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Factors Associated with Staff Attributions of Challenging Behaviour, and Trainee Clinical Psychologists' Experiences of Self-disclosing Mental Health Difficulties

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PREFACE

Decision-making is a high-level cognitive process by which one course of action is chosen over other alternative options. In healthcare professions, decision-making is integral to evidence-based practice, and is often a complex and dynamic process reliant heavily on contextual factors, which includes workplace culture. The current project explored decision-making in different health care contexts highly relevant to staff well-being and is presented as two papers consisting of 1) a systematic literature review; and 2) an empirical research study.

Paper one presents a systematic review in the area of intellectual disabilities and staff responses to challenging behaviour. Challenging behaviour of individuals with intellectual disabilities can have a significant impact on an individual's quality of life and their caregivers. Staff causal attributions play an important role in how staff respond to challenging behaviour. Therefore, to effectively support staff to work with individuals who engage in challenging behaviour we must first better understand attributions. Thirteen studies investigating factors associated with staff causal attributions were systematically reviewed for quality and to summarise evidence. Some evidence was found for the role of staff, service user and organisational factors associated with staff causal attributions however the evidence is limited. More high-quality research is needed in the area that balances rigour with ecological validity.

Paper two presents an empirical study designed and conducted after the original project in the area of intellectual disabilities was deemed no longer feasible. The empirical study presented explored trainee clinical psychologists' experiences of self-disclosing information of lived experience of mental health difficulties during training. Research shows that trainee clinical psychologists are highly likely to have lived experience of mental health difficulties. This raises the questions of whether and how to disclose this during doctoral training. Twelve trainee clinical psychologists with experience of disclosing information about their lived experience of mental health difficulties during training participated in semi-structured interviews. Grounded theory methodology was used to analyse the data from interviews

and to construct a theoretical model of disclosure experiences in training. The model that emerged is broadly consistent with literature of self-disclosure in the workplace and has important implications for trainees, supervisors and training programmes around how self-disclosure may be best supported and managed during training. Furthermore, the model that emerged suggests self-disclosure of mental health difficulties met with supportive responses can have powerful impacts for trainees and colleagues, including greater integration of personal and professional identities; more meaningful working relationships; and gaining appropriate support. The potential impact of this on competency development is also considered.

Knowing that research is always conducted in context, these disparate topics were chosen by the researcher for investigation due to their personal relevance. The researcher has personal experience of working in learning disabilities services and experiencing burnout while working in this area prior to training, which has been disclosed in part at various stages in training. Thus, the researcher chose these topics due to a personal interest and passion about both. Furthermore, these topics were chosen to develop competencies in critically appraising literature in an applied field and developing knowledge and skills in qualitative methods, namely grounded theory methodology.

These papers, though contrasting in topic area, are relevant to staff well-being literature and highlight the importance of organisational and relational information in decision-making and subsequent behaviours within the healthcare professions. Furthermore, they suggest a shared responsibility in supporting staff to make informed and effective decisions in the workplace, in relation to their work with both service users and colleagues.

PAPER 1 - SYSTEMATIC REVIEW

Prepared in accordance with author guidelines issued by Journal of Intellectual Disabilities Research (see Appendix A) with exception of word count for purpose of examination

Factors associated with staff attributions for challenging behaviour of adults with intellectual disabilities: A systematic review

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Abstract

Background: Challenging behaviour has been shown to be more prevalent in individuals with intellectual disabilities and can have a significant impact on an individual's quality of life and that of their caregivers. Causal attributions about challenging behaviours affect how carer's respond to such behaviour, which in turn can maintain difficulties. For care staff to work effectively with individuals with ID, more information is needed about what factors can affect staff attributions.

Objectives: To systematically review the quality and summarise the evidence for factors associated with staff causal attributions for challenging behaviour of adults with intellectual disabilities.

Results: Thirteen studies were included in the review. Some evidence was found for the role of certain staff psychological factors, service user factors and organisational factors associated with staff causal attributions however the scant extant literature and differences in methodologies limit these findings.

Conclusion: The evidence in this area is limited, and generally relatively low quality. Future research needs to balance ecological validity alongside the need for more high-quality evidence.

Keywords: care staff; attributions; intellectual disabilities; challenging behaviour

Introduction

Individuals with intellectual disabilities are more likely to engage in behaviours that challenge than those in the general population. Behaviours often described as challenging include, but are not limited to, aggressive behaviours directed towards other individuals or the environment; self-injurious behaviours; stereotyped behaviours; and sexually inappropriate behaviours. Emerson (1995) defined challenging behaviour as behaviours that are culturally abnormal, that occur at such intensity, frequency or duration that the safety of the individual or others is jeopardised, or behaviour that limits the individual's ability to engage in or access ordinary community facilities. The reported prevalence of challenging behaviour in individuals with intellectual disabilities varies considerably, however a recent population study estimated that around 18% of adults with intellectual disabilities who are known to services may show challenging behaviours (Bowring, et al., 2019). Research also suggests that challenging behaviour for many individuals may begin in childhood and can be highly persistent (Emerson, 1995; Taylor, et al., 2011).

Positive Behavioural Support (PBS) is the current approach used by many learning disability services to better understand challenging behaviour. PBS uses principles of Applied Behaviour Analysis alongside promoting values such as person-centred planning, inclusion, and choice (Carr, et al., 2002). PBS explains challenging behaviour as functioning to communicate unmet needs, arising between the individual and their social network. Responsibility is therefore attributed to an individual's social network to ensure needs are met, subsequently reducing distress, and increasing quality of life (Cooper & McElwee, 2015).

Moreover, the functions of challenging behaviour may arise from interactions between an individual's specific vulnerabilities, maintaining factors, and the impact the behaviour has on the individual and their social network (Hastings et al., 2013). Thus, one's environment plays an important role in the development and maintenance of challenging behaviour. In particular, research has found the interaction between an individual with intellectual

disabilities and caregivers (Hastings & Remington, 1994) can contribute significantly to the origin and persistence of challenging behaviour.

Carer Responses to Challenging Behaviour

Studies using functional analysis have demonstrated that socially mediated reinforcement can maintain challenging behaviour for some individuals (Iwata et al., 1982). NICE (2015) recommends addressing carer responses to challenge behaviour and the Division of Clinical Psychology Faculty for People with Intellectual Disabilities (2016) guidance for challenging behaviour emphasises working proactively and collaboratively with carers to provide Positive Behaviour Support.

A framework hypothesised by Hastings (2005) originally designed to explain challenging behaviour in children with intellectual disabilities integrates staff and service variables such as psychological resources, staff beliefs, service culture and staff stress in understanding challenging behaviour (Figure 1). This framework suggests that challenging behaviour may elicit emotional reactions from care staff that impacts perceived stress and staff behaviour. Furthermore, staff beliefs are hypothesised to have a direct impact on staff behaviour while organisational factors are hypothesised to assert an indirect influence. Despite being aimed at staff working with children with intellectual disabilities, it has been argued to be equally relevant for adults with intellectual disabilities (Lembrechts, et al., 2009).

In partial support of this model, organisational initiatives, such as practice leadership (Mansell, et al., 1994) - which provides a framework for managers to model and provide feedback on staff behaviour - has been shown to improve use of active support (Beadle-Brown, et al., 2013). Moreover, research has shown that being exposed to and managing challenging behaviour can have a significant impact on carers' psychological and emotional wellbeing, such as adding to caregiver burden, feelings of stress and burnout (Mills & Rose, 2011). These emotional reactions in turn affect carer responses to behaviour (Hastings,

2002). In particular, research in this area has used Weiner's attributional model (1985) to investigate the relationships between staff beliefs, emotional reactions, and responses.

Carer Attributions of Challenging Behaviour

Weiner's attributional model (1985) aims to explain how individuals may be motivated to engage in helping behaviour. When applied to the field of intellectual disabilities, this model theorises that staff attributions about challenging behaviour influence their emotional reactions, which in turn influence the likelihood of the staff member providing help. Attributions are beliefs about causal explanations for behaviour (Hastings & Brown, 2002) and can be categorised according to several key aspects:

1) Stability – whether the behaviour is stable or changeable
2) Controllability – whether the behaviour is controllable
3) Universality – whether the cause is common to all individuals
4) Globality – whether the cause affects all situations or not
5) Locus of control – whether the cause of the behaviour is internal or external

Much research has investigated the validity of applying Weiner's attributional model to staff responses to behaviours that challenge. In particular, research has tested the theory that staff attributions of uncontrollability will be associated with greater empathy, and greater motivation to engage in helping behaviour; while attributions of controllability will be associated with less empathy and lower motivation to engage in helping behaviour (Willner & Smith, 2007). Studies however have found mixed results. For example, Hill and Dagnan (2002) investigated helping behaviour, attributions, emotional reactions, and coping style in staff working with individuals with intellectual disabilities on a training course. The authors used a variety of questionnaire measures to explore the associations between the key variables and found that a practical coping style, and attributions of controllability and internality were independent predictors of effort to help. This finding partially supports the application of Weiner's model to staff responses to challenging behaviour, however emotional responses were not found to contribute significantly to effort to help. The authors comment that this may be due to the shared variance with other key variables.

Research by Jones and Hastings (2003) found little support for the role of attributions and emotions in the responses of staff in the context of challenging behaviour. They asked a range of staff working with individuals who engaged in challenging behaviour to watch two videos depicting an individual with intellectual disabilities engaging in self-injurious behaviour, in which information about the function of the behaviour was changed. Staff completed self-report measures, and the authors concluded that a significant association between affect and helping was found. However, the role of attributions was not supported. Similarly, when looking at challenging behaviour in dementia settings, research has found no consistent role for staff attributions of challenging behaviour (Todd & Watts, 2002) but has found that carers report greater feelings of burden when they attribute behaviours to be internal to the individual or to be enacted for malicious reasons (Polenick & Martire, 2013).

Another model of attributions called the symptom-controllability model has been used in mental health and dementia research. This model suggests family members place responsibility for a patient's behaviour either on the patient or on the illness (Hooley, 1987). This model characterises attributions along dimensions relating to the person's character, intentions, and control. These dimensions appear largely comparable to those included in Weiner's (1985) model, apart from the question of perceived intent.

A systematic review by Willner & Smith (2007) synthesised research applying attribution theory to helping behaviours towards individuals with intellectual disabilities and challenging behaviour. The authors found that the literature is mixed, and only provides partial support for Weiner's model. Interestingly, this finding is inconsistent with research in other areas. For example, a meta-analysis by Rudolph (2004) synthesised 64 studies investigating Weiner's attributional model of helping and findings were supportive of the model.

Willner & Smith (2007) propose the discrepancy between these areas of research may be due to several methodological limitations. Firstly, in challenging behaviour research some studies investigate staff helping using vignettes rather than real-life situations. This may provide some explanation for the inconsistency in findings. However, it is worth noting that Rudolph (2004) found that Wiener's model held true for both real and simulated events. A second methodological limitation in challenging behaviour research is the way helping behaviour is defined and measured. Indeed, many studies have asked staff to rate how likely they are to "put extra effort into helping". Firstly, staff may be biased to give a socially desirable answer to this. Secondly, helping may differ greatly depending on the behaviour and cause. Finally, findings may be inconsistent due to extraneous factors that impact on staff behaviour in these contexts. For example, studies have shown that other variables impact staff responses to challenging behaviour, such as staff training (Allen, et al., 1997). Overall, although findings in this area vary, it remains that this model has clinical utility and thus is worth further investigation.

Rationale for Current Review

Weiner's attributional model remains to be the most popular and clinically useful template to help understand staff responses to challenging behaviour. Hastings (2005) framework highlights wider variables such as staff psychological factors and organisational factors which have been hypothesised to play a role in staff responses, via cognitive and emotional processes. Although these have clinical utility, there is limited and inconsistent evidence that staff helping behaviour can be understood using this extant literature. Unless helping behaviours and the attributions that underpin them are better understood, there is perhaps limited scope for PBS to shape staff responses to challenging behaviour. In order to address this, Weiner's and Hasting's models suggest that attributions must be better understood.

Aims and Review Question

The current systematic review firstly aims to investigate whether interpersonal and organisational factors have an impact on the types of attributions staff have about

challenging behaviours. It is hypothesised that interpersonal and organisational factors will all have an impact on the likelihood of staff making internal, global, and stable attributions about challenging behaviour. Secondly, the current review aims to synthesise this research. Finally, the current review also aims to assess the quality of research in this area. A review by Williams (2011) identified changes to staff beliefs and attributions as a result of carer training in complex and challenging behaviour. Thus, studies investigating training will not be included in this review.

Methods

Search Strategy

Medline, PsychInfo and EMBASE databases were searched using terms selected based on previous literature in the area and clinical practice. Search terms included, and were based on alternative terms for, 'Intellectual Disability', 'challenging behaviour', and 'attributions'. Initial searches were conducted between September and October 2019 to clarify the search strategy and terms (see Appendix B). Main searches were then performed in January 2020 with a final check in April 2020 to ensure no new articles were missed. Handsearching reference lists and snowballing was also used to find potentially relevant articles. Prominent researchers in the area were contacted via email about relevant papers which may have been missed through searching (see Appendix C).

Inclusion and Exclusion Criteria

Types of Studies

For the purposes of this review, studies were considered relevant if they were empirical studies published in a peer-reviewed journal in the English language. No date limits were applied in order to ensure all relevant papers were captured.

Participants

Studies were considered relevant if their participant group was specified to be paid carers of individuals with intellectual disabilities. This included staff in direct care roles and care managers only. Participant groups which included allied health professionals, familial carers, or carers of children with intellectual disabilities were excluded as such groups may differ in attributions for various reasons such as differences in contact time and activities, training, and stability of behaviours. This was to ensure articles included in the review were as homogenous as possible.

Associated Variables

The current review criteria were also specified so that both theoretical and methodological strengths and limitations of studies could be appraised. The review was constrained to focus on studies which investigated **interpersonal** and **organisational** factors that might be associated with at least one causal attribution of challenging behaviour – namely dimensions of stability, internality, controllability, globality and universality. Studies which did not report attributions using these dimensions were excluded in order to better synthesise findings. *Studies only investigating factors as part of Weiner's attributional model (such as emotional reactions, optimism and helping behaviour) were excluded as previous research has considered the relationships between these factors and causal attributions at some length (Willner & Smith, 2007). Studies investigating the influence of staff training on attributions were also excluded as this has also been investigated previously (Williams, 2011).*

Thus, the current review differed in that it examined how interpersonal and organisational factors (Hastings, 2005) were associated with staff groups' attributions about the stability, internality, controllability, globality or universality of challenging behaviour.

Screening and Selection

The search yielded 371 titles. One reviewer screened titles and abstracts of articles found from the search. Handsearching and snowballing yielded 16 titles deemed to meet the inclusion criteria for the current review. No articles were identified by contacted authors. Duplicates were removed and any articles deemed relevant from titles and abstracts were retrieved as full texts. Fifty-four full texts were then screened with a selection tool created using inclusion and exclusion criteria. A second reviewer screened 25% of full texts for selection and discrepancies were discussed and resolved. In total, 13 articles were selected for inclusion. Figure 2 shows a flow diagram of the selection process.

Data Extraction and Quality Assessment

One reviewer extracted data from the studies which pertained to:

- Study Design
- Participant sample, including number of participants, age, and gender
- Setting of study
- Outcome measures: what factors were measured and how
- Results of the study
- Main conclusions

Articles were then quality assessed using the Agency for Health Research and Quality Methodology Checklist (AHRQ; see Appendix D). This tool was chosen as it is recommended in a review of review tools by Zeng et al., (2015) for cross-sectional studies. A second reviewer quality assessed 25% of the sample. Inter-rater reliability was 100%.

Methods of Synthesis/Analysis

Due to the diverse range of methodologies, designs and analyses applied in the studies which met the criteria, a narrative synthesis format was chosen for the review.

Results

Table 1 shows descriptive information of the 13 studies included in the current review. Of the 13 studies selected for review, six were completed in residential settings for adults with learning disabilities; three were completed in a mix of settings including residential, day centre, supported living and community settings; two were completed in day centres; and two were inpatient settings of which one was a secure forensic unit. Two studies did not specify the number of participants involved; seven did not specify a mean age of participants; and three did not specify gender split. Of those that did specify number of participants, the range in sample size was 15 to 160 participants. Mean age reported was from 32.4 years to 42.7 years. Of those that reported gender information for their participant sample, the percentage of females in each study sample ranged from 39% to 80%. Conversely, the percentage of males in each sample ranged from 20% to 61%. One study reported 6% of participants did not disclose their gender.

Table 1.

Descriptive Results of Reviewed Papers.

