health, quitting smoking, traumatic experience?
- How will I respond to a request to share something I'm not comfortable with?
- What amount of personal information do I want to share? (marital status, children, religion, sexuality)
- What has happened before?

Questions about motivation

COMPETENCE
- What am I trying to achieve?
- Why am I feeling the need to share?
- Am I happy for the information to be shared with other service users / colleagues? (If not, don't)
- Does my team / organisation back up sharing?
- How strongly do I feel around this issue? (Why do I feel so strongly?)
  - Is it in the past, can I talk positively about it, is it resolved / managed, will I feel the same tomorrow?
- What imformation do I put on social media?

What are my motivations?

CONFIDENCE

Healthy
- Normalising / demystifying
- Offering hope / recovery
- Sharing learning
- Being seen as human
- Strengthening a relationship
- Offering ideas for coping

Warning signs
- Wanting to see a service user after discharge
- Wanting to spend more time with a service user
- Developing personal feelings
- Thinking about a service user outside work (more than normal)
- Wanting to share information solely with one service user
- Wanting help for myself
- Feeling obliged to share

Questions about the impact on the service user

RELEVANCE

How much to share
- Don't assume similar experiences
- Ensure the focus stays on the service user
- Consider:
  - Length: how much time do I talk for?
  - Breadth: what range of topics do I share?
  - Intimacy: how personal is the information?
- If in doubt, start small and respond to the service user's response
- Check back with the service user to see if it was helpful
- Consider asking the service user if sharing would be helpful to them
- Use past disclosures to plan for future conversations

COMFORT
- Will sharing improve or harm our relationship?
- Is sharing clearly justified?
- Will it help learning / recovery / hope?
- Will it have a positive outcome?
- Will the service user still think I can cope and make good decisions?
- What could be the risks of sharing?
- What could be the risks of not sharing?

Questions for supervision

SUPERVISION
- How did the disclosure go?
- What worked, what didn't and why?
- What was the impact on the client?
- What made me disclose at that point in time?
- How did the disclosure make me feel then and now?
- Do I want to share my experience with the team?

integrity | simplicity | caring

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(Dunlop et al., 2022)

Appendix K – Confirmation of Ethical Approval

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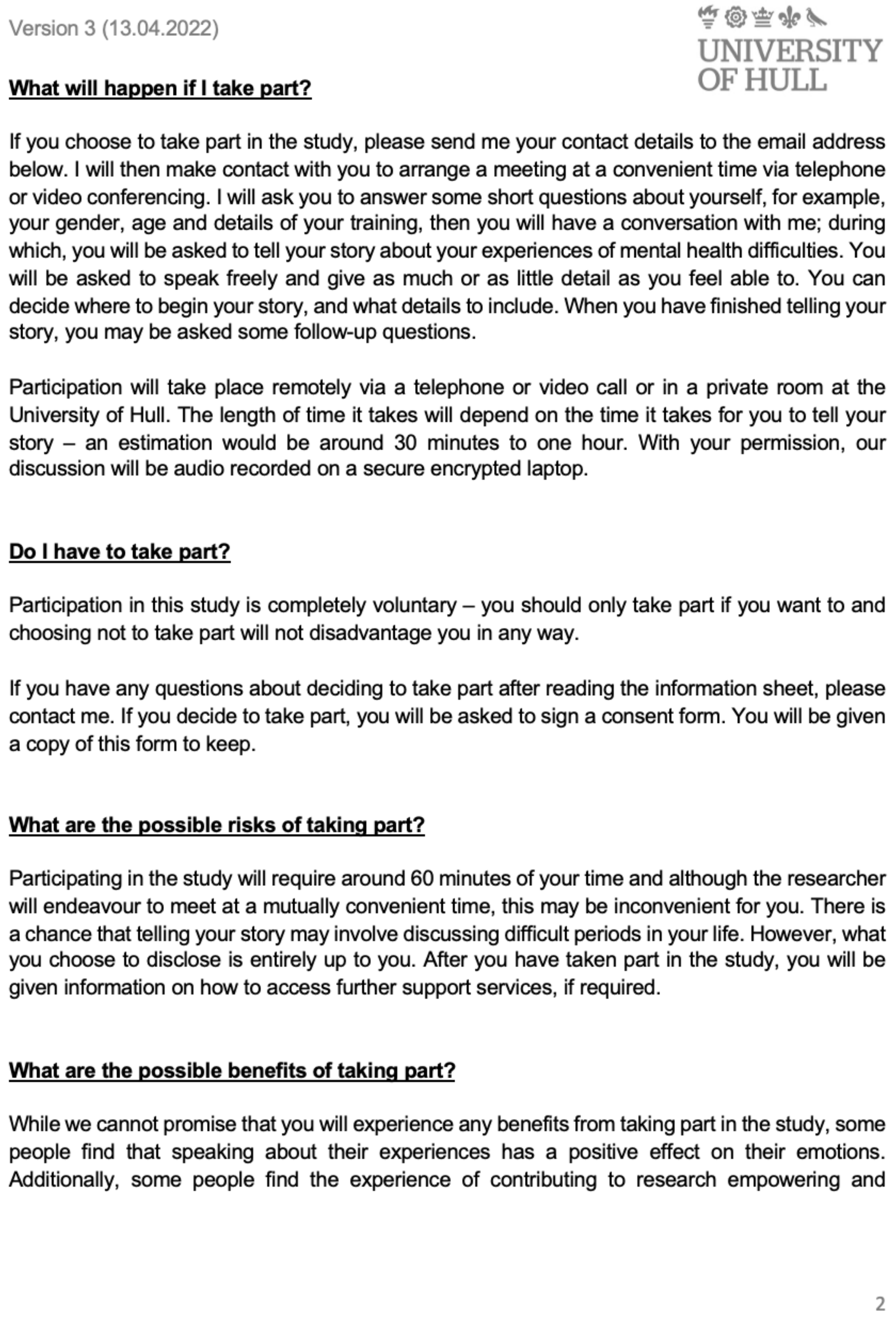
Appendix L – Participant Information Sheet



Version 3 (13.04.2022)

UNIVERSITY
OF HULL

What will happen if I take part?

If you choose to take part in the study, please send me your contact details to the email address below. I will then make contact with you to arrange a meeting at a convenient time via telephone or video conferencing. I will ask you to answer some short questions about yourself, for example, your gender, age and details of your training, then you will have a conversation with me; during which, you will be asked to tell your story about your experiences of mental health difficulties. You will be asked to speak freely and give as much or as little detail as you feel able to. You can decide where to begin your story, and what details to include. When you have finished telling your story, you may be asked some follow-up questions.

Participation will take place remotely via a telephone or video call or in a private room at the University of Hull. The length of time it takes will depend on the time it takes for you to tell your story – an estimation would be around 30 minutes to one hour. With your permission, our discussion will be audio recorded on a secure encrypted laptop.

Do I have to take part?

Participation in this study is completely voluntary – you should only take part if you want to and choosing not to take part will not disadvantage you in any way.

If you have any questions about deciding to take part after reading the information sheet, please contact me. If you decide to take part, you will be asked to sign a consent form. You will be given a copy of this form to keep.

What are the possible risks of taking part?

Participating in the study will require around 60 minutes of your time and although the researcher will endeavour to meet at a mutually convenient time, this may be inconvenient for you. There is a chance that telling your story may involve discussing difficult periods in your life. However, what you choose to disclose is entirely up to you. After you have taken part in the study, you will be given information on how to access further support services, if required.

What are the possible benefits of taking part?

While we cannot promise that you will experience any benefits from taking part in the study, some people find that speaking about their experiences has a positive effect on their emotions. Additionally, some people find the experience of contributing to research empowering and

2

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What are the possible benefits of taking part?

While we cannot promise that you will experience any benefits from taking part in the study, some people find that speaking about their experiences has a positive effect on their emotions. Additionally, some people find the experience of contributing to research empowering and valuable. The findings of this study may help to inform Universities on how they might support Trainee Clinical Psychologists with these potentially difficult experiences.

What if I change my mind about taking part?

You are free to withdraw at any point during the study, you will not be asked to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until data analysis (5 days after your discussion with the researcher). After this date, the withdrawal of your data will no longer be possible due to the data being anonymised and analysed.

Data handling, protection and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’.

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

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. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an on-line storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen and the researcher will try to discuss this with you.

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data from the study up until data analysis has commenced, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed. Information collected from this study will be used for this study only and will not be used for any other purpose.