Authors	Location and Setting	Participants and Groups	Design	Variables Investigated	Key Findings
Bailey et al. (2006)	NorthWest England, UK Day centres for adults with ID	43 staff (mean age = 40.95; Gender information not reported)	Cross-sectional design using questionnaires and observations	Attributions of challenging behaviour Emotional reactions to challenging behaviour Optimism Willingness to help Observed helping behaviour	Significant difference found between uncontrollable and stable attributions for SIB vs other types of challenging behaviour
Dagnan & Cairns (2005)	Unspecified location, UK Residential homes from health, social services and independent sector	62 staff (mean age = 36.2; 32 female/30 male)	Cross-sectional design using questionnaire administered using latin-square	Attributions of challenging behaviour Anger Sympathy Helping intention Responsibility for development of behaviour Responsibility for change	Responsibility significantly correlated with attribution of controllability
Dagnan (2012)	Unspecified location, UK Residential homes (n=10)	62 staff (mean age = 34; 39 female/23 male) Conditions – named vignette versus unnamed vignette	2 conditions within-groups design using questionnaire	Attributions of challenging behaviour Anger Sympathy Optimism Helping intention Self-injury behavioural understanding	Named vignettes attributed as more internal and more global Similar, non-significant trend was found for attributions of controllability and stability. Correlations stronger between attributions, emotions, and optimism for named condition

Dagnan, et al. (1998)	Unspecified location, UK Residential homes	40 staff Group 1 – staff working with individuals with challenging behaviour 20 staff (Mean age = 32.4; 10 female/10 male) Group 2 – staff working with individuals with no significant challenging behaviour 20 staff (Mean age = 35.5; 16 female/4 male)	Cross-sectional, 2 group design using interview and questionnaire	Attributions of challenging behaviour Evaluation of the behaviour Optimism Willingness to help Emotional responses	Significant correlation between negative evaluation of person and negative evaluation of behaviour and attribution of control
Dilworth et al., (2011)	Unspecified location, UK Residential homes	43 care managers (age and gender not reported) 139 care staff (43 keyworkers and 96 other care staff; age range between 18-66 years; 108 females, 31 males) Groups determined through staff rated severity and frequency	Cross-sectional, between subjects natural group design using survey	Severity and frequency of challenging behaviour Adaptive behaviour Attributions of challenging behaviour Service characteristics	No significant correlations between attributions of control and staff age, years worked in ID, or years worked in home, or number of hours worked. No significant difference with respect to attributions and gender No significant main effect of shift pattern No sig correlation between attributions of control and

		of each typography of challenging behaviour (severe, lesser or none for severity; marked, lesser or none for frequency)			frequency of challenging behaviour or severity of problem to others. Significant main effect of severity of management problem and frequency of challenging behaviour with respect to attributions of control, meaning that physical aggression was deemed more under control if presented severe management problem and was more frequent. SIB was significantly less under control if presented as a problem, presented as severe, and was marked in frequency. No significant correlation between attributions of control and personal, community and personal-social self-sufficiency. Significant negative correlation between attributions of control and level of organisational function - control lower if staff displayed positive attitude towards client, physical and social environment was appropriate,

					and overall approach to care well structured.
Kleinberg & Scior (2014)	London, UK

Private and third sector residential homes, supported living, day services, respite services and other services | 160 staff (mean age = 36.5; 83 female/67 male/10 undisclosed gender)

Group 1 – male service user vignette (Responded to by 44 female/35 male/6 gender unknown staff)

Group 2 – female service user vignette Responded to by 39 female/32 male/4 gender unknown staff) | 2x2 (staff gender x service user gender) between-subjects design using vignettes and questionnaires | Emotional reactions to challenging behaviour Attributions of challenging behaviour Behavioural intentions | Staff and service user gender had no influence on staff attributions

Length of work experience and training received did not predict emotional reactions or attributions |
| MacKinlay & Langdon (2009) | East England, UK

Secure forensic unit | 48 care staff (age information not reported; 54% female/46% male) | Cross-sectional, related samples design | Attributions of challenging behaviour Full scale IQ Seriousness of offence | Sexual offending rated as significantly different as more external to staff; more stable than challenging behaviour; and less controllable by client. No significant correlation between attributions to challenging behaviour and full scale IQ For offending, significant negative correlation found between |

					internality to client and full scale IQ Positive correlation between controllability to client and full scale IQ Positive correlation between universality and seriousness of offence, and negative correlation between attributions of controllability to staff and seriousness of offence (indicating staff attributed more serious offending behaviour as uncontrollable by staff).
Noone, et al. (2006)	Unspecified location, UK Residential home	Study 1) 34 staff (16 female/18 male) Study 2) 23 staff (9 female/14 male) Study 2 Conditions Client A Client B (Known clients who engage in similar challenging behaviours but for different	Study 1) Cross-sectional design using interviews Study 2) Quasi-experimental, within group design using questionnaires	Attributions of challenging behaviour	1) No relationship between demographics and attributions. 2) No relationships between attributions and demographics. Attributions differed between clients on internality, universality, and controllability, but not stability.

| | | functions)

Age information not reported for either study. | | | |
|---|---|---|---|---|---|
| Rose & Rose (2005) | Midlands, UK

Residential community homes in the NHS | 107 staff (mean age = 35.73; 76 female/31 male)

Groups split into staff working with highest and lowest levels of challenging behaviour - Group 1 – low level group (33 staff) Group 2 – high level group (28 staff)

Groups also split into staff who reported perceptions of challenging behaviour as high or low. Group 1 – high perception group (27 staff) Group 2 - low perception group (27 staff) | Cross-sectional and between groups designs using questionnaires | Attributions of challenging behaviour Emotional reactions to challenging behaviour Optimism Helping intention Stress Burnout Challenging behaviour Perception of challenging behaviour in home | Stress not correlated with any attributions

Levels of challenging behaviour and perceived challenging behaviour not associated with differences in any variables (attributions, emotional reactions, optimism, helping intention, stress, burnout) |

Snow, et al. (2007)	East Anglia, UK Inpatient setting	41 staff (mean age = 36.9; gender information not reported)	Cross-sectional design using questionnaires	Burnout Attributions of challenging behaviour	Correlation between length of time working with SIB and number of attributions, and more internal and unstable attributions No relationships between age, length of time working with adults with ID and causal attributions Significant negative correlation between frequency of stable attributions and emotional exhaustion.
Tynan & Allen (2002)	Unspecified location Residential home	42 staff in total (90% aged between 21-45 years; gender information not reported) Group 1 Severe challenging behaviour condition – (age information not reported; 62% female/38% male) Group 2 Mild challenging behaviour condition – (age information not reported; 57% female/43% male)	2 group experimental design using questionnaires	Attributions of challenging behaviour Severity of behaviour	In mild group, service user was perceived to have significantly more control over behaviour. No difference for stability or locus of control.

Wanless & Jahoda (2002)	Unspecified location Day centres	38 staff (mean age = 42.7; 22 female/16 male) Conditions: Vignette of verbal aggression Vignette of physical aggression Real incident of verbal aggression Real incident of physical aggression	Cross-sectional, within-subjects design using questionnaires and interviews	Attributions of challenging behaviour Emotional reactions to challenging behaviour Optimism Helping behaviour	Staff reported more anger and less sympathy for real incident of aggression. The individual was evaluated more negatively in real incident than vignettes. Attributions of control were positively correlated with anger, and negatively correlated with sympathy for both real incidents and vignettes. Negative evaluations of person and their behaviour was significantly positively associated with attributions of internality and control for real incidents only.
Weigel, et al., (2006)	Unspecified location, UK Community services	15 staff (Age and gender information not reported) Conditions: A client who engages in challenging behaviour A client who does not engage in challenging	Cross-sectional related samples design using questionnaire and Five-Minute Speech Sample (FMSS)	Attributions of challenging behaviour Expressed emotion	Staff rated behaviour of client with challenging behaviour as significantly more internal and controllable. For the individual with challenging behaviour, a positive correlation was found between attributions of universality to client and internality to client, and a negative correlation found

		behaviour			between uncontrollability and universality for client Significant difference found between high/low expressed emotion and attribution ratings – low expressed emotion more likely to attribute challenging behaviour to external to client and uncontrollable by client. High expressed emotion more likely controllable by client.

When considering the factors that the studies investigated, six studies examined staff psychological factors such as perceptions of responsibility of challenging behaviour, staff behavioural understanding, evaluations of individuals and behaviour, expressed emotion, stress, burnout. Four studies investigated staff demographic information such as age, gender, training, and length of work experience. Five studies investigated carer attitudes to service user factors such as using vignettes of named individuals versus unnamed individuals; using vignettes versus known individuals; level of disability; IQ; and gender. Nine studies investigated features of service user behaviour, such as whether or not an individual engaged in challenging behaviour; typography, severity, frequency, or function of challenging behaviour; and seriousness of offending behaviour. Finally, one study investigated service characteristics as rated by team managers, such as appropriateness of environment and service approach to care.

Quality of Included Articles

A quality assessment of the selected articles was completed and showed that of the 13 articles included in the current review, three (Dilworth, et al., 2011; Kleinberg & Scior, 2014; and Weigel et al., 2006) were deemed to be of relatively high quality; two (Snow, et al. 2007; and Wanless & Jahoda, 2002) were deemed to be of moderate quality; and the remaining eight were deemed to be of low quality. It is worthy of note that most studies included in this review used a cross-sectional design and non-validated measures to operationalise variables such as emotional reactions, optimism, and willingness to help. All studies appeared to use convenience sampling or voluntary samples, and none reported power analyses calculations to inform the sample size. Only three studies (Dilworth, et al., 2011; Kleinberg & Scior, 2014; Rose & Rose, 2005) utilized relatively large sample sizes (N > 100) that may have given sufficient power, however Kleinberg & Scior (2014) note that due to the number of predictors used in regression analysis, the study may be underpowered. Most studies however did assess or control for potential confounding factors, but only one (Kleinberg & Scior, 2014) explained how missing data were handled during analysis.

Findings

Staff Psychological Factors

As already stated, six of the selected studies investigated staff psychological factors in relation to attributions of challenging behaviour. Of these, one study (Dagnan & Cairns 2005) investigated perceived responsibility of challenging behaviour; one (Rose & Rose, 2005) investigated perception of level of challenging behaviour; one (Dagnan, 2012) investigated behavioural understanding of self-injury; one (Dagnan, et al., 1998) investigated evaluations of the individual and their behaviour; one (Weigel et al.,2006) investigated expressed emotion; and two (Rose & Rose, 2005; and Snow, et al., 2007) investigated staff stress and burnout.

Of the higher quality studies included in this review, Weigel, et al. (2006) investigated expressed emotion and attributions, and found a significant difference between level of expressed emotion and attribution ratings, meaning that individuals who displayed high expressed emotion were more likely to attribute challenging behaviour as controllable by the client, while individuals who displayed low expressed emotion were more likely to attribute challenging behaviour as external and uncontrollable to the client. Snow, et al. (2007) investigated stress, burnout, and attributions, and found a significant correlation between frequency of stable attributions and emotional exhaustion so that staff who reported higher exhaustion made fewer stable attributions for SIB.

Of the lower quality studies, one study (Dagnan & Cairns, 2005) found that judgements of responsibility for development of challenging behaviour and for change were significantly correlated with attributions of controllability. Similarly, regarding evaluations of individuals and behaviour, this study found significant correlations between staff negative evaluations of the individual and the attribution of control, and negative evaluation of behaviour and the attribution of control. Conversely to findings by Snow, et al. (2007), a study by Rose and Rose (2005) found stress was not correlated with any attributions.

Staff Demographic Information

Four studies (Dilworth, et al., 2011; Noone, et al., 2006; Snow, et al., 2007; and Kleinberg & Scior, 2014) investigated demographic information including staff gender, age, and length of work experience.

Considering these four studies, only one study by Snow, et al. (2007) of relatively good quality found correlations between length of time working with self-injurious behaviour and number of attributions made by staff, and length of time working with self-injurious behaviour and internal, unstable attributions. Dilworth, et al. (2011) and Kleinberg and Scior (2014) were also deemed to be high quality studies but found no significant correlations between staff gender, staff age, years working in intellectual disabilities services, years working in current home, number of hours worked per week and attributions. Similar results were found by Noone et al., (2006).

Service User Factors

Five studies investigated service user factors in relation to staff attributions of challenging behaviour. Attributions were elicited using one of a number of techniques including named versus unnamed vignettes (Dagnan, 2012); vignettes compared with real incidents or individuals (Wanless & Jahoda); level of disability and/or IQ (Dilworth, et al., 2011; Tynan & Allen, 2002; MacKinlay & Langdon, 2009); or service user gender (Kleinberg & Scior, 2014).

Of those deemed higher quality, Kleinberg & Scior (2014) investigated service user gender and found no influence of this on staff attributions. Considering level of intellectual disability, Dilworth, et al. (2011) found no significant correlation between attributions of controllability and personal, community and social self-sufficiency. Considering use of vignettes, Wanless & Jahoda (2002) found attributions of control were positively correlated with anger, and negatively correlated with sympathy for both real incidents and vignettes, but attributions of internality and control were significantly positively associated with negative evaluations of the person and their behaviour for real incidents only.

Of those studies deemed lower quality, one found no correlation between attributions and full-scale IQ for challenging behaviours (MacKinlay & Langdon, 2009). However, the same study did find a significant negative correlation between internality to client and full-scale IQ for sexual offending behaviour, and a significant positive correlation between controllability to the client and full-scale IQ. Finally, one study (Tynan & Allen, 2002) found that service users with mild intellectual disability were perceived to have significantly more control over challenging behaviour, but no difference was found between attributions of stability or externality.

Dagnan (2012) investigated the use of named vignettes versus non-named vignettes and found that in named vignette conditions challenging behaviour was attributed as significantly more internal and global, while a similar non-significant trend was found for attributions of controllability and stability. Finally, the only study (MacKinlay & Langdon, 2009) to have investigated sexual offending found a positive correlation between attributions of universality and seriousness of offending behaviour, and a negative correlation between controllability for staff and seriousness of offending behaviour.

Features of Service User Behaviour

Of these studies, three (Bailey et al., 2006; Mackinlay & Langdon, 2009; and Wanless & Jahoda, 2002) investigated typography of challenging behaviour; three (Dilworth, et al., 2011; Rose & Rose, 2005; and Tynan & Allen, 2002) investigated severity of challenging behaviour, of which Dilworth, et al., (2011) and Rose and Rose (2005) also investigated frequency; and one (Noone, et al., 2006) investigated function of behaviour. Two studies (Weigel, et al., 2006; Dagnan, et al., 1998) also compared challenging behaviour to non-challenging behaviour.

Of the higher quality studies, Wanless and Jahoda (2002) found no significant differences between attributions for different typographies of behaviour. Dilworth, et al. (2011) found a

main effect of severity of management problem it presented and frequency, so that physical aggression was deemed more controllable if more severe a management problem and more frequent, while self-injury was less controllable if perceived as a severe problem and if more frequent. Finally, Weigel, et al. (2006) found staff rated behaviour of a client with challenging behaviour as significantly more internal and controllable. Also, a positive correlation was found between attributions of the behaviours as universal and internal to the client, and a negative correlation found between uncontrollability and universality for client behaviours.

Lower quality studies found significant differences in the attributions made for different types of behaviour. Bailey et al., (2006) found attributions for self-injury to be uncontrollable and stable, compared to other forms of challenging behaviour, while MacKinlay & Langdon (2009) found attributions of sexual offending behaviour to be perceived as more external to staff control, more stable than other challenging behaviour, and less controllable by the client. Of the lower quality studies that investigated severity and frequency of challenging behaviour, no correlations were found between attributions and severity or frequency of behaviour. Dagnan, et al. (1998) found no significant differences in attributions between care staff of individuals who engaged in challenging behaviour and those who did not. Finally, Noone, et al. (2006) found a significant difference between attributions of internality, universality, and controllability but not stability for different functions of behaviour.

Organisational Factors

One study (Dilworth, et al., 2011) which was of relatively high quality investigated organisational factors in relation to attributions of challenging behaviour. The authors found no significant main effect for shift pattern, but found a significant negative correlation between attributions of control and level of organisational functioning, meaning attributions of control of challenging behaviour was deemed lower if staff had a positive attitude towards clients, the environment was considered appropriate for the individual, and the approach to care in the service was perceived to be well structured.

Overall Comment

The current review demonstrated that the literature in this area is extremely varied and generally of relatively low quality, which may be largely attributable to its applied nature in clinical and community settings. Some higher quality studies show that some features of service user behaviour such as severity, manageability, and frequency can be significantly associated with the kind of attributions staff make about behaviour. Staff psychological factors such as high expressed emotion and emotional exhaustion may also be associated with the type and frequency of attributions staff make about challenging behaviour. Also, organisational factors which might be indicative of better organisational functioning may be associated with staff attributions of service user control. Figure 3 provides a suggested diagrammatic synthesis of these findings.

Discussion

Key Findings and Related Research

The aims of the current review were to synthesise research investigating factors that are associated with care staff attributions towards behaviours that challenge of adults with intellectual disabilities, and to assess the quality of research in this area. It was noted that factors included as part of Weiner's attributional model have been the focus of earlier reviews (Willner & Smith, 2007) and therefore the current review attended to other factors so far not examined. Also, the impact of staff training was excluded as this has also already been reviewed (Williams, 2011). The current review found a number of factors that may be associated with staff attributions of challenging behaviour, outlined below.

Staff Psychological Factors

Considering the evidence for staff psychological factors associated with staff attributions of challenging behaviour, the best quality evidence suggests there is a relationship between expressed emotion and attributions, so that individuals showing high expressed emotion are more likely to attribute challenging behaviour as controllable by the client, and those showing low expressed emotion are more likely to attribute challenging behaviour as

external and uncontrollable by the client. This finding has some face validity in that high expressed emotion can include criticism and hostility, thus staff might be observed to express more hostility if they felt the behaviour was more controllable by the client. This also fits with extant findings that anger may be positively correlated with attributions of control (Wanless & Jahoda, 2002) and supports research showing similar relationships between expressed emotion and attributions in mental health contexts (Barrowclough & Hooley, 2003). However, the direction of this relationship is unknown. Expressed emotion has been shown to be a good indicator of relational environment in mental health (Sher-Censor, 2015) and has been extended to intellectual disabilities research, showing that expressed emotion may be related to challenging behaviour, and carer stress and burnout (Hastings, et al., 2006). Thus, it appears that high expressed emotion may be an indicator of carer distress and is also associated with attributions of control.