You can find out more about how we use your information at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx or by emailing University of Hull Information Compliance Manager (dataprotection@hull.ac.uk). If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's online repository – https://hydra.hull.ac.uk. The research may also be published in academic journals or presented at conferences.

Who should I contact for further information?

If you have any questions or require more information about this study, or wish to register your interest in participating please contact me using the following contact details:

Anna Reid
E-mail: a.e.reid-2017@hull.ac.uk

Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX

What if I have further questions, or if something goes wrong?

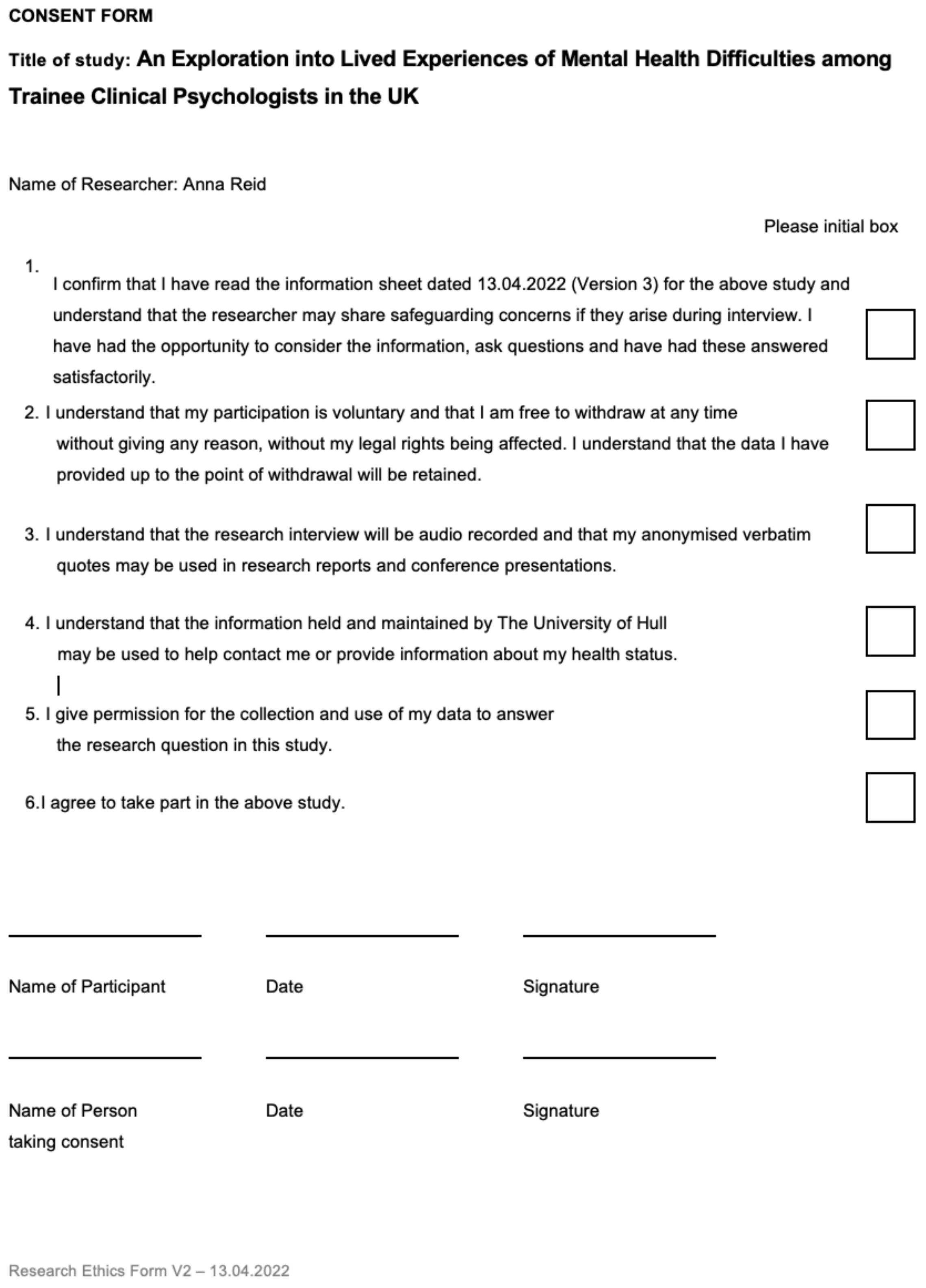
If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisors details below for further advice or information:

Dr Nick Hutchinson
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX

Email address: N.hutchinson@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix M – Participant Consent Form



CONSENT FORM

Title of study: An Exploration into Lived Experiences of Mental Health Difficulties among Trainee Clinical Psychologists in the UK

Name of Researcher: Anna Reid

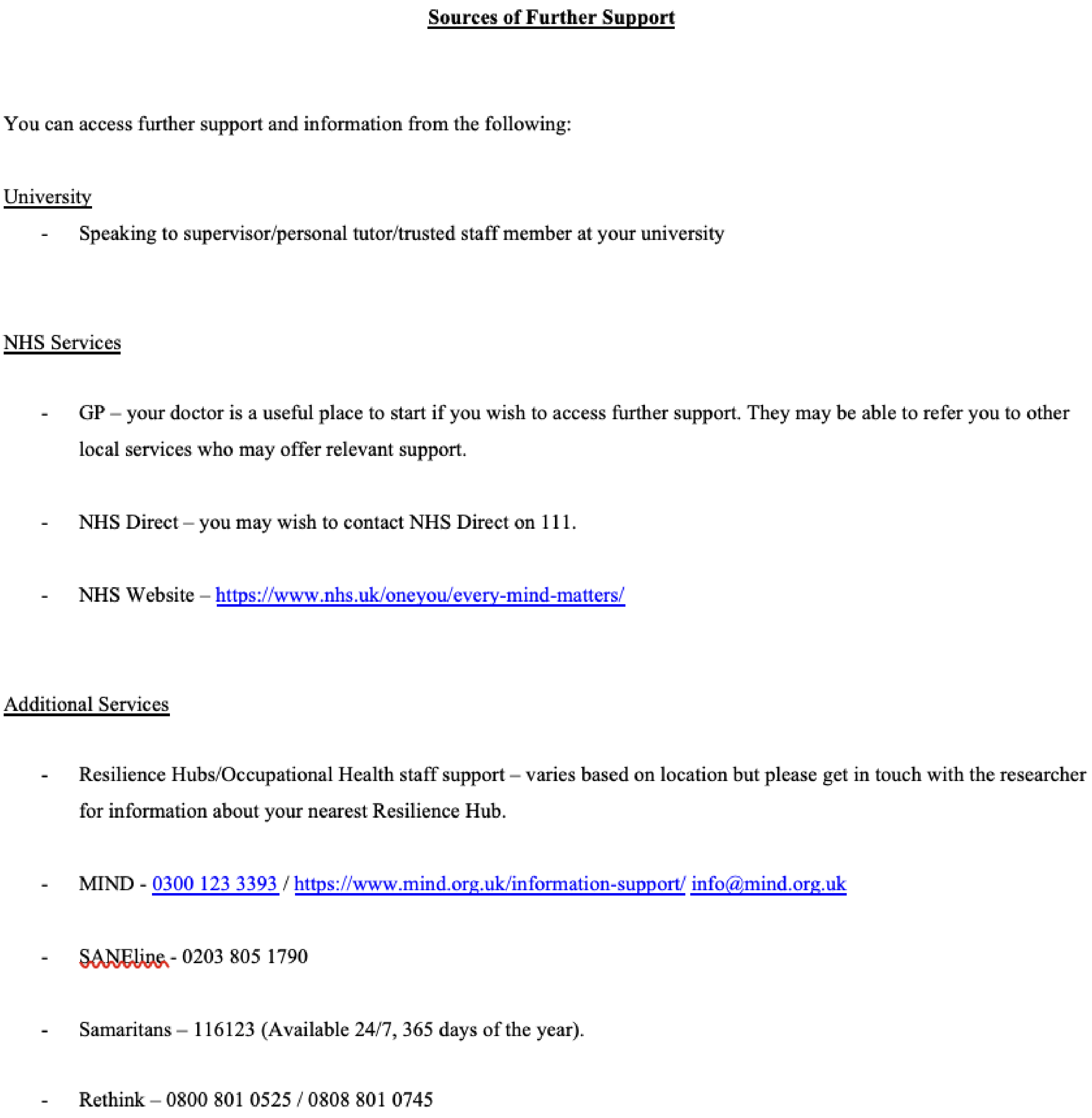
Please initial box

1. I confirm that I have read the information sheet dated 13.04.2022 (Version 3) for the above study and understand that the researcher may share safeguarding concerns if they arise during interview. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. I understand that the data I have provided up to the point of withdrawal will be retained. ☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I understand that the information held and maintained by The University of Hull may be used to help contact me or provide information about my health status. ☐
5. I give permission for the collection and use of my data to answer the research question in this study. ☐
6. I agree to take part in the above study. ☐