There was also some evidence from some lower quality studies in this review to suggest that judgements of responsibility, and staff evaluations of the individual and their behaviour may be associated with attributions. The findings from this review also suggest staff stress does not have an impact on attributions, but that there may be some association between emotional exhaustion and frequency of stable attributions.

Staff Demographic Information

There was no evidence to suggest that staff gender, age, length of work or hours worked per week were associated with attributions; however there was some small evidence to suggest that for self-injurious behaviour in particular, length of time working with such behaviours was associated with number of attributions made and also more internal, unstable attributions. This may suggest staff who have worked longer with challenging behaviours may have a more complex understanding and may be more likely to make attributions that could be used to promote change, thus supporting the role of network training and team formulation to improve staff understanding and encourage new ways of working.

Service User Factors

Considering level of disability and IQ, there was a small amount of lower quality evidence to suggest that although functional ability was not associated with attributions for challenging behaviour, full scale IQ may be associated with attributions and level of intellectual disability (for example, mild vs severe) may be associated with attributions, so that staff may attribute challenging behaviour as less controllable for individuals with lower IQ or more severe intellectual disability. Again, this finding has face validity, however there is to the author's knowledge no other research that could support such findings. It may be that only certain services, which are possibly more medical-oriented or better resourced, will have measured and documented this information, however for other services this raises the question of whether staff will make attributions based on their perception of a person's IQ and ability, rather than their actual ability. Some research suggests staff are liable to overestimate individuals' ability (Banat, et al., 2002). Thus, this could be a factor considered more in formulation and training to ensure staff make more accurate judgements of an individual's abilities and in turn, more accurate attributions for behaviours. It was also found that using named vignettes was associated with more internal and global attributions, and seriousness of sexual offending behaviour also had an effect, so that more serious offences were attributed to be more universal and less controllable for staff.

Features of Service User Behaviour

There was some evidence from lower quality studies that suggests some factors relating to the challenging behaviour itself, such as typography and function of behaviour could be related to staff attributions of causes. Again, such findings would support research that shows staff training which considers behavioural principles such as function, and that aims to increase understanding of reasons for a client's behaviour does change staff causal attributions (Cooper & McElwee, 2016; Williams, 2011). There may also be some small evidence that severity, frequency and management difficulty may be associated with attributions, however it is likely that these factors may also depend on typography and function, and also could indirectly influence attributions through perceived stress, burnout

or other emotional reactions. With limited research in this area, it is difficult to draw conclusions.

Organisational Factors

The findings from this review suggest staff shift patterns do not have an impact on attributions, but there was some evidence to suggest organisational factors such as attitudes towards service users, environment appropriateness and approach to care may be associated with lower attributions of client control over challenging behaviour. Some of these findings support Hastings (2005) framework to understand relationships between staff, service user and service factors, however the role of staff stress was not supported.

Strengths and Limitations

The findings of this review have some important implications for Hastings (2005) framework. Firstly, this review is largely supportive of the factors included within the framework, namely organisational factors, staff psychological factors, and features of service user behaviour. The role of staff demographic factors is not supported by this review, and also are not included in Hastings (2005) framework. The role of organisational factors in Hastings (2005) framework is largely supported by this review, as influencing staff beliefs. However, the relationships between factors in the framework are not as well supported by these findings. Indeed, it may be posited that service user behaviour could be elaborated and may influence staff beliefs and behaviour indirectly. It may also be posited that staff psychological factors such as expressed emotion and emotional exhaustion be included in Hastings (2005) framework and conceptualised as impacting staff beliefs, rather than staff stress impacting staff behaviour directly. A review by Lembrechts, et al. (2008) found inconsistent evidence for the role of staff variables influencing responses to challenging behaviour but argued Hastings (2005) framework would be a useful tool for further research using more systematic approaches to determine relationships between variables. Figure 4 shows a contrasting framework by Dilworth, et al., (2010) which proposes relationships between staff behaviour, client behaviour and organisational characteristics all

influencing staff attributions, however it is worth noting that it does not include staff psychological factors or emotional reactions. It appears that a combination of both may be helpful for future research, with some refinement of certain variables. A suggested framework building on this recommendation is presented in Figure 5. However, it is noted that factors presented and suggested relationships between them are tentative and require further investigation.

Concerning the methods of the current review, the inclusion and exclusion criteria used appeared to capture most relevant studies as few others were identified and selected from other methods. The quality assessment tool used in the current review also had strengths and weaknesses. It was a recommended tool for cross-sectional studies (Zeng et al., 2015) and, although the rating system was categorical and simple, it appeared to be highly relevant and helpful for assessing the quality of the studies included. Furthermore, an advantage of its simplicity was that it was easy to use and apply to the included studies. To check the robustness of the quality assessment findings, a comparison was done with the Critical Appraisal Skills Programme (CASP, 2019) Checklist which showed reliability between both tools to be 85%, however the CASP checklist felt less relevant for included studies. Thus, it appears the AHRQ was the most appropriate tool for the current review. It is also worth noting that all studies included were based within the UK, and largely England in particular; therefore, these findings may not be generalisable to other countries and cultures. The current review did include searching of European and American databases, though were limited to English language studies; therefore, it appears that studies from other English language countries were excluded when applying inclusion/exclusion criteria. The criteria used in this review aimed to create a homogeneity between studies, however in doing so, may have indirectly excluded studies from other countries. In future, it may be useful to review studies from outside the UK specifically, and compare findings to explore the generalisability of attributions literature across countries.

Implications

Overall, attributions appear worthy of consideration in clinical contexts. The findings from the current review show that there may be some important factors to consider in particular. There is little evidence that staff demographic variables influence attributions. However, level of expressed emotion, emotional exhaustion, judgements of the individual, severity of management problem, and some organisational factors may be associated with different attributions. Thus, it can be argued that it would be important to address staff judgements and understanding of behaviour, not only through training in behavioural approaches but also through network training (Cooper & McElwee, 2015), case workshops (Ingham, 2011) and possibly team formulation (Johnstone, 2013; Whitton, et al., 2016). Such approaches have a limited but growing evidence-base and could provide space to openly address attributions; incorporate them into formulations; and develop an evidenced-based understanding with more helpful beliefs.

Furthermore, organisational initiatives could also be beneficial to staff attributions, including addressing staff well-being; ensuring service users are placed in appropriate environments; and using psychologically informed environmental planning. Interestingly, despite growing acknowledgement that individuals with intellectual disabilities are significantly more likely to have experienced trauma, and calls for trauma-informed approaches in learning disabilities services (Keesler, 2014; Truesdale, et al., 2019) no studies to the author's knowledge have investigated awareness of an individual's trauma history on staff attributions, emotional reactions or helping behaviour. Thus, this could be a clinically relevant factor that has been long overlooked. Similarly, there has been a move towards values-based recruitment following the abuses seen at Winterbourne View (Francis, 2013) in order to ensure employment of individuals whose values, beliefs and behaviours will align with those endorsed in healthcare professions. It may be useful to consider the relationships between values, attributions, and behaviour to better understand what factors contribute to a culture of care and how we might better develop this in services.

One framework which may help make better sense of the role of attributions could be the idea of slow and fast thinking (Kahneman, 2011) where staff may rely on fast, instinctive explanations and responses due to mental effort and stress when confronted with challenging behaviour. Following this, it would make sense to use interventions that may make slow, more considered 'system two' attributions easier to access. For example, through the kind of initiatives outlined above; as well as regular supervision to reflect on practice; and practice leadership, to model PBS-based explanations and responses to challenging behaviour. This theory would also help services better understand staff behaviour; could facilitate more helpful conversations around adverse events; and also supports the use of active monitoring strategies as part of PBS.

It is also important that evidence-based measures such as the Controllability Beliefs Scale (Dagnan, et al., 2004) or Challenging Behaviour Attributions Scale (Hastings, 1997) are used to accurately assess attributions when staff may be struggling, and to evaluate the outcomes of interventions.

Future Directions

The current review has shown that the evidence in this area is limited, fragmented, and generally relatively low quality. Future research should consider balancing ecological validity alongside the need for more high-quality research studies. For example, using quasi-experimental or longitudinal designs may help elucidate the relationships between key variables. It is evident that much more research is required in this area, particularly considering factors relating to staff psychological factors and organisational factors, as these factors may have good potential for intervention. It could also be helpful to design studies to elucidate the role of slow and fast thinking, and how this may affect attributions and responses. Furthermore, critical appraisal of the evidence base and modifying previous models as appropriate could help develop theory and research in this area. This could lead to developing a better understanding of staff responses to challenging behaviour and generate improved interventions

References

Agency for Healthcare Research Quality. Checklist for cross-sectional/prevalence studies. [online] Available at: https://guides.temple.edu/systematicreviews/criticalappraisal [Accessed 13th May 2020}.

Allen, D., McDonald, L., Dunn, C., & Doyle, T. (1997). Changing care staff approaches to the prevention and management of aggressive behaviour in a residential treatment unit for persons with mental retardation and challenging behaviour. *Research in Developmental Disabilities*, *18*(2), 101-112. Available from https://doi.org/10.1016/S0891-4222(96)00043-1

Bailey, B. A., Hare, D. J., Hatton, C., & Limb, K. (2006). The response to challenging behaviour by care staff: emotional responses, attributions of cause and observations of practice. *Journal of Intellectual Disability Research*, *50*(3), 199-211. Available from https://doi.org/10.1111/j.1365-2788.2005.00769.x

Banat, D., Summers, S., & Pring, T. (2002). An investigation into carers' perceptions of the verbal comprehension ability of adults with severe learning disabilities. *British Journal of Learning Disabilities*, *30*(2), 78-81. Available from https://doi.org/10.1046/j.1468-3156.2001.00148.x

Bowring, D. L., Painter, J., & Hastings, R. P. (2019). Prevalence of challenging behaviour in adults with intellectual disabilities, correlates, and association with mental health. *Current Developmental Disorders Reports*, *6*(4), 173-181. Available from https://doi.org/10.1007/s40474-019-00175-9

Bromley, J., & Emerson, E. (1995). Beliefs and emotional reactions of care staff working with people with challenging behaviour. *Journal of Intellectual Disability Research*, *39*(4), 341-352. Available from https://doi.org/10.1111/j.1365-2788.1995.tb00526.x

Carr, E G, Dunlap G, Horner, R H, Koegal, R L, Turnball, A P, Sailor, W et al. (2002). Positive behaviour support: evolution of an applied science. Journal of Positive Behaviour Interventions, 4, 1, 4–16. Available from https://doi.org/10.1177/109830070200400102

Critical Appraisal Skills Programme (2019). CASP (cohort studies) Checklist [online]. Available at: https://casp-uk.net/casp-tools-checklists/ [Accessed 13th May 2020].

Cooper, K., & McElwee, J. (2016). Network training for a boy with learning disabilities and behaviours that challenge. *British Journal of Learning Disabilities*, *44*(4), 337-344. Available from https://doi.org/10.1111/bld.12156

Dagnan, D. (2012). Carers' responses to challenging behaviour: a comparison of responses to named and unnamed vignettes. *Journal of Applied Research in Intellectual Disabilities*, *25*(1), 88-94. Available from https://doi.org/10.1111/j.1468-3148.2011.00649.x

Dagnan, D., & Cairns, M. (2005). Staff judgements of responsibility for the challenging behaviour of adults with intellectual disabilities. *Journal of Intellectual Disability Research*, *49*(1), 95-101. Available from https://doi.org/10.1111/j.1365-2788.2005.00665.x

Dagnan, D., Grant, F., & McDonnell, A. (2004). Understanding challenging behaviour in older people; the development of the controllability Beliefs Scale. *Behavioural and Cognitive Psychotherapy*, *32*(4), 501-506. Available from https://doi.org/10.1017/S1352465804001675

Dagnan, D., Trower, P., & Smith, R. (1998). Care staff responses to people with learning disabilities and challenging behaviour: a cognitive—emotional analysis. *British Journal of Clinical Psychology*, *37*(1), 59-68. Available from https://doi.org/10.1111/j.2044-8260.1998.tb01279.x

Division of Clinical Psychology Faculty for People with Intellectual Disabilities (2016). *Challenging behaviour: A unified approach. [online]. Available at* https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Challenging%20behaviour-%20a%20unified%20approach%20%28update%29.pdf. [Accessed 12th May 2020].

Dilworth, J. A., Phillips, N., & Rose, J. (2011). Factors relating to staff attributions of control over challenging behaviour. *Journal of Applied Research in Intellectual Disabilities*, *24*(1), 29-38. Available from https://doi.org/10.1111/j.1468-3148.2010.00570.x

Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. [online]. Available at: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry [Accessed 8th May 2020].

Hastings, R. P. (1997). Measuring staff perceptions of challenging behaviour: the Challenging Behaviour Attributions Scale (CHABA). *Journal of Intellectual Disability Research*, *41*(6), 495-501. Available from https://doi.org/10.1111/j.1365-2788.1997.tb00742.x

Hastings, R. P. (2005). Staff in special education settings and behaviour problems: Towards a framework for research and practice. *Educational Psychology. 25*(2-3), 207-221. Available from https://doi.org/10.1080/0144341042000301166

Hastings, R. P., & Brown, T. (2002). Behavioural knowledge, causal beliefs and self-efficacy as predictors of special educators' emotional reactions to challenging behaviours. *Journal of intellectual disability research*, *46*(2), 144-150. Available from https://doi.org/10.1046/j.1365-2788.2002.00378.x

Hastings, R. P., & Remington, B. (1994). Staff behaviour and its implications for people with learning disabilities and challenging behaviours'. *British Journal of Clinical Psychology*, *33*(4), 423-438. Available from https://doi.org/10.1111/j.2044-8260.1994.tb01140.x

Hastings, R. P., Allen, D., Baker, P., Gore, N. J., Hughes, J. C., McGill, P., et al. (2013). A conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities. *International Journal of Positive Behavioural Support*, *3*(2), 5-13.

Hill, C., & Dagnan, D. (2002). Helping, attributions, emotions and coping style in response to people with learning disabilities and challenging behaviour. *Journal of Learning Disabilities*, *6*(4), 363-372. Available from https://doi.org/10.1177/146900470200600403

Hooley, J. M. (1987). The nature and origins of expressed emotion. In K. Hahlweg & M. J. Goldstein (Eds.), *The Family Process Press monograph series. Understanding major mental disorder: The contribution of family interaction research* (p. 176–194). Family Process Press.

Ingham, B. (2011). Collaborative psychosocial case formulation development workshops: a case study with direct care staff. *Advances in Mental Health and Intellectual Disabilities*. Available from http://doi.org/10.5042/amhid.2011.0107

Iwata, B. A., Dorsey, M. F., Slifer, K. J., Bauman, K. E., & Richman, G. S. (1982). Toward a functional analysis of self-injury. *Analysis and intervention in developmental disabilities*, *2*(1), 3-20. Available from https://doi.org/10.1901/jaba.1994.27-197

Johnstone, L. (2013). Using formulation in teams. In *Formulation in Psychology and Psychotherapy* (pp. 236-262). Routledge.

Jones, C., & Hastings, R. P. (2003). Staff reactions to self-injurious behaviours in learning disability services: attributions, emotional responses and helping. *British Journal of Clinical Psychology*, *42*(2), 189-203. Available from https://doi.org/10.1348/014466503321903599

Kahneman, D. (2011). *Thinking, Fast And Slow*. New York: Random House Audio.

Keesler, J. M. (2014). A call for the integration of trauma-informed care among intellectual and developmental disability organizations. *Journal of Policy and Practice in Intellectual Disabilities*, *11*(1), 34-42. Available from https://doi.org/10.1111/jppi.12071

Kleinberg, I., & Scior, K. (2014). The impact of staff and service user gender on staff responses towards adults with intellectual disabilities who display aggressive behaviour. *Journal of intellectual disability research*, *58*(2), 110-124. Available from https://doi.org/10.1111/j.1365-2788.2012.01640.x

Lambrechts, G., Kuppens, S., & Maes, B. (2009). Staff variables associated with the challenging behaviour of clients with severe or profound intellectual disabilities. *Journal of Intellectual Disability Research*, *53*(7), 620-632. Available from https://doi.org/10.1111/j.1365-2788.2009.01162.x

MacKinlay, L., & Langdon, P. E. (2009). Staff attributions towards men with intellectual disability who have a history of sexual offending and challenging behaviour. *Journal of Intellectual Disability Research*, *53*(9), 807-815. Available from https://doi.org/10.1111/j.1365-2788.2009.01194.x

Mills, S., & Rose, J. (2011). The relationship between challenging behaviour, burnout and cognitive variables in staff working with people who have intellectual disabilities. *Journal of Intellectual Disability Research*, *55*(9), 844-857. Available from https://doi.org/10.1111/j.1365-2788.2011.01438.x

NICE (2015) Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NG11). [online]. Available at: https://www.nice.org.uk/guidance/ng11. [Accessed 12th May 2020].

Noone, S. J., Jones, R. S., & Hastings, R. P. (2006). Care staff attributions about challenging behaviors in adults with intellectual disabilities. *Research in Developmental Disabilities*, *27*(2), 109-120. Available from https://doi.org/10.1016/j.ridd.2004.11.014

Polenick, C. A., & Martire, L. M. (2013). Caregiver attributions for late-life depression and their associations with caregiver burden. *Family process*, *52*(4), 709-722. Available from https://doi.org/10.1111/famp.12032

Rose, D., & Rose, J. (2005). Staff in services for people with intellectual disabilities: the impact of stress on attributions of challenging behaviour. *Journal of Intellectual Disability Research*, *49*(11), 827-838. Available from https://doi.org/10.1111/j.1365-2788.2005.00758.x

Sher-Censor, E. (2015). Five Minute Speech Sample in developmental research: A review. *Developmental Review*, *36*, 127-155. Available from https://doi.org/10.1016/j.dr.2015.01.005

Snow, E., Langdon, P. E., & Reynolds, S. (2007). Care staff attributions toward self-injurious behaviour exhibited by adults with intellectual disabilities. *Journal of Intellectual Disabilities*, *11*(1), 47-63. Available from https://doi.org/10.1177/1744629507073998

Taylor, L., Oliver, C., & Murphy, G. (2011). The chronicity of self-injurious behaviour: a long-term follow-up of a total population study. *Journal of Applied Research in Intellectual Disabilities*, *24*(2), 105-117. https://doi.org/10.1111/j.1468-3148.2010.00579.x

Todd, S. J., & Watts, S. C. (2005). Staff responses to challenging behaviour shown by people with dementia: An application of an attributional-emotional model of helping behaviour. *Aging & Mental Health*, *9*(1), 71-81. Available from https://doi.org/10.1080/13607860412331310254

Truesdale, M., Brown, M., Taggart, L., Bradley, A., Paterson, D., Sirisena, C., et al. (2019). Trauma-informed care: A qualitative study exploring the views and experiences of professionals in specialist health services for adults with intellectual

disabilities. *Journal of Applied Research in Intellectual Disabilities*, *32*(6), 1437-1445. Available from https://doi.org/10.1111/jar.12634

Tynan, H., & Allen, D. (2002). The impact of service user cognitive level on carer attributions for aggressive behaviour. *Journal of Applied Research in Intellectual Disabilities*, *15*(3), 213-223. Available from https://doi.org/10.1046/j.1468-3148.2002.00120.x

Wanless, L. K., & Jahoda, A. (2002). Responses of staff towards people with mild to moderate intellectual disability who behave aggressively: A cognitive emotional analysis. *Journal of Intellectual Disability Research*, *46*(6), 507-516. Available from https://doi.org/10.1046/j.1365-2788.2002.00434.x

Weigel, L., Langdon, P. E., Collins, S., & O'Brien, Y. (2006). Challenging behaviour and learning disabilities: The relationship between expressed emotion and staff attributions. *British Journal of Clinical Psychology*, *45*(2), 205-216. Available from https://doi.org/10.1348/014466505X67510

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological review*, *92*(4), 548. DOI: 0033-295X/85/S00.75

Whitton, C., Small, M., Lyon, H., Barker, L., & Akiboh, M. (2016). The impact of case formulation meetings for teams. *Advances in Mental Health and Intellectual Disabilities*. Available from https://doi.org/10.1108/AMHID-09-2015-0044

Willner, P., & Smith, M. (2008). Attribution theory applied to helping behaviour towards people with intellectual disabilities who challenge. *Journal of Applied Research in Intellectual Disabilities*, *21*(2), 150-155. Available from https://doi.org/10.1111/j.1468-3148.2007.00390.x

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Figure 1. Hastings (2005) framework of staff, service user and service variables.

Records identified through database searching (n =371)

Records identified through other sources (n = 16)

Records after duplicates removed (n = 267)

Records screened (n =267)

Records excluded (n =213)

Not concerning attributions (n= 119)
Tool development (n=11)
Review articles (n=13)
Parents (n=10)
Teachers (n=8)
Children (n=18)
Qualitative (n=24)
Not peer-reviewed (n=7)
Not LD (n=3)

Full-text articles assessed for eligibility (n =54)

Full-text articles excluded (n =41)

Not internal/stable/global attributions (n=20)
Staff training (n=5)
Not peer-reviewed (n=4)
Teachers/other AHP(n=4)
Setting unspecified (n=3)
Non-LD population included (n=3)
Children included (n=2)

Records included in review (n =13)

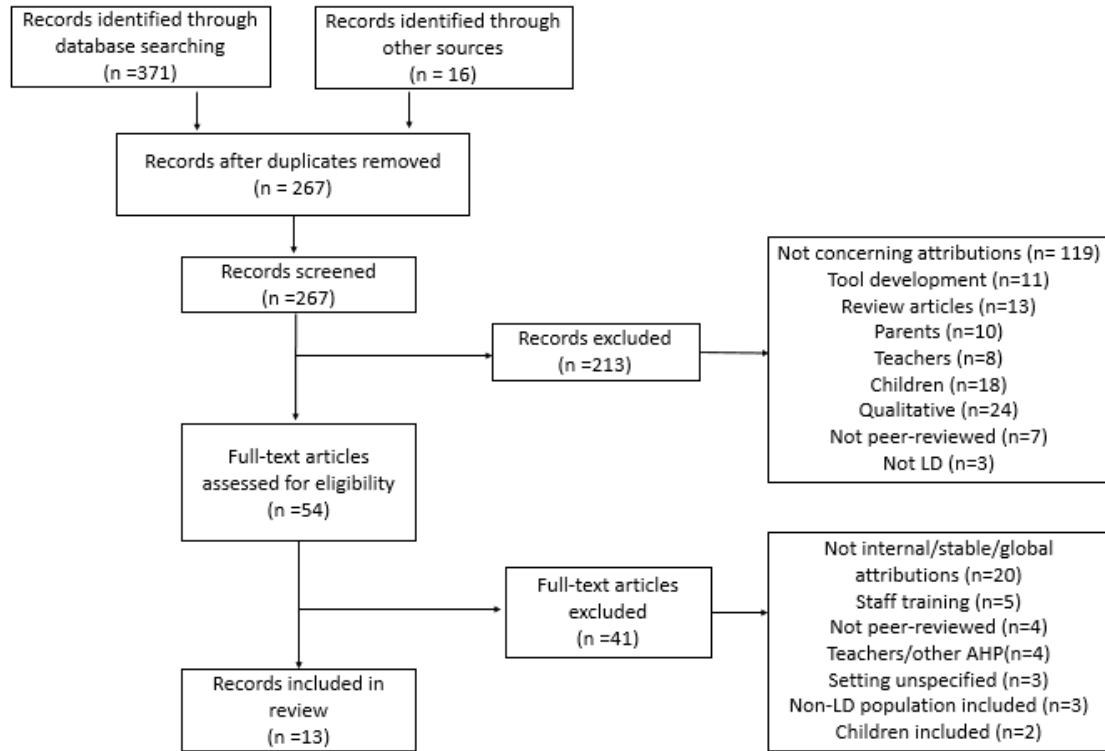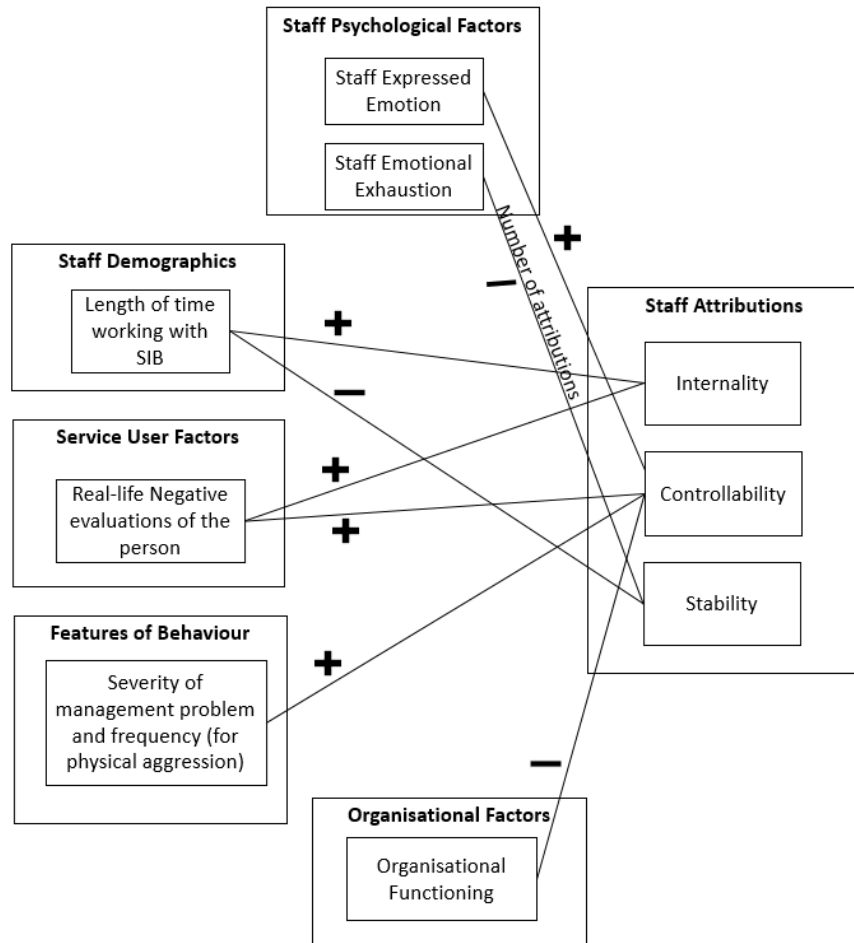*Figure 2.* Flow diagram showing selection process.

Figure 3. Representation of factors from higher quality studies and their relationships with different dimensions of attributions. Direction of relationship is shown with + (positive) or − (negative) symbols.

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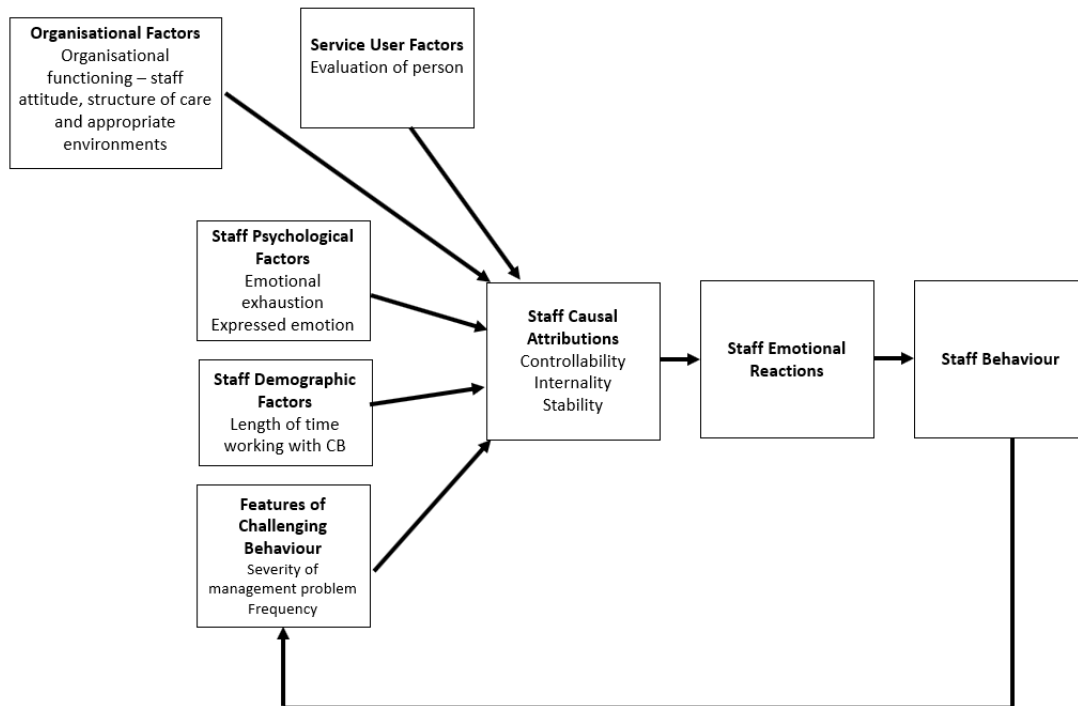*Figure 4*. Proposed framework by Dilworth et al., (2010).

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┌─────────────────────┐   ┌─────────────────────┐
│ Organisational Factors │   │ Service User Factors │
│   Organisational     │   │  Evaluation of person │
│ functioning – staff  │   └─────────────────────┘
│ attitude, structure of care │
│ and appropriate      │
│   environments       │
└─────────────────────┘

┌─────────────────────┐
│ Staff Psychological  │
│      Factors         │
│     Emotional        │
│    exhaustion        │        ┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│  Expressed emotion   │        │ Staff Causal │   │ Staff Emotional │  │ Staff Behaviour │
└─────────────────────┘        │ Attributions │ → │  Reactions    │ → │              │
                                │ Controllability │ │              │   │              │
┌─────────────────────┐        │  Internality │   └──────────────┘   └──────────────┘
│ Staff Demographic    │        │   Stability  │
│      Factors         │        └──────────────┘
│  Length of time      │
│  working with CB     │
└─────────────────────┘

┌─────────────────────┐
│   Features of        │
│   Challenging        │
│   Behaviour          │
│    Severity of       │
│ management problem   │
│    Frequency         │
└─────────────────────┘
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Figure 5. A suggested framework using findings from the current review to understand staff responses to challenging behaviour.

"I think it does just opens it up and… you're not hiding it anymore": Trainee Clinical Psychologists' experiences of self-disclosing Mental Health Difficulties

Running title: TRAINEE EXPERIENCES OF SELF-DISCLOSURE

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Abstract

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

Practitioner Message:

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

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

Introduction

It is estimated that in the last week, 1 in 6 adults will have experienced mental health difficulties. Half of such difficulties will have developed before the age of 14 (Office for National Statistics, 2016). Research shows that trainee clinical psychologists are as likely, if not more likely, to experience mental health difficulties than the general population (Brooks, Holtum & Lavender, 2002; Cushway, 1992; Stafford-Brown & Pakenham, 2012). Moreover, individuals with personal experiences of psychological distress may be more likely to be drawn to such career paths (Aina, 2015; Murphy & Halgin, 1995; Smith & Moss, 2009). Thus, not only are there trainees who have lived experience of mental health difficulties which may or may not recur while on training, there are also those who may experience the onset of mental health difficulties during training.

To pursue qualified status, clinical psychology trainees balance multiple demands during training, to develop competence in clinical, professional, academic and research domains (British Psychological Society; BPS, 2019). Studies have found training itself to be a source of stress. Cushway (1992) found trainee rates of distress to be higher in year two and three than year one, which may be due to additional research pressures in these years; and over the course of training, trainees experience increased depression and interpersonal difficulties (Kyuken, Peters, Power and Lavender, 2003). Particular stressors include academic pressure, work/life balance, research pressures and compassion fatigue (El-Ghoroury, Galper, Sawaqdeh & Bufka, 2012).

Trainees also hold a dual identity as postgraduate students and NHS employees and as such must also conform to the fitness to practice criteria set by their institution, the Health and Care Professionals Council (HCPC) and BPS codes of practice and ethics. Elevated stress can have a detrimental impact on a practitioner's well-being and professional functioning (Pakenham & Stafford-Brown, 2012). Thus, developing a greater understanding of stress and mental health within the clinical psychology workforce in training would arguably be beneficial not only for clinicians, but for client care and service quality.

Related but separate to the issue of managing the impact of clinician distress, there has also been increased recognition and valuing of lived experience in mental health professionals. There have recently been moves towards compassionate leadership and the importance of integrating lived experience into reflective practice and teaching (HCPC, 2017; In2Gr8MentalHealth, 2020; The Kings Fund, 2017). Some research suggests that having lived experience may help therapists feel more connected with clients, but conversely that they may at times find themselves over-identifying too (Aina, 2015). Despite this increased recognition, there have been few attempts to harness the resource that lived experience of psychological distress or mental health difficulties represents during training or to facilitate its application within the curriculum, research, or clinical work. Furthermore, guidance on how to support and value lived experience in clinical psychology training is as yet unpublished (Kemp, 2020).

Although health professionals may recognise the relevance of their lived experience to competence development, many experience a dilemma as to whether or not to disclose information about their personal experiences of distress, and if so, how much to disclose and to whom (Waugh, Lethem, Sherring & Henderson, 2017; Valley, 2018). Self-disclosure may be described as the process by which an individual reveals previously unknown information about themselves to another individual (Chaudoir & Fisher, 2010). Often, self-disclosure research has focused on verbal disclosures of hidden, stigmatized identities, including mental health difficulties (Follmer, Sabat & Siuta, 2019). A model which aims to explain the process of self-disclosure of stigmatized identities as a whole is the Disclosure Processes Model (DPM; Chaudoir & Fisher, 2010). The DPM (see Figure 1) posits that antecedent goals, which may be approach- or avoidant- focused (based on what the individual aims to gain or avoid from the disclosure) will impact the disclosure event. The content of the disclosure and response of the receiver will in turn have mediating effects (such as changing social support, alleviating inhibition or change perceptions of those involved) which then impact long-term outcomes at individual, dyadic and social levels. Furthermore, the DPM also posits that outcomes will impact future antecedent goals, and the likelihood of future disclosures.