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

Research Ethics Form V2 – 13.04.2022

Appendix N– Sources of Support Sheet



Sources of Further Support

You can access further support and information from the following:

University

- Speaking to supervisor/personal tutor/trusted staff member at your university

NHS Services

- GP – your doctor is a useful place to start if you wish to access further support. They may be able to refer you to other local services who may offer relevant support.
- NHS Direct – you may wish to contact NHS Direct on 111.
- NHS Website – https://www.nhs.uk/oneyou/every-mind-matters/

Additional Services

- Resilience Hubs/Occupational Health staff support – varies based on location but please get in touch with the researcher for information about your nearest Resilience Hub.
- MIND - 0300 123 3393 / https://www.mind.org.uk/information-support/ info@mind.org.uk
- SANEline - 0203 805 1790
- Samaritans – 116123 (Available 24/7, 365 days of the year).
- Rethink – 0800 801 0525 / 0808 801 0745

Appendix O – Example of Holistic-Form Analysis

[Removed for digital archiving]

Appendix P – Example of a Categorical-Content Analysis

[Removed for digital archiving]

Principle sentences contributing to minor category 'Experiences of Support'.

Participant 1:

"It just felt again like that support option wasn't there and I also felt quite angry with psychologists and the system… it just felt like there were these double standards everywhere..."

Participant 2:

"I had disclosed to my personal tutor… who's been really great, in terms of like, we have like an annual review at the end of each year and she's always saying that I should have a goal to bring my lived experience into my identity as a clinician."

Participant 3:

"they [employee support service] *said my mental health was the reason that I wasn't in work they couldn't support me with that because it has to be that you've experienced something at work that's made your mental health deteriorate, and I was like 'it is', because the course is really overwhelming and then I've got these other things going on and it's all mixing together and causing this distress."*

Participant 4:

"I've shared that [lived experience] *with peers on the course and some course staff... and placements, I found it to be… yeah, quite supportive in that respect…"*

Participant 5:

"I think I first went to the GP, like, maybe when I was like 18 or 19, erm, to get medication and to actually talk to someone about it…"

“I did actually get referred… for CBT at that point… I found that really helpful, and really, like, *challenged my anxiety and managed really well”*

Participant 6:

“…where do I actually get this support as a trainee? They tell you to look at your personal and professional self, y’know reflect in supervision but I got this real sense that it was, like, only to a *certain point… don’t think about yourself too much, don’t bring too much.”*

Participant 7:

“everyone’s just been super nice and supportive and seem to just want to help each other…”

Participant 8:

“I went through… the university GP, and they sent me to counselling… which I was really up for in the beginning, but I had quite bad experience of it actually”

Participant 9:

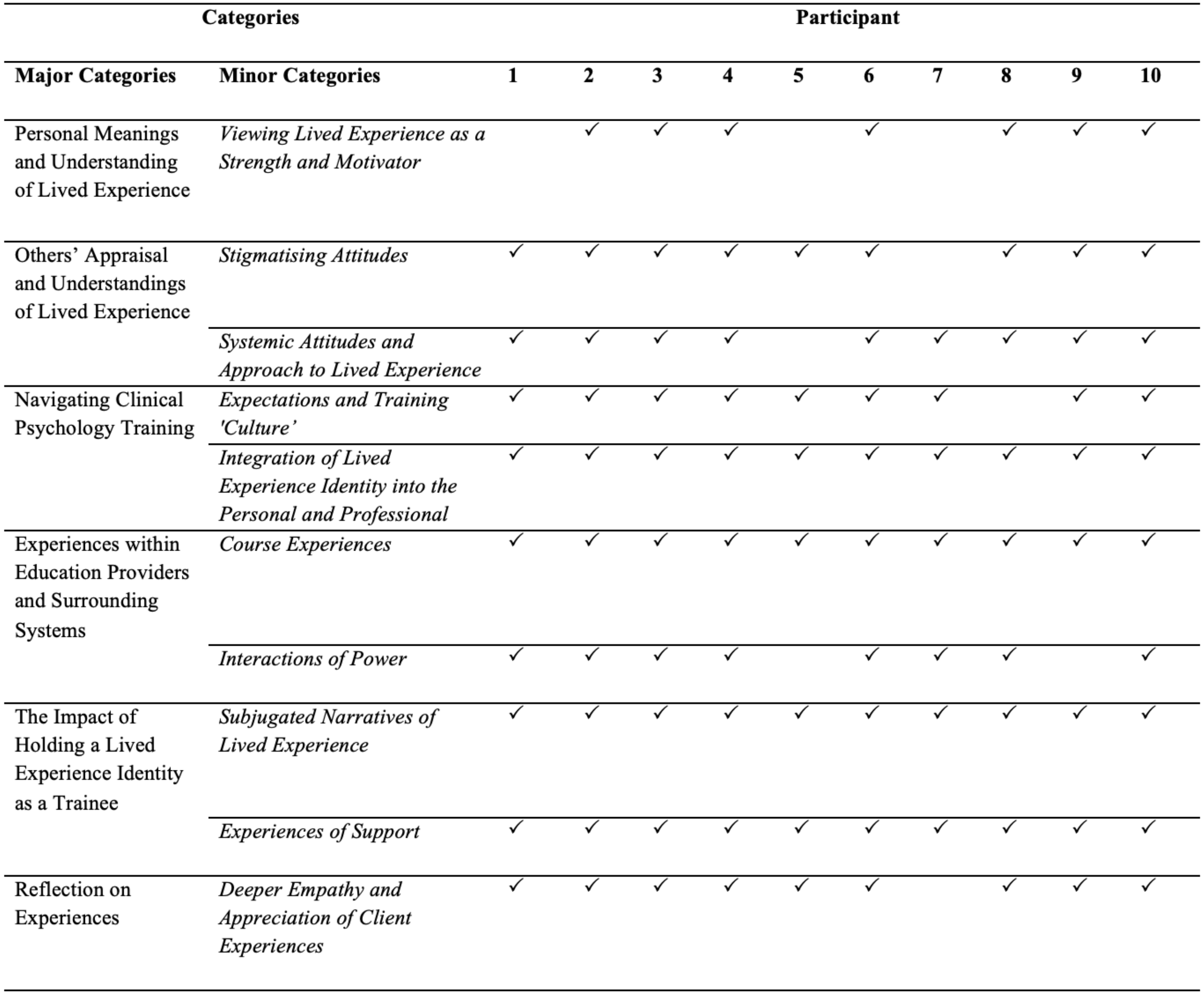
“then I became more aware of it and I was like OK this is a problem and this isn't OK um, so I access support from friends and family and my parents tried their absolute hardest to help in any way that they could whilst also not having any support and direction into how to help me*”*

“So I went to my GP and um… was basically diagnosed with PTSD and prescribed medication”

Participant 10:

“I've had a lot of support from the course to be fair, they've been really, really helpful about it, *erm… really helpful about it*

Appendix Q – Overview of Categorical-Content Themes Across Participants



Categories		Participant									
Major Categories	**Minor Categories**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Personal Meanings and Understanding of Lived Experience	*Viewing Lived Experience as a Strength and Motivator*		✓	✓	✓		✓		✓	✓	✓
Others' Appraisal and Understandings of Lived Experience	*Stigmatising Attitudes*	✓	✓	✓	✓	✓	✓		✓	✓	✓
	Systemic Attitudes and Approach to Lived Experience	✓	✓	✓	✓		✓	✓	✓	✓	✓
Navigating Clinical Psychology Training	*Expectations and Training 'Culture'*	✓	✓	✓	✓	✓	✓	✓		✓	✓
	Integration of Lived Experience Identity into the Personal and Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Experiences within Education Providers and Surrounding Systems	*Course Experiences*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Interactions of Power	✓	✓	✓	✓		✓	✓	✓		✓
The Impact of Holding a Lived Experience Identity as a Trainee	*Subjugated Narratives of Lived Experience*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Experiences of Support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reflection on Experiences	*Deeper Empathy and Appreciation of Client Experiences*	✓	✓	✓	✓	✓	✓		✓	✓	✓

Appendix R – Additional Supporting Quotes

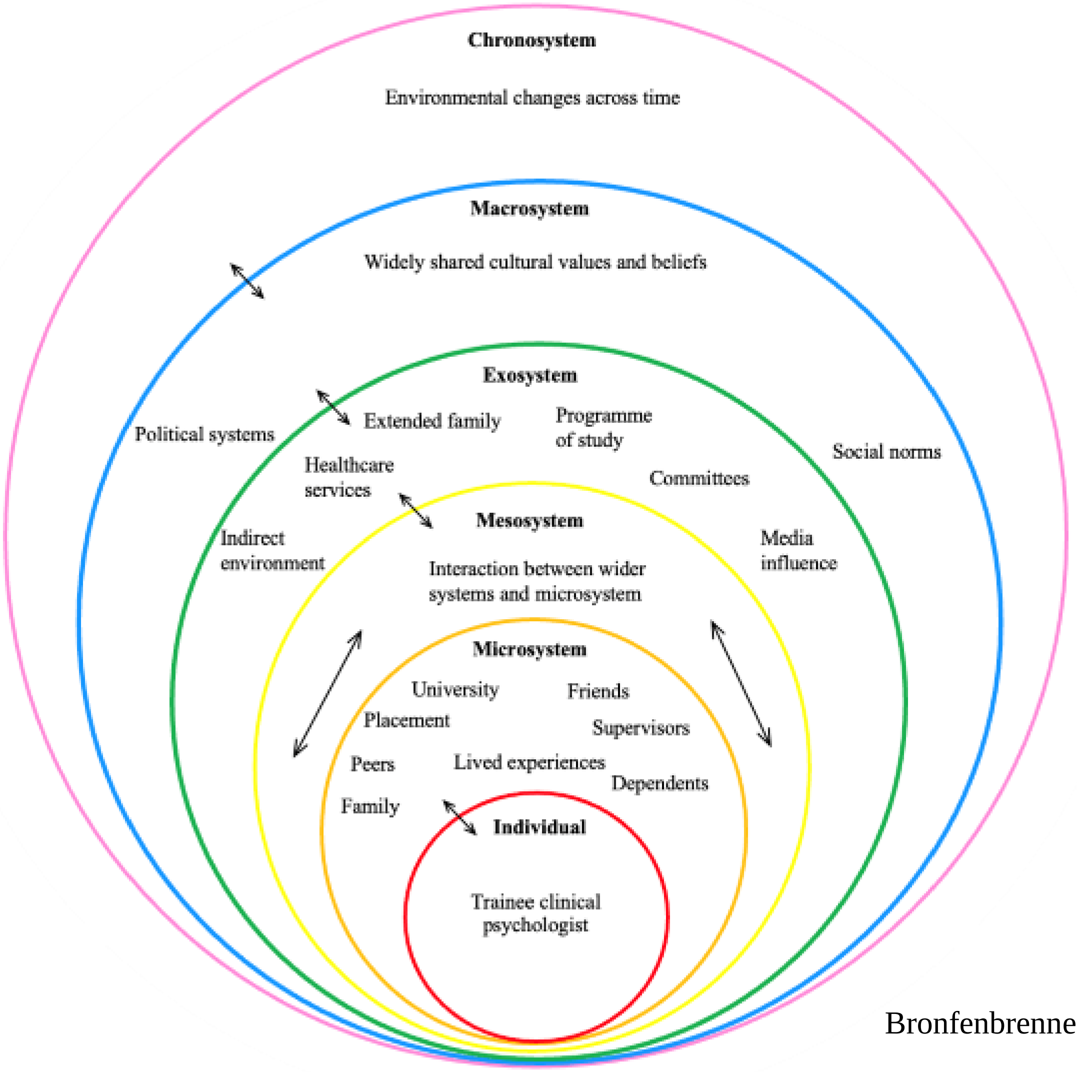
Holistic Form	
Early Struggles	*"I had depression during my teenage years… I think it links back to bullying as a kid where I didn't feel like I fit in…low self-*esteem *developing from there." (Participant 1)* *"…it sort of was highlighted in childhood that I struggled with… anxiety and things." (Participant 4)*
Turbulent Times	*"…there's been times where my mental health has suffered more I think. There's been a couple of traumatic events at work… and sort of, seeing the impact on the staff and the conflicts that ensue from that was really tricky."* (Participant 8) *"I was really really struggling, other things were going on in my personal life and work felt really hard, I found second year really challenging… I found it really hard and I knew I was struggling."* (Participant 5)
Low Ebb	*"I felt very vegetative for a long time…"* (Participant 10)
Renewed Hope	*"I think maybe I've got more comfortable across training, being able to draw on my lived experience. I think a lot of that is due to my personal tutor…" (Participant 2)*
Heading into the Optimistic Unknown	*"… it all unravelled positively then and I was making fewer mistakes and I was less tired and they* [supervisors] *could see my confidence improving and that was shown with positive feedback and I was being told I was*