The DPM provides a framework that is hypothesised be a universal process of disclosure for a range of stigmatized identities and contexts. However, it is acknowledged that some factors require further consideration. For example, type of identity may influence the process due to differential social stigma and devaluation (Chaudoir & Fischer, 2010). Secondly, the DPM does not account for contextual factors that may facilitate or inhibit disclosures. Thirdly, confidant characteristics are not considered beyond antecedent goals. Finally, the DPM does not appear to consider how one's professional identity and values may influence disclosure. Therefore, it is important to develop an understanding of disclosure processes in specific contexts so that such individual, relational, and contextual factors may be better understood.

Considering mental health in the workplace, a review by Brohan et al., (2012) found that type of mental health problem has been associated with disclosure; as well as severity and management of symptoms at work; and the level of anticipated stigma. The level of trust with the receiver of the disclosure has also been found to be important (Grice, 2017). Thus, it is evident that many factors potentially mediate, and impact the likelihood of, disclosure in the workplace. For mental health professionals in particular, research shows fear of stigma and discrimination is a barrier to disclosing information about lived experience, including fears of confidentiality and career progression being affected negatively (Adame, 2011; Garelick, 2012; Winter, 2017). However, workplace disclosure may also have advantages such as improved relationships, being able to be more authentically oneself, and being able to gain support (Brouwers, Joosen, van Zelst & Van Weeghel, 2020). Furthermore, in professional training programmes, self-disclosure during teaching and clinical supervision may be beneficial for client care and student development, facilitating reflection on the process of clinical practice (Staples-Bradley, Duda & Gettens, 2019; Szczygiel, 2019).

In clinical psychology, research has found 62.7% of psychologists have experience of mental health problems (Tay, Alcock & Scior, 2018). Furthermore, the main reasons for non-disclosure were concerns of negative judgement, having a negative impact on career and

self-image, and feelings of shame. In partial support of this, research has found that 67% of trainee clinical psychologists reported past or current experience of mental health difficulties (Grice, et al., 2018). Stigma was a concern, but findings suggested that trainees may weigh disclosure based on perceived value and need. Recently, the Honest, Open, Proud for Mental Health Professionals (HOP-MHP) self-help intervention has been developed to support professionals around reaching decisions to disclose (Scior, 2019). Findings suggest the intervention reduced distress about 'being found out' by colleagues and increasing likelihood of disclosures of past difficulties. However, there was little change to likelihood of disclosure of current difficulties (Mills, 2018). To the author's knowledge, no published research has explored experiences of disclosure during clinical psychology training, and the factors that impact or mediate the disclosure cycle.

Aims and Rationale

It is evident that disclosure in the workplace is a complex process, not least for those working in mental health contexts. In clinical psychology, there are still considerable barriers to self-disclosure and help-seeking for personal experiences of distress, despite the profession valuing lived experience in others (BPS, 2010). As both a student under appraisal and an NHS employee in training, experiences of disclosure may differ greatly to disclosures made as a qualified clinical psychologist. However, for both trainee and qualified clinical psychologists, the potential impact of non-disclosure when needed could be hugely detrimental, including reducing quality of client care, and increasing risk of practitioner burnout, substance misuse, and suicide (Pakenham & Stafford-Brown, 2012). Conversely, considering the Job Demands-Resource Model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) disclosure may mitigate unnecessary stressors in a workforce already subject to significant stress. Additionally, self-disclosure may improve management of any associated risk; improve service provision; reduce sickness rates; allow for workplace adaptations; and facilitate reflective practice, improving sustainability of one's career and the profession more widely. The current study thus aimed to investigate the process of self-disclosure of lived experience of mental health difficulties of trainees. In particular, the aim was to explore how and why disclosures of this nature occur during training.

Methods

Participants

Twelve trainee clinical psychologists were recruited from accredited Doctoral Programmes in Clinical Psychology throughout the UK. Recruitment rate was calculated to be approximately 1%. Participants were recruited and interviewed consecutively.

Inclusion and Exclusion Criteria

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

Measures

Demographic Information

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

Interview Schedule

An interview schedule (see Appendix G) informed by the literature on self-disclosure of hidden identities was designed to elicit responses regarding how and why the disclosure took place and identify factors which mediated the disclosure. The DPM (Chadoir & Fischer, 2010) informed the flow of questions to some extent in order to capture all parts of the process.

Well-being

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

Design

The current study utilised a qualitative research design. A series of semi-structured interviews were conducted via Skype. Interviews were conducted until no new themes appeared to emerge, indicating theoretical saturation. The interview schedule was designed to elicit perceptions of disclosing mental health difficulties to peers, supervisors, and tutors while on training, including how and why such disclosures arose and how they were managed. Interviews were recorded, transcribed, and analysed by the author. A grounded theory method (Charmaz, 2000; 2006) was used to develop a theory about how trainees approach and manage disclosures and of those factors which might precipitate or inhibit disclosure of lived experience to psychology colleagues during training.

Procedure

Pilot

To refine the procedure and materials a qualified clinical psychologist with experience of disclosing mental health difficulties to colleagues during training gave feedback on the consent form (see Appendix I), participant information sheet (see Appendix J), poster advert (see Appendix K). The interview schedule was also piloted with the same individual, without recording, and minor amendments to question delivery and content were made based on feedback.

Recruitment

A recruitment email (which included ethics approval information, see Appendix L) was sent to courses where willingness to disseminate the project to trainee had been negotiated. The email contained a poster advert which prompted interested individuals to email the researcher directly for more information. Social media was also utilised to disseminate the poster advert. Those who enquired about the project were sent an email with further information, including the participant information sheet and consent form. Once individuals completed the consent form and sent it back, a time suitable for interview was scheduled.

Interviews

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

Ethical Issues

Ethical approval was granted by Cardiff University School of Psychology Ethics Committee (EC.19.11.12.5888R2A) for use of the method and procedure described above. In compliance with Ethics Committee criteria, confidentiality was ensured by storing participant identifiable information separately to raw data. All electronic data was stored securely using password protection, and hard copies of data were kept in locked storage. Identifiable information was omitted from audio recordings at the point of transcription, and gender-neutral pseudonyms were allocated to participant interviews.

Data Analysis

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

Quality and Rigour

Quality was considered and sought through adherence to guidance by Yardley (2000), which outlines principles pertaining to 1) sensitivity to context, 2) commitment and rigour, 3) transparency and coherence, and 4) impact and importance. Thus, the researcher engaged in methods that would facilitate these. Reflexive bracketing was used through discussion with other researchers and a reflective journal (Ahern, 1999; see example Appendix N) to consider personal, socio-cultural, and research contexts (El Hussein, et al., 2017). A personal position statement was created for consideration of sensitivity to context and transparency (see Appendix O). The process of analysis was documented, including use of memo writing and excerpts (see Appendix P), and direct quotations are provided to demonstrate

transparency and evidence themes (Street, et al., 2016). The researcher fully engaged in the data through interview, transcription, and analysis processes, exhibiting commitment. A way to situate the sample was used, and theoretical saturation was felt to have been achieved, both of which help demonstrate rigour. Grounded theory was chosen as the methodology as it was felt to fit well with the questions posed in the current study, thus exhibiting coherence. Concerning importance and impact, anecdotally several participants commented on the importance of the current study but mainly, this will be determined by the contribution to the research in self-disclosure, and the usefulness to clinical psychology as a profession.

Results

Demographic Information

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

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

Participants demonstrated awareness of support systems available for trainees on their programmes, including peer-led support groups; reflective practice groups; personal tutors; the course team and reps; mentors or independent tutors; a buddy system; personal therapy provision or network; personal and professional development provision; university services; and NHS employee support.

Results from the SWEMWBS showed that participants' well-being was comparable to that of the general population. No participants exceeded the cut-off for probable depression and anxiety (Shah, et al, in press). One participant fell within the cut-off for possible depression and anxiety but considering their personal context and presentation at the time of interview, it was felt this provided no cause for exclusion.

Theoretical Model of Trainee Self-Disclosure

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

Motivations

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

Feeling the struggle and needing support

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

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

Being understood

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

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

Professional values and duty

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

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

Influencing narratives

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

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

Enablers

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

Trusting relationships

Trainees reported finding it easier to disclose when they perceived they had a good relationship with receivers of the disclosure. For example, participants talked about trusting the receiver of the disclosure to respond in a helpful way and be empathetic and containing.

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

Feeling safe

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

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

Having an 'in-road'

Trainees felt more able to disclose because of the disclosure having some relevance to the conversation. For example, the conversation around mental health was made easier because something else, like academic work or clinical work, could invite discussion of more difficult feelings.

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

Barriers

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

Worrying about the impact on training

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

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

Voicing the unspoken

Lived experience was perceived to be a topic not often raised or voiced in training, and in psychology more generally. Trainees felt that because others did not speak about lived

experience, they had little understanding of how to talk about it, and whether talking about it was 'acceptable'.

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

Internalising stigma

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

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

Features of Disclosure

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

Being selective

Although the content and manner of disclosures varied, there were some commonalities in the judgements trainees made. For example, trainees spoke about having disclosed to people they trusted and disclosing gradually, with smaller disclosures over time. Some trainees also spoke about people they disclosed to still 'not knowing the full story'. Some trainees also spoke of giving a general overview about their lived experience, keeping things

'surface-level' or asking themselves what the person 'needed to know' rather than going into more depth with disclosures.

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

'Spilling out' vs 'controlled disclosures'

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

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

'Testing the waters'

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

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

Responses

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

Listening vs 'jumping to fix'

Many trainees spoke of positive experiences where they had felt the responder had taken time to listen and had been open and accepting to the idea of not needing to do anything to 'fix' it (for example, in the case of trainees disclosing who were not looking for further support). Some trainees however reported feeling the responder was invalidating or appeared to 'jump' to questions about risk or solutions.

Drew: *They gave me time to talk about it and I suppose to think about it, again without coming up with solutions. But they did also, once I'd had that opportunity to express what was going on, to talk about oh what happens next? Like, what can we do to practically support you? But that was always the uh second part if that makes sense, rather than leaping into, let's sort the problem.*

Exploring vs lack of curiosity

This category linked to the preceding 'listening' category and reflected trainees experiences of responders taking time to explore the disclosure and potential support with curiosity, versus experiences where responders lacked curiosity. Trainees appeared to appreciate when responders asked questions about experiences and explored what trainees felt would be the most helpful response. In comparison, some trainees talked about some experiences where responders had seemed to lack curiosity, possibly due to being unsure how to respond to a disclosure from a peer or colleague.

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

Impact

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

Making it 'easier' to be open

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

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

Growing connections

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

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

Integrating different parts of self

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

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

'Finding the right support'

Disclosure functioned as a pathway for some trainees to support when needed. Trainees spoke about a variety of practical and emotional supports offered, from extensions for assignments, adaptations to work through occupational health, accessing personal therapy, to colleagues 'checking up' on them a little more than before. Trainees appeared to have individualised views on what kind of support was helpful or not as helpful, and recommended others in similar positions found the 'right support' for them.

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

Clarifying positions

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

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

Core categories and subcategories were organised into a model to explain the process of self-disclosure of mental health difficulties by trainees (Figure 2).

Discussion

Main Findings and Relationship to Past Research

The current study aimed to explore the process of self-disclosure of mental health difficulties, with particular interest in how and why such disclosures occur during clinical psychology training. When compared against demographic data (Leeds Clearing House, 2018), the sample of trainees recruited (N=12; mean age = 30.09 years, SD = 3.47; 75% female, 25% male) was representative with some features improving participant group homogeneity (more second and third year trainees; more from Clinical Psychology programmes with higher numbers of trainees). It is difficult to speculate why fewer first year trainee participants were recruited. It might have been that they had fewer opportunities to disclose, due to less time to build trusting relationships, and less exposure to other's disclosures, so felt less able to discuss the process. Furthermore, first year trainees may be more worried about appearing competent, being new in the course system. Indeed, this is

supported by research concerning self-disclosure during clinical supervision (Hess, et al., 2008). Further research could consider when trainees are more or less likely to disclose lived experience during training and whether reasons for disclosure change over time.

The range of mental health difficulties described by participants was consistent with previous research showing qualified clinical psychologists reported experiencing a range of mental health difficulties (Tay, et al., 2018). Participants in this study additionally reported experiences of complex trauma, PTSD, Adverse Childhood Experiences (ACEs), emotion regulation difficulties, and historical difficulties of self-harm and suicidal ideation. This may be because participants were asked to describe their lived experiences in their own words rather than using pre-set diagnostic labels. Trainees with experiences of psychosis, eating disorders or substance misuse were not represented, perhaps due to perceived stigma or worries about fitness to practice being questioned. Indeed, some research suggests that such mental health difficulties may be viewed as more stigmatized and thus health professionals may be less likely to disclose these (Brohan, 2012; Grice, 2017). The majority of participants also reported their difficulties beginning in childhood or adolescence and reported experience of more than one type of difficulty. This supports previous research which found about half of qualified clinical psychologists have experienced more than one type of mental health difficulty during their life (Tay, et al., 2018).

Trainees in this study described the current nature of their lived experience in a variety of ways, such as recovered, ongoing, managed, or cyclical. Results from the SWEMWBS showed that participants' well-being was comparable to that of the general population which suggests that none were experiencing significant active difficulties with mental health at the time of interview, despite the inherent demands of training and the start of the COVID-19 outbreak. Although the exclusion criteria used for this study excluded individuals with significant active mental health difficulties such as current self-harm or suicidal ideation, this finding is somewhat inconsistent with previous literature suggesting high levels of psychological distress in trainees (Cushway, 1992; Stafford-Brown & Pakenham, 2012). This could be explained by the use of a general well-being measure rather than

diagnosis-oriented self-report measures used in other research, and may also suggest trainees have the resources to manage their well-being, perhaps even more so for those who have lived experience of mental health difficulties. However, this may also be due to a self-selecting bias, whereby trainees who felt more distressed at the time of recruitment may have chosen not to take part or decided that they did not meet inclusion criteria.

Model of Self-Disclosure of Mental Health difficulties in Trainees

The model created from the data suggests there are many aspects to self-disclosure in a trainee population. Several factors emerged which related to why trainees suggested they had been motivated to disclose, and the enablers and barriers that facilitated or hindered disclosure. It appeared that these factors interact and contribute to whether a disclosure takes place. The model incorporates the disclosure event, including features of disclosure (the content and methods used) and responses received. These factors appear to influence one another in a feedback loop that further guides disclosure content and methods. Finally, the model describes the impacts that disclosure can have on trainees individually and relationally. The model posited in this study is acknowledged to bear similarity to the DPM (Chadoir & Fisher, 2010) in the respect that it includes goals or motivations, disclosure event and response features, mediating processes, and outcomes or impacts. Some categories included are also comparable, such as motivations to be 'fully understood' in the context of one's personal history, or to educate others; content and depth of disclosure; and alleviation of inhibition (or 'testing the waters'). The impact of disclosure for trainees also seems to be comparable to those outlined by the DPM, including changing likelihood of disclosure, feelings about self and changes to relationships. However, there are some important differences also. Firstly, the trainee model describes factors specific to the trainee context, such as fear of having to stop training, and feelings that lived experience is not voiced in training. It also includes trainee-specific differences between motivations (which appear comparable to antecedent goals) and things that enable and are barriers to disclosure, which are not captured by the DPM. In the DPM, goals are also approach or avoidance oriented, however in the current study this was not seen to be a necessary distinction to make for trainees, possibly because this study looked only at individual who had disclosed rather than including individuals who have not yet done so (or who may be

guided more by avoidance-coping). Overall, it appears that findings regarding trainee disclosure fit largely with wider literature about disclosure of hidden or stigmatised identities (Follmer, et al., 2019).

The trainee disclosure model also appears to support other previous research in self-disclosure, and trainee and qualified clinical psychologist mental health. For example, it has been shown that trusting relationships make disclosure in the workplace easier (Grice, 2017). Fear of stigma was also found to be a barrier for trainees, and this is supportive of previous research in clinical psychology and other healthcare professionals (Grice, 2018; Tay, Alcock & Scior, 2018; Waugh et al., 2017). Worries concerning the impact on training, including fitness to practice was also a significant barrier to disclosure, and this has also been found for trainee doctors (Aaronson et al., 2018; Winter, 2017). However, unlike trainee doctors, issues such as lack of time; concerns of confidentiality; presenteeism; inter-student competition; and investment from self and family were not found to be themes, perhaps due to different cultures of psychology and medicine. Similar to findings from other health care professions, the model of trainee disclosure also highlights the lack of discussion of lived experience on training as a significant barrier to self-disclosure (Waugh, et al., 2017). It is hoped that as research in this area and discourses in clinical psychology training continue to evolve, this will become less of a barrier.

Findings about the methods and content of disclosure by trainees, preparing the disclosure and being selective about who to disclose to and what to disclose, lends support to previous research in the workplace (Brouwers, et al., 2020). Moreover, some of the outcomes found in the current study are also consistent with previous research which has found potential advantages to disclosure such as improving relationships; being able to be more authentic; and gaining support (Brouwers et al., 2020). Finally, the current study found several trainee motivations for disclosure, which partially support previous findings. For example, Waugh, et al., (2017) found health professionals felt that individuals may be more understanding if they know about the difficulty, which appears similar to the motivation for trainees to be better understood.

Strengths and Limitations

The current study has several strengths and limitations to consider. Firstly, this study is one of the first to explore trainee experiences of self-disclosure during training. Previous unpublished work (Willets, 2018) focused only on the decision of whether or not to disclose rather than the process as a whole. In the current study a rigorous recruitment methodology ensured a homogenous sample of individuals who had experience of disclosure. Thus, in providing a partial replication and extension to Willets (2018) and in addressing lived experience of mental health difficulties it adds to the evidence base concerning disclosure in mental health professions and workplaces. Secondly, the use of grounded theory methodology in this study means that the findings provide a framework of how trainee disclosures of mental health difficulties occur and how they are managed, thus it improves awareness of factors that may be particularly relevant for trainees and potential receivers of disclosures. Thirdly, as no new patterns appeared to emerge it can be argued that theoretical saturation was reached, and thus the validity and quality of the data gathered is arguably high.

Considering limitations of the current study, interviews relied on participant self-report and recollections of disclosure experiences and thus are subject to bias and error (Jobe and Mingay, 1991). Thus, findings must be considered with this in mind. Participants also were voluntary and self-selecting and thus it can be suggested that those who took part may have had particular interest and motivations for participating. It is notable that participants shared a variety of experiences from differing situations and had used disclosure for different reasons, however, the findings of this study should still be considered within this context. It is also recognised that use of Skype interview may have limited richness of data to some extent (Seitz, 2016), although participants reported feeling comfortable with this medium. Also, although the methodology used provides a useful way to explore data and build a model to explain the process of self-disclosure, it provides a limited understanding of how the variables interact. Further research is needed to test the model and the directions of relationships between these factors. Furthermore, it is recognised that due to the

subjective and constructivist nature of grounded theory methodology, other models may be applied to the process of disclosure (Willets, 2018).

Implications

The current study has important implications for both clinical psychology training programmes and clinical practice. Firstly, it is clear that disclosure conversations do happen within the context of training and these conversations are relational in nature. This study provides a framework for trainees, supervisors and training programmes to consider when approaching conversations around self-disclosure. Trainees with lived experience of mental health difficulties could use information from this model to scaffold their own position on disclosing, and when and where it would feel helpful and safe to do so, including considering fitness to practice (Grice, 2017). Training programmes and supervisors also play a vital role (Valley, 2019) and should consider engineering spaces designed for trainees to reflect on lived experiences safely, with exposure to different individuals they may trust. This could include protected clinical supervision, reflective practice, personal therapy, and peer-led groups. Such self-disclosures during training could also help address implicit biases that professionals may hold, and their impact on practice (Sukhera & Watling, 2018).

This model also suggests that trainees may feel that lived experience is not discussed openly on course programmes, which acts as a barrier to disclosure, as in other workplaces (Waugh et al., 2017). Thus, programmes should consider making lived experience conversations part of the curriculum, for individuals to participate in or not as they wish. Also, worries around questions of fitness to practice may be a barrier, particularly considering the HCPC as an external non-psychological organisation regulates such decisions for clinical psychology. Programmes could improve transparency of such processes around gaining practical support to help trainees understand the process better and feel less worried about potential consequences (Winter, 2017). Furthermore, this model could help training programmes reduce sources of stress for trainees. For example, when viewed alongside the Job Demands-Resource model (Demerouti, et al., 2001), a better understanding of self-

disclosure could help address things such as management support; trainee feelings of control; and psychological demands; thus, making training more protective and sustainable.

Importantly, this model shows that trainees disclose for a variety of reasons and suggests helpful ways to respond for anyone receiving disclosures, including exploring the trainee's perspective. The author recognises that there may be times when such disclosures do need to be considered for fitness to practice, however, exploring the reason for disclosure and impact on the trainee and their work may facilitate better risk assessment than 'jumping' to problem-solving. Routinely applied responses in clinical practice may not always translate to professional and workplace situations. Overall, this model suggests that the process of disclosure and supportive responses can have positive impacts for individuals and the workplace (Brouwers, et al., 2019), including being able to create more meaningful working relationships and gain appropriate support where needed. Furthermore, it appears that disclosure improves integration of personal and professional identities. This could be significant for competence development, as it may reduce unhelpful rumination and improve one's sense of coherence (Marin & Rotondo, 2017), facilitating reflection and learning (Szczygiel, 2019). Thus, future research could investigate the potential relationships between these factors.

Future Research

The current study explored trainee experiences of self-disclosure of mental health difficulties during training and identified factors that interact in the decision-making process. Future research could examine exactly how motivations, barriers and enablers interact together to help develop a better understanding of this decision-making process. Research could also explore the experiences of receivers of disclosure to better understand the factors that drive responses and the impact that hearing disclosures may have on the receiver. The current study examined experiences of self-disclosure, but future research could consider non-disclosure and its potential impact for trainees, and also explore self-disclosure for qualified clinical psychologists and course trainers, for whom different factors may exert influence. Finally, this study suggests that mental health difficulties, including

trauma and ACE's, may be relevant in the development of personal and professional identities. Thus, quantitative research could investigate relationships between these factors to better understand the role of mental health and trauma in identity development and professional practice.

References

Aaronson, A. L., Backes, K., Agarwal, G., Goldstein, J. L., & Anzia, J. (2018). Mental health during residency training: assessing the barriers to seeking care. *Academic Psychiatry*, *42*(4), 469-472. https://doi.org/10.1007/s40596-017-0881-3

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative health research*, *9*(3), 407-411. https://doi.org/10.1177/104973239900900309

Adame, A. L. (2011). Negotiating discourses: The dialectical identities of survivor-therapists. *The Humanistic Psychologist*, *39*(4), 324-337. https://doi.org/10.1080/08873267.2011.618038

Aina, O. (2015). *Clinical psychologists' personal experiences of psychological distress.* (Unpublished thesis). University of East London, London. Retrieved 13th May 2020 from https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.667986

British Psychological Society (2010). *Good practice guidelines to support the involvement of service users and carers in clinical psychology services*. Retrieved 6th May 2020 from https://consaludmental.org/publicaciones/Goodpracticeinvolvementserviceuserscarersclinicalpsychologyservices.pdf

British Psychological Society (2019). *Standards for the accreditation of Doctoral programmes in clinical psychology*. Retrieved 6th May 2020 from https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., ... & Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC psychiatry*, *12*(1), 11. https://doi.org/10.1186/1471-244X-12-11

Brooks, J., Holtum, S., & Lavender, A. (2002). Personality style, psychological adaptation and expectations of trainee clinical psychologists. Clinical Psychology and Psychotherapy, 9, 253–270. https://doi.org/10.1002/cpp.318

Brouwers, E. P. M., Joosen, M. C. W., van Zelst, C., & Van Weeghel, J. (2020). To disclose or not to disclose: A multi-stakeholder focus group study on mental health issues in the work environment. *Journal of Occupational Rehabilitation*, *30*(1), 84-92. https://doi.org/10.1007/s10926-019-09848-z

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In NK Denzin, YS Lincoln (Eds*.), Handbook of Qualitative Research* (pp. 509-535). Thousand Oaks, CA: Sage Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological bulletin*, *136*(2), 236. https://doi.org/10.1037/a0018193

Cushway, D. (1992). Stress in clinical psychology trainees. *British journal of clinical psychology*, *31*(2), 169-179. https://doi.org/10.1111/j.2044-8260.1992.tb00981.x

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied psychology*, *86*(3), 499. https://doi.org/10.1037//0021-9010.86.3.499

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6*(2), 122. https://doi.org/10.1037/a0028768

El Hussein, M. T., Kennedy, A., & Oliver, B. (2017). Grounded theory and the conundrum of literature review: Framework for novice researchers. *The Qualitative Report*, *22*(4), 1199.

Fat, L. N., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh mental well-being scale (SWEMWBS): findings from the health survey for England. *Quality of Life Research*, *26*(5), 1129-1144. https://doi.org/10.1007/s11136-016-1454-8

Follmer, K. B., Sabat, I. E., & Siuta, R. L. (2019). Disclosure of stigmatized identities at work:
An interdisciplinary review and agenda for future research. *Journal of Organizational
Behavior*, *41*(2), 169-184. https://doi.org/10.1002/job.2402

Garelick, A. I. (2012). Doctors' health: stigma and the professional discomfort in seeking
help. *The Psychiatrist*, *36*(3), 81-84. https://doi.org/10.1192/pb.bp.111.037903

Grice, T., Alcock, K., & Scior, K. (2018). Mental health disclosure amongst clinical
psychologists in training: Perfectionism and pragmatism. *Clinical psychology &
psychotherapy*, *25*(5), 721-729. https://doi.org/10.1002/cpp.2192

Health and Care Professions Council (2017). Standards of education and training guidance.
Retrieved 10th May 2020 from https://www.hcpc-
uk.org/globalassets/resources/guidance/standards-of-education-and-training-
guidance.pdf

Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., ... & Hoffman, M. A. (2008).
Predoctoral interns' nondisclosure in supervision. Psychotherapy Research, 18(4),
400-411.https://doi.org/10.1080/10503300701697505

In2Gr8MentalHealth (2020). Retrieved 6th May 2020 from
https://www.in2gr8mentalhealth.com

Jobe, J. B., & Mingay, D. J. (1991). Cognition and survey measurement: History and
overview. *Applied Cognitive Psychology*, *5*(3), 175-192.
https://doi.org/10.1002/acp.2350050303

Kemp, N. (12th February, 2020). Supporting and valuing lived experience of mental health
difficulties in clinical psychology training [blog post]. Retrieved from
https://www.in2gr8mentalhealth.com/post/guide-supporting-valuing-lived-
experience-in-training

Kuyken, W., Peters, E., Power, M. J., & Lavender, T. (2003). Trainee clinical psychologists'
adaptation and professional functioning: A longitudinal study. *Clinical Psychology &
Psychotherapy: An International Journal of Theory & Practice*, *10*(1), 41-54.
https://doi.org/10.1002/cpp.350

Leeds Clearing House (2018). *Equal Opportunities Data for 2018 Entry.* Retrieved 6th May 2020 from https://www.leeds.ac.uk/chpccp/equalopps2018.pdf

Marin, K. A., & Rotondo, E. K. (2017). Rumination and self-reflection in stress narratives and relations to psychological functioning. *Memory*, *25*(1), 44-56. https://doi.org/10.1080/09658211.2015.1124122

Mills, H. (2018). *The feasibility of a new self-help intervention supporting mental health professionals with lived experience in reaching disclosure decisions* (Unpublished thesis). University College London, London. Retrieved 13th May 2020 from https://discovery.ucl.ac.uk/id/eprint/10060013/1/Thesis_final_volume1_Mills.pdf

Murphy, R. A., & Halgin, R. P. (1995). Influences on the career choice of psychotherapists. *Professional Psychology: Research and Practice*, *26*(4), 422. https://doi.org/10.1037/0735-7028.26.4.422

NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 11, 2015.

Office for National Statistics (2016). *Fundamental facts about mental health.* Retrieved 6th May 2020 from https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: Current research status and future directions. *Australian Psychologist*, *47*(3), 147-155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Scior, K., Rüsch, N., White, C., & Corrigan, P. W. (2019). Supporting mental health disclosure decisions: the Honest, Open, Proud programme. *The British Journal of Psychiatry*, 1-3. https://doi.org/10.1192/bjp.2019.256

Seitz, S. (2016). Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: A research note. *Qualitative Research*, *16*(2), 229-235. https://doi.org/10.1177/1468794115577011

Shah, N., Cader, M., Andrews, W.P., Stewart-Brown, S. L. (In press). Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS): performance in a clinical sample in relation to PHQ-9 and GAD-7.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice*, *16*(1), 1-15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

Stafford-Brown, J., & Pakenham, K. I. (2012). The effectiveness of an ACT informed intervention for managing stress and improving therapist qualities in clinical psychology trainees. *Journal of clinical psychology*, *68*(6), 592-513. https://doi.org/10.1002/jclp.21844

Staples-Bradley, L. K., Duda, B., & Gettens, K. (2019). Student self-disclosure in clinical supervision. *Training and Education in Professional Psychology*, *13*(3), 216. https://doi.org/10.1037/tep0000242

Street, R., Mercer, J., Mills-Bennett, R., O'Leary, C., & Thirlaway, K. (2016). Experiences of physical activity: A phenomenological study of individuals with cystic fibrosis. *Journal of health psychology*, *21*(2), 261-270. https://doi.org/10.1177/1359105314527141

Sukhera, J., & Watling, C. (2018). A framework for integrating implicit bias recognition into health professions education. *Academic Medicine*, *93*(1), 35-40. https://doi.org/10.1097/ACM.0000000000001819

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of clinical psychology*, *74*(9), 1545-1555. https://doi.org/10.1002/jclp.22614

The King's Fund (2017). *Caring to change: How compassionate leadership can stimulate innovation in health care*. Retrieved 10th May 2020 from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Vaingankar, J. A., Abdin, E., Chong, S. A., Sambasivam, R., Seow, E., Jeyagurunathan, A., ... & Subramaniam, M. (2017). Psychometric properties of the short Warwick Edinburgh mental well-being scale (SWEMWBS) in service users with schizophrenia, depression and anxiety spectrum disorders. *Health and quality of life outcomes*, *15*(1), 153. https://doi.org/10.1186/s12955-017-0728-3

Vally, Z., 2018. Mental health stigma continues to impede help-seeking and self-care efforts among trainees in mental health professions. *Perspectives in Psychiatric Care*, 55(2), pp.161-162. https://doi.org/10.1111/ppc.12294

Waugh, W., Lethem, C., Sherring, S., & Henderson, C. (2017). Exploring experiences of and attitudes towards mental illness and disclosure amongst health care professionals: a qualitative study. *Journal of mental health*, *26*(5), 457-463. https://doi.org/10.1080/09638237.2017.1322184

Willets, L. (2018). *Exploring the Impact of Personal Therapy and Factors that Affect Disclosure of Mental Health Difficulties in Applied Psychology Trainees.* (Unpublished thesis). University of Liverpool, Liverpool.

Winter, P., Rix, A., & Grant, A. (2017). Medical student beliefs about disclosure of mental health issues: a qualitative study. *Journal of veterinary medical education*, *44*(1), 147-156. https://doi.org/10.3138/jvme.0615-097R

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, *15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Table 1.

Demographic Information for Participants.

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

Table 2.

Core categories and subcategories arising from the data.

Core Category	Sub-categories
Motivations *Describes trainee motivations for self-disclosure. Motivations, enablers and barriers appeared to all contribute to the occurrence of the disclosure event together.*	'Feeling the struggle' and needing support
	Being 'understood'
	Professional values and duty
	Influencing narratives
Enablers *Describes factors that facilitated self-disclosure, alongside motivations and barriers.*	Trusting relationships
	Feeling 'safe'
	Being relevant to the conversation
Barriers *Describes factors that inhibited self-disclosure, alongside enablers and motivation.*	Worrying about the impact on self and training
	Not voicing lived experience
	Internalising stigma
Features of Disclosure *Describes features (content and methods) of how trainees self-disclosed. Features of disclosure appeared to be in a reciprocal relationship with responses, so that individuals may alter content and methods depending on response received.*	Being selective
	'Spilling out' vs 'controlled disclosures'
	'Testing the waters'
Responses *Describes responses of receivers during self-disclosure experience.*	Listening vs jumping to fix
	Exploring vs lack of curiosity
Impact *Describes perceived individual, relational and social impacts of self-disclosure. These impacts appeared to exert influence back on motivations, enablers and barriers, influencing future likelihood of disclosures.*	Making it 'easier' to be open
	Growing connections
	Integrating different parts of self
	'Finding the right support'
	Clarifying positions

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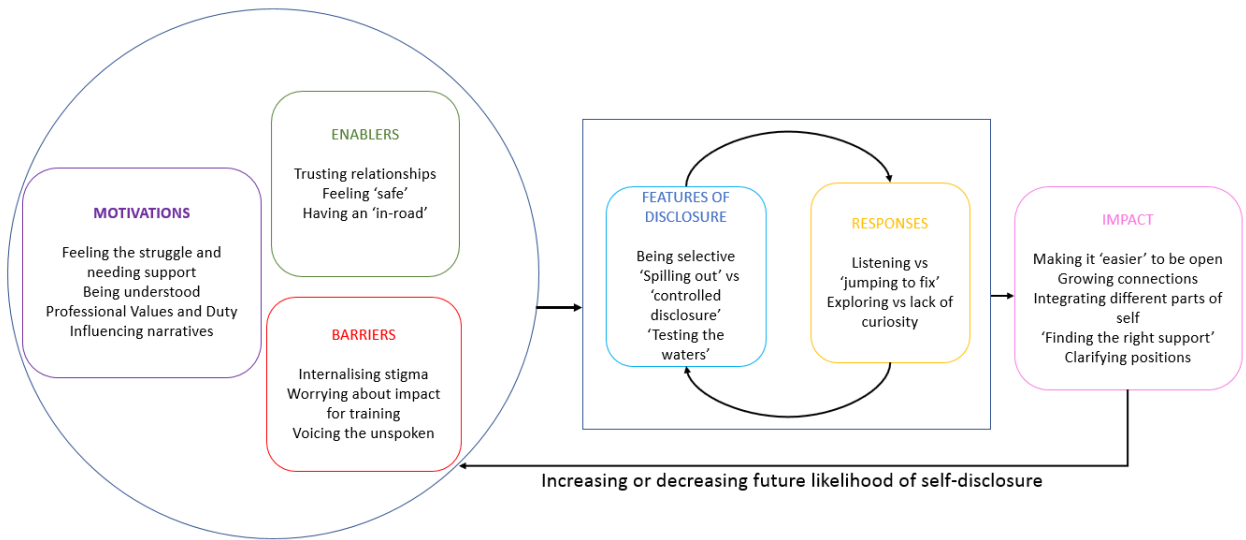*Figure 1*. The Disclosure Processes Model (Chaudoir & Fisher, 2010).