	'good enough'. It had a very happy ending, but it felt so hopeless at the time." (Participant 1)
Categorical Content	
Viewing Lived Experience as a Strength and Motivator	*"Yeah, yeah, yeah, and I think I'm just quite passionate about it, like I've always been really passionate about lived experience being something that's just incorporated that it's just there and forms a part of our systems, but I think I've always been quite an advocate for that and things… I think its stuff that I'm quite passionate about and it drove me to want to go into the profession to start with."* (Participant 4)
Stigmatising Attitudes	*"I kind of think that I still to this day worry about the stigma of sharing that, you know, being in healthcare and sharing those experiences and there has been other people who have had differing views on lived experience within other cohorts, which has been a bit difficult to navigate."* (Participant 4)
Systemic Attitudes and Approach to Lived Experience	*"it just feels like it was a message saying… almost like a blanket assumption that people haven't had therapy themselves, or aren't trying to access therapy because, god forbid, they have mental health difficulties."* (Participant 3)
Expectations and Training 'Culture'	*"I think there's still maybe an element of, like, needing to show that you're coping and that you're managing and that you're doing alright."* (Participant 7) *"it definitely impacted how I felt about the course, like wondering was it worth doing it. Was it worth going through all that and… just not having felt like that before, it was really scary actually."* (Participant 7)
Integration of Lived Experience Identity into the	*"I can see, like, the merit of having lived experience… I would never judge anyone else and think about how much of a benefit that is, but it's so hard to apply that to yourself when you're in that situation, especially*

Personal and Professional	*as a patient and you're trying to navigate that… am I a professional here or not?"* (Participant 8) *"I think over the years of training, I'm able to bring more of myself to my professional identity now which feels nice. And also, have... like, clients have fed back that it's been refreshing not to have the cookie cutter psychologist, erm, so yeah, I think that's something that's changed."* (Participant 2)
Course Experiences	*"Discussing mental health on the course… I guess I do want to be asked even though I might be a bit prickly, inside I'm desperate for people to know how hard it is. It's really tiring holding this guard up all of the time and being like 'yes yes I'm fine' when actually it's really exhausting."* (Participant 5)
Interactions of Power	*"It didn't feel that traditional routes that other professions would take, like being signed off with stress were an option… how would that look to my supervisor if I signed off with stress? This person's going to pass or fail me at the end of this placement, so I need to keep up a positive impression at all times."* (Participant 1) *"Because of the power of placing and the time you invest on trying to get onto training and then you kind of feel like 'oh great, I've been given this amazing opportunity I should be so grateful for this position that I'm in', so I don't want to say that anything's not okay about it because I'm so privileged to be here."* (Participant 4)
Subjugated Narratives of Lived Experience	*"I think it's helped me in terms of handling situations quite delicately and being able to resonate with people when they're feeling a certain way, and how the work that I do with them might challenge that in a way that's either helpful or not helpful… I try to think of it as this is something that's happened to me what can I take from this in order to help me work with*

	people better or be more understanding or more empathic towards people." (Participant 9)
Experiences of Support	*"I think if you're sort of like having a lot of questions about 'Should I be here? Am I well enough to be here? Some people think that I shouldn't be here because I have lived experience of mental health difficulties and then you get a supervisor who's not particularly good at being supportive. I think it can make you feel really like you shouldn't be there."* (Participant 10)
Deeper Empathy and Appreciation of Client Experiences	*"I think it's helped me in terms of handling situations quite delicately and being able to resonate with people when they're feeling a certain way, and how the work that I do with them might challenge that in a way that's either helpful or not helpful… I try to think of it as this is something that's happened to me what can I take from this in order to help me work with people better or be more understanding or more empathic towards people."* (Participant 9)

Appendix S - Bronfenbrenner's Ecological Systems Model: Encompassing Trainee Experiences



Bronfenbrenner, 1979