Figure 2. Model of the Process of Trainee Self-Disclosure

APPENDICES

APPENDIX A: Author Guidelines for Journal of Intellectual Disabilities Research

APPENDIX B: Systematic Review Search Terms and Strategy

APPENDIX C: Example email to prominent researchers

APPENDIX D: Agency for Health Research and Quality Methodology Checklist

APPENDIX E: Author Guidelines for Clinical Psychology and Psychotherapy

APPENDIX F: Demographics Questionnaire

APPENDIX G: Interview Schedule

APPENDIX H: The Short Warwick-Edinburgh Mental Well-being Scale, Scoring and Email Approval to Use

APPENDIX I: Consent Form

APPENDIX J: Participant Information Sheet

APPENDIX K: Poster advert

APPENDIX L: Recruitment email and ethical approval letter

APPENDIX M: Debrief form

APPENDIX N: Excerpt from reflective journal

APPENDIX O: Researcher perspective statement

APPENDIX P: Coding and memo excerpts

APPENDIX A

Author Guidelines for Journal of Intellectual Disabilities Research

Systematic Reviews
The maximum word length for systematic reviews is 6,000 words.

PREPARATION OF THE MANUSCRIPT
Author Services
Prior to submission, we encourage you to browse the 'Author Resources' section of the Wiley 'Author Services' website here. This site includes useful information covering such topics as copyright matters, ethics and electronic artwork guidelines.
Writing for Search Engine Optimization
Optimize the search engine results for your paper, so people can find, read and ultimately cite your work. Simply read our best practice SEO tips – including information on making your title and abstract SEO-friendly, and choosing appropriate keywords.
Pre-submission English-language editing
Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Visit our site to learn about the options. All services are paid for and arranged by the author. Please note using the Wiley English Language Editing Service does not guarantee that your paper will be accepted by this journal.
Spelling
• Spelling should conform to The Concise Oxford Dictionary of Current English.
• A high proportion of papers are submitted with the term 'behavior' as opposed to 'behaviour'; please use 'behaviour'.
• Where applicable the journal standard is to use words ending in –ise as opposed to –ize. For example, use 'analyse' 'standardise' as opposed to 'analyze' and 'standardize'
Units of measurements, symbols and abbreviations should conform with those in Units, Symbols and Abbreviations (1977) published and supplied by the Royal Society of Medicine. This specifies the use of SI units.
Terminology
It is important that the term 'intellectual disabilities' or 'intellectual disability' is used when preparing manuscripts. The term 'person', 'people', 'children' , 'participant(s)' or other appropriate term should be used as opposed to, for example, 'patient(s)'.
Optimising your paper on social media
If your paper is accepted for publication we would like to present three, headline style summary statements on our facebook and twitter feed. When you submit your article you will be asked to enter up to three short headlines (key statements) capture the importance of your paper.
MANUSCRIPT STRUCTURE
The manuscript should be submitted in separate files: title page; main text file; figures.
Title page
A 'Title Page' must be submitted as part of the submission process as a 'Supplementary File Not for Review. The title page should contain:
(i) a short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips), and should normally be no longer than 15 words in length;
(ii) the full names of the authors;
(iii) the author's institutional affiliations at which the work was carried out;
(iv) the full postal and email address, plus telephone number, of the author to whom correspondence about the manuscript should be sent;
(v) acknowledgements;
(vi) conflict of interest statement.

The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Acknowledgements

Contributions from anyone who does not meet the criteria for authorship should be listed (including any advisors/consultees with intellectual disability), with permission from the contributor, in an Acknowledgments section. See section on Authorship for more detail. Material support should also be mentioned Thanks to anonymous reviewers are not appropriate.

Main text

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

The main text of the manuscript should be presented in the following order: (i) structured abstract and key words (ii) text, (iii) references, (vi) endnotes, (vii) tables (each table complete with title and footnotes), and (ix) figure legends. Figures should be supplied as separate files. Footnotes to the text are not allowed and any such material should be incorporated as endnotes.

Abstract

For all submissions, a structured summary should be included at the beginning of the article, incorporating the following headings: Background, Method, Results, and Conclusions. These should outline the questions investigated, the design, essential findings, and the main conclusions of the study.

Keywords

The author should also provide up to six keywords. Please think carefully about the keywords you choose as this will impact on the discoverability of your paper during literature searches (https://authorservices.wiley.com/bauthor/seo.asp)

References

• The journal follows the Harvard reference style.

• References in text with more than two authors should be abbreviated to (Brown et al. 1977).

• Where more than six authors are listed for a reference please use the first six then 'et al.'

• Authors are encouraged to include the DOI (digital object identifier) for any references to material published online. See www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

• Authors are responsible for the accuracy of their references.

The reference list should be in alphabetical order thus:

Giblett E.R. (1969) Genetic Markers in Human Blood. Blackwell Scientific Publications, Oxford.

Moss T.J. & Austin G.E. (1980) Preatherosclerotic lesions in Down's syndrome. Journal of Mental Deficiency Research 24, 137- 41.

Seltzer M. M. & Krauss M.W. (1994) Aging parents with co-resident adult children: the impact of lifelong caregiving. In: Life Course Perspectives on Adulthood and Old Age (eds M. M. Seltzer, M.W. Krauss & M. P. Janicki), pp. 3–18. American Association on Mental Retardation, Washington, DC.

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, Table 2, etc., and give a short caption.

Figure Legends

Figure 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.

Figures

All illustrations (line drawings and photographs) are classified as figures. Figures should be numbered using Arabic numerals,and cited in consecutive order in the text. Each figure should be supplied as a separate file, with the figure number incorporated in the file name.

Preparing Figures. Although we encourage authors to send us the highest-quality figures possible, for peer-review purposes we are happy to accept a wide variety of formats, sizes, and resolutions. 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.

Color figures. Color figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures at Early View publication, they will be invited to complete a colour charge agreement in RightsLink for Author Services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

Supporting Information

Supporting information is information that is not essential to the article but that provides greater depth and background. It is hosted online, and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc. Click here for Wiley's FAQs on supporting information.

Please note that the provision of supporting information is not encouraged as a general rule. However, supporting information will be assessed by reviewers and editors and will be accepted if it is essential.

APPENDIX B

Systematic Review Search Terms and Strategy

Example Medline Strategy

Step	Search
1	Keyword search 1: (Nursing Staff or Caregivers or care staff or care adj1 worker or carer or staff).mp.
2	Keyword search 2: (Attitude* or attribution* or belief*).mp.
3	Keyword search 3: (Problem Behavior or Aggression or Self-Injurious Behavior or Stereotyped Behavior or challeng* adj1 behaviour* or physical aggression or self-injur* or aggres* Problem* adj1 behavio*r* or maladaptive behavio*r or aberrant behavio*r or self-harm* or stereotyp* or repetitive behavio*r or disruptive behavio*r or destructive behavio*r).mp.
4	Keyword search 4: (Intellectual Disability or Learning Disorders or Autistic Disorder or Developmental Disabilities or intellectual disabilit* or learning diabilit* or developmental disab* or mental handicap or mental retardation or mental deficiency or autis* or learning disorder or intellectual impairment or neurodevelopmental disab* or learning difficult*).mp.
5	Combined search: 1+2+3+4
6	Limit 5 to English language

[mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

APPENDIX C

Example email to prominent researchers

Dear [name],

My name is [name] and I am a Trainee Clinical Psychologist on the South Wales Doctoral Programme in Clinical Psychology.

I am currently doing a systematic literature review looking at factors associated with care staff attributions towards challenging behaviours of adults with learning disabilities. I am getting in touch in order to ask you, as a published expert in this area, whether you are aware of any pertinent recent papers or reviews in this area that I may have missed, or that are perhaps due to be published within the next 3 months? My most recent papers are by two by Van Den Bogaard (2019). This will help me ensure I am including all relevant papers, and not duplicating any other reviews.

Thank you so much for taking the time to read my email,

Yours Sincerely,

Kellie Turner

Trainee Clinical Psychologist

South Wales Doctoral Programme in Clinical Psychology

Floor 11, Tower Building

School of Psychology
Cardiff University
Cardiff

CF10 3AT

APPENDIX D

Agency for Health Research and Quality Methodology Checklist

Agency for Healthcare and Research Quality Methodology Checklist	Bailey et al., (2006)	Dagnan & Cairns	Dagnan (2012)	Dagnan, Trower &	Dilworth et al., (2011)	Kleinberg & Scior (2014)	Mackinlay & Langdon	Noone (2006)	Rose & Rose (2005)	Snow (2007)	Tynan & Allen (2002)	Wanless & Jahoda	Weigel (2006)
1) Define the source of information (survey, record review)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2) List inclusion and exclusion criteria for exposed and unexposed subjects (cases and controls) or refer to previous publications	N	N	N	N	Y	Y	Y	N	N	Y	N	Y	N
3) Indicate time period used for identifying patients	N	N	N	N	N	N	N	N	N	N	N	N	N
4) Indicate whether or not subjects were consecutive if not population-based	N	N	N	N	N	N	N	N	N	N	N	N	N

Agency for Healthcare and Research Quality Methodology Checklist	Bailey et al., (2006)	Dagnan & Cairns	Dagnan (2012)	Dagnan, Trower &	Dilworth et al., (2011)	Kleinberg & Scior (2014)	Mackinlay & Langdon	Noone (2006)	Rose & Rose (2005)	Snow (2007)	Tynan & Allen (2002)	Wanless & Jahoda	Weigel (2006)
5) Indicate if evaluators of subjective components of study were masked to other aspects of the status of the participants	Y	NA	NA	NA	Y	NA	NA	N	NA	N	NA	NA	Y
6) Describe any assessments undertaken for quality assurance purposes (e.g., test/retest of primary outcome measurements)	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y
7) Explain any patient exclusions from analysis	N	N	N	N	Y	Y	N	N	N	N	N	N	Y
8) Describe how confounding was assessed and/or controlled.	N	Y	Y	Y	N	Y	N	Y	N	Y	Y	Y	Y

Agency for Healthcare and Research Quality Methodology Checklist	Bailey et al., (2006)	Dagnan & Cairns	Dagnan (2012)	Dagnan, Trower &	Dilworth et al., (2011)	Kleinberg & Scior (2014)	Mackinlay & Langdon	Noone (2006)	Rose & Rose (2005)	Snow (2007)	Tynan & Allen (2002)	Wanless & Jahoda	Weigel (2006)
9) If applicable, explain how missing data were handled in the analysis	NA	NA	NA	NA	NA	Y	NA	NA	NA	NA	NA	N	NA
10) Summarize patient response rates and completeness of data collection	N	N	N	Y	Y	Y	N	NA	Y	N	N	Y	Y
11) Clarify what follow-up, if any, was expected and the percentage of patients for which incomplete data or follow-up was obtained	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Clinical Psychology and Psychotherapy Author Guidance

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research articles: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Reviews: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Assessments: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Practitioner Reports: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures.

File types

Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

New Manuscript
Non-LaTeX users: Upload your manuscript files. At this stage, further source files do not need to be uploaded.
LaTeX users: For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

Revised Manuscript

Non-LaTeX users: Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.
LaTeX users: When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. 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;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement, if applicable
8. Abstract, Key Practitioner Message and keywords;
9. Main text;

10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship

Please refer to the journal's **Authorship** policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

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, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the **Conflict of Interest** section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Data Sharing and Data Accessibility

The journal encourages authors to archive all the data from which their published results are derived in a public repository. The journal encourages all accepted manuscripts to include a data availability statement to confirm the presence or absence of shared data. If authors have shared data, this statement will describe how the data can be accessed, and include a persistent identifier (e.g., a DOI or an accession number) from the repository. For more details, see the full **Data Sharing and Data Accessibility** policy below.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner MessageAll articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords (see **Wiley's best practice SEO tips**).

Main Text

1. The journal uses US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article
Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with

maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: **10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

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.

Figure Legends

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.

Figures

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.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points

The following points provide general advice on formatting and style.

1. **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.
2. **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.
3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If

proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Appendix F

Demographics Questionnaire

Demographic Information

What course do you attend?

What year are you currently in?

1st	2nd	3rd

What gender do you identify as?

Female	Male	Other (please specify)	Prefer not to disclose

How old are you?

How would you classify or describe the type of mental health difficulty/difficulties you have experience of?

When did these difficulties first start?

Do you consider these difficulties to be resolved, or ongoing?

Interview Schedule

South Wales Doctorate Programme in Clinical Psychology
School of Psychology
Cardiff University
Cardiff
CF10 3AT

Interview Schedule

1. Tell me a little about the experience of being a trainee clinical psychologist on your programme.
2. Tell me briefly about a time/times when you disclosed information about your lived experience of mental health difficulties to a colleague/colleagues during training.
3. In relation to this experience of disclosure, why did to decide to disclose at this time?
4. What personal factors contributed to you managing to disclose at this time?
5. What contextual factors supported your disclosure? Was there anything that made it more difficult or prevented your disclosure?
6. How did you approach the disclosure?
   - Prompt: How did you decide what and how much to disclose?
7. How did the person/s you disclosed to respond, and how did this affect your disclosure experience?
8. How did the disclosure change things, if at all, personally and professionally?
   - Prompt: How did your disclosure affect your relationship with the person/s to whom you disclosed?
   - Prompt: What were the outcomes?
   - Prompt: How did it affect your experience of training thereafter?
9. How did your disclosure affect future disclosures?
   - Prompt: Do you have any advice or recommendations for other trainees with lived experience?
   - Prompt: Do you have any advice for colleagues on how to respond to similar disclosures?
10. Is there anything else you'd like to say before ending the interview?

The Short Warwick-Edinburgh Well-being Scale (SWEMWBS), Scoring and Email Approval to Use

The Short Warwick-Edinburgh
Mental Well-being Scale
(SWEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

This image has been removed by the author of this thesis for copyright reasons

Kellie Turner

Thank you – this email confirms you have permission to use WEMWBS in accordance with the details entered in your registration shown below. We suggest you bookmark this page for future reference:
https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwarwick.ac.uk%2Ffac%2Fsci%2Fmed%2Fresearch%2Fplatform%2Fwemwbs%2Fusing%2Fregister%2Fresources&data=01%7C01%7CTurnerK7%40cardiff.ac.uk%7C3332b7548833489fb97008d77e30abe7%7Cbdb74b3095684856bdbf06759778fcbc%7C1&sdata=XW035g08gToTocrbYP9GtutH0K5LBQIjfww1U5iXlvA%3D&reserved=0
If you have any questions please feel free to contact us via email: ventures@warwick.ac.uk

Question: Organisation name
Answer:
 South Wales Doctoral Programme in Clinical Psychology, Cardiff University/Cardiff and Vale UHB

Question: Type of organisation
Answer:
 University

Question: Size of Organisation

Answer:
 University

Question: Size of Organisation
Answer:
 51-500

Question: If public sector (other), please detail
Answer:

Question: Country of organisation
Answer:
 UK

Question: Website
Answer:

Question: Organisation Address
Answer:
 South Wales Doctoral Programme in Clinical Psychology School of Psychology Floor 11, Tower Building 70 Park Place Cardiff University CF10 3AT

Question: Primary contact
Answer:
 Kellie Turner

Question: Primary email address
Answer:
 TurnerK7@cardiff.ac.uk

1

Question: Job Title at the Organisation
Answer:
 Trainee Clinical Psychologist

Question: Secondary contact
Answer:

Question: Secondary email address
Answer:

Question: Planned start date
Answer:
 06/01/2020

Question: Planned finish date
Answer:
 19/12/2020

Question: Study geographical scope:
Answer:
 National

Question: Preferred version of
Answer:
 SWEMWBS - Shortened 7 item scale

Question: In which language(s) are you planning to use ?
 Tick all that apply
Answer:
 English

Question: If other, please specify
Answer:

Question: Settings:
 Tick all that apply
Answer:
 Workplace or occupational setting
 University or college

Question: If other, please specify
Answer:

Question: Type of use:
Answer:
 Other

Question: If other, please specify
Answer:
 Complementing qualitative interviews to situate well-being or sample and as part of debrief

Question: Type of intervention (if applicable) Tick all that apply
Answer:
 Other (eg routine NHS provision; other service provision)

Question: If other, please specify

Answer:
 As part of interviews with trainee clinical psychologists from universities in UK about ability to disclose mental health difficulties while on courses to university staff and NHS supervisors, and peers.

Question: Number of participants
Answer:
 11-50

Question: Age of participants (Tick all that apply)
Answer:
 18-64

Question: I have read and agreed to the terms of the standard license for non-commercial use
https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwarwick.ac.uk%2Ffac%2Fsci%2Fmed%2Frese
arch%2Fplatform%2Fwemwbs%2Fusing%2Fregister%2Ftcs.pdf&data=01%7C01%7CTurnerK7%40cardiff.ac.uk%
7C3332b7548833489fb97008d77e30abe7%7Cbdb74b3095684856bdbf06759778fcbc%7C1&sdata=hZpblBDscY
h0F6Azy%2BheSRGyX%2F3Dz7RqapR22NrbCOI%3D&reserved=0
Answer:
 Yes

Question: Would you be willing to be contacted with regard to the results of your study?
Answer:
 No

Question: Would you be willing to share an anonymised version of the data collected in your study?
Answer:
 No

Question: I agree to my contact details being shared with third parties for the purposes of product development of
Answer:
 No

South Wales Doctorate Programme in Clinical Psychology
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Cardiff
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Consent form

Please read all of the Participant Information Sheet before completing this form.

Below is a list of statements. Please read each statement and initial the box next to it to confirm that you agree with the statement.

After placing your initials next to the statements you agree with, please sign page two of this form if you wish to participate.

If anything on this form is unclear, please speak to me before signing.

**I have read the Participant Information Sheet (V5.0)
and have been given a copy to keep.**

**Before agreeing to take part, I was given the opportunity
to ask any questions about this project and my questions have
been answered satisfactorily**

**I am aware that
interviews will be audio recorded and will be transcribed in such
a way to omit identifiable information. Audio recordings
will be deleted immediately after transcription.
Demographic information collected
will be reported only using ranges/percentages to prevent
possible identification. Therefore, all information I provide
will be made anonymous and it will not be possible to identify
me in any reports or publications.**

I am aware that my participation is voluntary.
I can withdraw my consent to take part at any time
until data is anonymised. I am aware that I do not need
to provide a reason for withdrawing and this will not
affect me in any way.

I consent to take part in this project.

Name of participant .... Date ....

Signature of participant ....

Name of researcher .... Date ....

Signature of researcher ....

Appendix J

Participant Information Sheet

South Wales Doctorate Programme in Clinical Psychology
School of Psychology
Cardiff University
Cardiff
CF10 3AT

I would like to invite you to take part in a research project about trainee experiences of self-disclosure of mental health difficulties while on training. Before deciding to participate it is important that you understand why this research is being completed. It is also important for you to know what will be involved if you decide to take part. Please read the following information carefully and ask questions if there is anything you do not understand or would like more information on.

Who is doing the research?

This study is being conducted by Kellie Turner (Trainee Clinical Psychologist, South Wales DClinPsy Programme) and is supervised by Dr Jenny Moses (Lead Academic Tutor, South Wales DClinPsy Programme).

What is the purpose of the research?

The purpose of this study is to investigate trainee clinical psychologist experiences of disclosing mental health difficulties to peers, supervisors and/or course staff while on training. In particular, we are interested in how trainees approach disclosing and what helps or hinders trainees to disclose to others. It is hoped that this research could help inform accredited DClinPsy courses around the UK to be able to facilitate disclosures of mental health difficulties while on training, furthering the culture of self-care and compassion on training courses, and in turn help trainees seek relevant support when needed.

Who can participate in the research?

- Trainee clinical psychologists from accredited DClinPsy courses around the UK
- who have experience of disclosing *either* a history of mental health difficulties, *or* disclosing experiencing mental health difficulties at the time of disclosure to peers, clinical supervisors or course staff
- who are not currently experiencing significant active mental health difficulties affecting social, occupational or personal functioning or an interruption of studies.

What will taking part involve?

Taking part will involve emailing the principal investigator (Kellie Turner) to register interest. You can choose if you wish to create an alias email address for the purpose of this study. You will then be sent a full information sheet and consent form. You will be given the opportunity to ask any questions about the project you may have, and asked questions to ensure inclusion criteria are met. If you are happy to participate, you will be asked to complete and send back the consent form electronically. We can then arrange a time for a

short (30min to 1 hour) interview which will be conducted via skype at a time convenient for you. You will be asked to create an account with skype if you do not already have one. If you agree to take part, I will also ask for your GP details. Your GP will not be informed about your taking part in the research. I will only need to use these details if there are any safeguarding issues or concerns about risk during the interview (see below). If there are no concerns, these details will be destroyed following the interview.

For the interview, you can choose whether or not to have video on. You will be asked questions about one disclosure experience in particular and how it went, including things that lead to it, and outcomes from it. At the end of the interview you will be asked to complete the short well-being scale. You will also be asked for some basic demographic data including things such as age, gender, your course support systems, and some information about the mental health difficulties you have experienced. You will be thanked for your time and a debrief will be conducted to ensure you are content with the interview and that you have not experienced any adverse effects. If you experience any difficult feelings at this time, you may be signposted to and talked through avenues for support. A debrief form will be emailed to you after interview also.

What are the possible advantages of taking part?

Advantages for taking part are that it is hoped the project's findings will inform DClinPsy courses across the UK as to how they can facilitate a positive culture around disclosure of mental health difficulties and stress that feels supportive to trainees.

Participants will also be entered into a prize draw to have a chance to win a £50 book token.

Are there any risks or disadvantages in taking part?

There may be a very small risk that discussions of disclosing mental health difficulties may bring up unwanted or distressing feelings or thoughts. If this happens, the interview will be paused. You will be supported to feel less distressed and decide whether you wish to continue with the interview or not. A full debrief will be conducted at the end of the interview to ensure that you are left feeling content with the interview before ending. You may also be signposted to relevant support systems. Also, in the unlikely event that you share that you or anyone else is at current risk of harm, the interview will be stopped. This will be discussed and shared with relevant people or services to ensure safety of all involved.

What happens if I decide I don't want to take part?

Participation is completely voluntary and there are no anticipated adverse outcomes for you should you wish to not take part. You also have the right to withdraw, without penalty, prior to data being anonymised. If you wish to withdraw before this time, please contact the principal researcher at TurnerK7@cardiff.ac.uk. You do not need to give any reason to withdraw.

South Wales Doctorate Programme in Clinical Psychology
School of Psychology
Cardiff University
Cardiff
CF10 3AT

Will my information be kept confidential?

All information provided will be kept strictly confidential. Personal information provided via consent forms will be stored securely and separately to interview data. Interview data will be audio recorded via digital recorder and transcribed without personally identifiable data. The audio recording will then be deleted. Transcriptions will thus be anonymised and stored using password protection. Gender-neutral pseudonyms will be used for participants in any written reports created from the project. Demographic data will be reported using ranges or percentages and therefore will not be able to be used to identify participants.

Cardiff University is the Sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the Data Controller for this study. This means that we are responsible for looking after your information and using it properly. Cardiff University will keep identifiable information about you for 15 years after the study has finished. The legal basis we will rely upon to collect and store your information is consent. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection The University's Data Protection Officer can be contacted at: inforequest@cardiff.ac.uk

What will happen with the findings?

The anonymised findings will be used in fulfilment of qualification for DClinPsy and will be written up in thesis format. The report may be submitted for publication in a relevant journal or used for verbal or poster presentation at relevant conferences if appropriate.

What to do if you have a problem or a complaint?

Please contact the Cardiff University School of Psychology Ethics Committee at psychethics@cardiff.ac.uk in the first instance. Alternatively, you may wish to contact Dr Vic Samuels (Research Tutor, South Wales DClinPsy) at SamuelV3@cardiff.ac.uk

Contact details

If you are interested in taking part, please contact Kellie Turner (Trainee Clinical Psychologist and Principal Investigator, South Wales DClinPsy) on the following email address: TurnerK7@cardiff.ac.uk

Thank you for your interest and for considering taking part in this project.

Appendix K

Poster Advert

South Wales Doctorate Programme in Clinical Psychology
School of Psychology, Cardiff University, Cardiff, CF10 3AT

Dr Jenny Moses (Chief Investigator, Academic Director)
Jenny.Moses@wales.nhs.uk

Kellie Turner (Principal Investigator, Trainee Clinical Psychologist)
TurnerK7@cardiff.ac.uk

Disclosing lived experience of mental health difficulties on clinical psychology training: what helps and what hinders?

Trainee Clinical Psychologists Needed

Trainee Clinical Psychologists are just as likely, if not more likely, to experience mental health difficulties as those in the general population. This study aims to investigate experiences of self-disclosure of mental health difficulties while on clinical psychology training.

We are looking for current trainees from all years of training who are not currently experiencing significant difficulties with mental well-being to take part in semi-structured interviews about their experiences of disclosure of mental health difficulties experienced prior to or during training to peers, supervisors or course tutors.

Interviews will be conducted via skype and will last approximately 30-45 minutes. You will be asked questions about the experience of disclosure and effects of disclosure personally and relationally. You will also be asked to complete a well-being scale and asked about basic demographic information too. All participants will also be entered into a prize draw for the chance to win a £50 book voucher.

If you are interested in taking part or would like more information, please email TurnerK7@cardiff.ac.uk and the Principal Investigator will be in touch with more information. Participation is completely voluntary and all personal information will be kept confidential.

Thank you for taking the time to read about this project.

Version 1.0
15.11.19

Recruitment Email and Ethical Approval Letter

Dear [Programme Director],

I am contacting you to ask for your support in disseminating my study, 'Disclosing lived experience of mental health difficulties on clinical psychology training: what helps and what hinders?' to trainees in [area].

I have ethical approval from Cardiff University School of Psychology Research Ethics Committee, reference [EC.19.11.12.5888R2A]. Please see the ethical approval letter attached. The study is a qualitative study which involves semi-structured interviews about trainees' and recently qualified clinical psychologists' experiences of disclosing information about previous or current mental health difficulties while on training. Interviews will be conducted via skype at a convenient time for participants, and interviews are anticipated to last approximately 30-45 minutes. Participation is completely voluntary and all data will be anonymised and stored separately to any personally identifiable information.

If you are happy to participate, I would be grateful if you could send the attached poster to all trainees on your course. There is a link embedded within the poster that they can then click on to email me to register their interest to take part.

Thanks in advance for you time,

[Name]

[Job Title]

[Course]

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www.cardiff.ac.uk/psychology

School of Psychology

Ysgol Seicoleg

Ref: AJH/KT

10ᵗʰ February 2020

Project proposal: Disclosing lived experience of mental health difficulties on clinical psychology training: what helps and what hinders? (EC.19.11.12.5888R2A)

Dear Kellie,

I am writing as the Secretary of the School of Psychology Ethics Committee to confirm that the Committee has reviewed the amendments to the work to be carried out under the proposal listed above. The research is ethical and can be carried out in an appropriate fashion.

If you have any further queries, please feel free to contact us on psychethics@cardiff.ac.uk.

Yours Sincerely,

Jo Beach
School of Psychology Research Ethics Committee

Appendix M

Debrief Form

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYⱮ

Thank you so much for taking part in the project "disclosures of mental health difficulties in training: what helps and what hinders?"

The current project aims to gather information from individuals' experiences of disclosing mental health difficulties while on training to peers, university staff and placement supervisors, in order to help us better understand how these kinds of conversations occur and what can facilitate them being helpful experiences for those involved. Your contribution to this project is greatly appreciated.

What will happen with the findings?

Anonymised findings will be used in fulfilment of qualification for DClinPsy and will be written up in thesis format. The report may be submitted for publication in a relevant journal or used for verbal or poster presentation at relevant conferences if appropriate. Any quotes used will be fully anonymised using a gender-neutral pseudonym to ensure confidentiality.

Where can I go for further support if needed?

Some of the things we have talked about might have been quite difficult. Should you require any further support after our interview, please be aware that you can contact a number of places for support, including:

- Your clinical/appraisal/personal tutor
- Other course tutors
- Your placement supervisor
- Your university well-being and support service
- Peer, "buddy", or "mentor" support
- Your GP

What to do if you have a problem or a complaint?

Please contact Cardiff University School of Psychology Ethics Committee at psychethics@cardiff.ac.uk in the first instance or Dr Vic Samuels (Research Tutor, South Wales DClinPsy) at SamuelV3@cardiff.ac.uk

Contact details

If you have any further questions about this project, please contact Kellie Turner (Trainee Clinical Psychologist and Principal Investigator, South Wales DClinPsy) on the following email address:
TurnerK7@cardiff.ac.uk

Version 1.0
11.12.19

Appendix N

Excerpts from Reflective Journal

"**After first interview Feb 2020**

Noticing feelings – I noticed feeling anxious and wanting to put the respondent at ease, while equally noticing some awkwardness in the flow of the interview.

I noticed some ideas coming up that both fitted and didn't fit with my own views. For example:

- Not wanting to be treated different because of MH
- Matter-of-fact dealings with supervisor and tutor
- Idea of 'different hats'
- Peers for more emotional support
- Being close to peers but not telling everyone
- Being checked on – nice and not
- Something about being honest with this in work we do
- Reflection of Impact of work on self encouraged by course
- Feeling 'fine' with how worked out

Feedback – respondent feedback usefulness of having starter question about difficulties to help draw out more information, as felt it 'went straight into it'.

Feeling positive about coding during this stage. Read about initial coding first in the Charmaz (2000) book and then gave it a go with my first transcript.

Transcribing was relatively straightforward for this interview as it wasn't very long and was my first. I listened to it and transcribed as I listened and it brought back some of the thoughts from after interview, particularly thinking how different this experience was to what I thought I might hear, particularly the difficulty and how individuals responded.

Initial coding seemed to work well. I tried to just read and code quite quickly and instinctually, as suggested for initial coding by Charmaz (2000). The difficulty I had was with trying to keep codes active and using gerunds to get at the underlying process rather than describing the data."

"**Process**

Theoretical sampling is sampling to develop emerging theoretical categories (Charmaz, 2006) and to help explain and clarify categories, and later may help demonstrate links between them. Theoretical sampling can be done through recruiting and interviewing further participants with specific experiences, but methods can vary including conducting observations or interviewing with particular focus on specific emergent categories (Charmaz, 2006).

Discussed using theoretical sampling in supervision. Discussed the purpose to develop conceptual and theoretical categories, not for representation or generalisability of the population. Discussion with supervisors around theoretical sampling and discussed that sampling participants with specific experiences may be difficult due to time-limitations and potentially unnecessary as use of prompts and modifications to interview schedule would help develop categories further.

When analysing data, I used memo writing to query categories as they started to emerge from the data and made small changes to prompts in the interview schedule to be able to develop categories further. For example, quite early on a category appeared to emerge from things that helped around good relationships. I queried more what this meant – what made a good relationship? What did that look like? What did people mean? I then used a prompt "can you explain what you mean by that?" to ask what people meant when they mentioned 'good relationships' and it started to come out that people meant they felt they trusted the person to listen and understand, and respond how they hoped they would. Prompts were used in these ways, and data was gathered until no further new theoretical insights of categories appeared."

"Discussion with X (Fellow 3rd Year Trainee Researcher)

Speaking to X, who's research was with qualified psychologists' experiences of mental health difficulties, was valuable to think about biases. X recognised a number of themes and factors from their work, including:

- A great number of individuals interested in taking part
- The anxiety participants might have about sharing these issues, stigma, and ramifications
- 'am I bad enough'? question – how to clarify this
- Lots of conversations around disclosure to people
- No space given for these conversations on training or after
- How psychologists didn't consider discussing it on training in case their right to be there was questioned
- The fitness to practice question!!
- Personal biases around fitting with own experience
- The personal impact of hearing people's stories and bearing witness
- Views around using diagnostic labels in demographics
- Bias around 'does it influence my work'
- Interviewing qualified psychologists – change to power dynamics from trainee feeling less power to being in position of more power interviewing people about something personal

I found these reflections and discussion really interesting. In particular, I related to being pleased with the number of people coming forward, and also the 'am I bad enough' question as these had come up for me.

I also didn't fully appreciate the anxiety some may have as maybe I am a little more open at times, and how some had never come forward, so I think I would have thought of this more in my poster and IS if I had done it again.

It was good to hear that disclosures came up a lot, this felt like it validated my research question and it was needed. It was interesting to hear about the experience of interviewing qualified psychologists also and thinking about the difference for trainees – feeling there is more 'peerness' and might facilitate openness.

Biases like not having space on course, fitting with own experience, influencing work, diagnostic labels felt very relatable to me too – this is why I steered away from diagnostic criteria, and it made me think I needed to be very aware of my biases and what I would be surprised to hear, like people not struggling at all with their mental health disclosures, or finding staff more helpful?"

"Reflections on Interviews

It has been interesting interviewing trainees when thinking back to X's experience of interviewing qualified psychologists. I think I have felt the one holding a lot of power as I'm doing the interviewing and I haven't been so aware of feeling concerned over coming across 'professionally' as I think X had talked about. It definitely feels quite 'peer-to-peer' when talking and more so at the end when I ask if they have any more questions, some have been interested in my experiences also. The fact that many are also going through research and placement too has felt helpful to rapport as we have spoken about what they've been up to before starting and it's helped things feel more comfortable, although I am aware this is only from my perspective and for participants it may be different. I think

overall it's felt more equal quicker than for if I interviewed qualified psychologists and maybe from that allowed for more openness than if we had different roles. I think I've also been able to have discussions around language used in my documents too, as one participant picked up on the 'anti-diagnosis' wording I've used in my questionnaire and it felt quite helpful for rapport that we discussed this at the start before the interview as it came up as a question and share our thoughts. The participant seemed to be happy with my reasoning and I let them know it was to allow participants to use whatever wording they prefer and then used that in the interview.

It's also at this point I'm more aware of the previous literature in the area and ensuring it is not influencing what I've found. I have had to do some literature searches for my proposal, including considering models of disclosure, but I haven't done too much in depth at this stage. Mostly I am aware of the Disclosure Process Model and so when looking at the data I am trying to stay grounded in this when considering emerging themes and categories and asking myself what the data is saying. I think this has helped as it feels like although some of these themes are similar they are also different in some ways too to the previous research I have seen. "

Appendix O

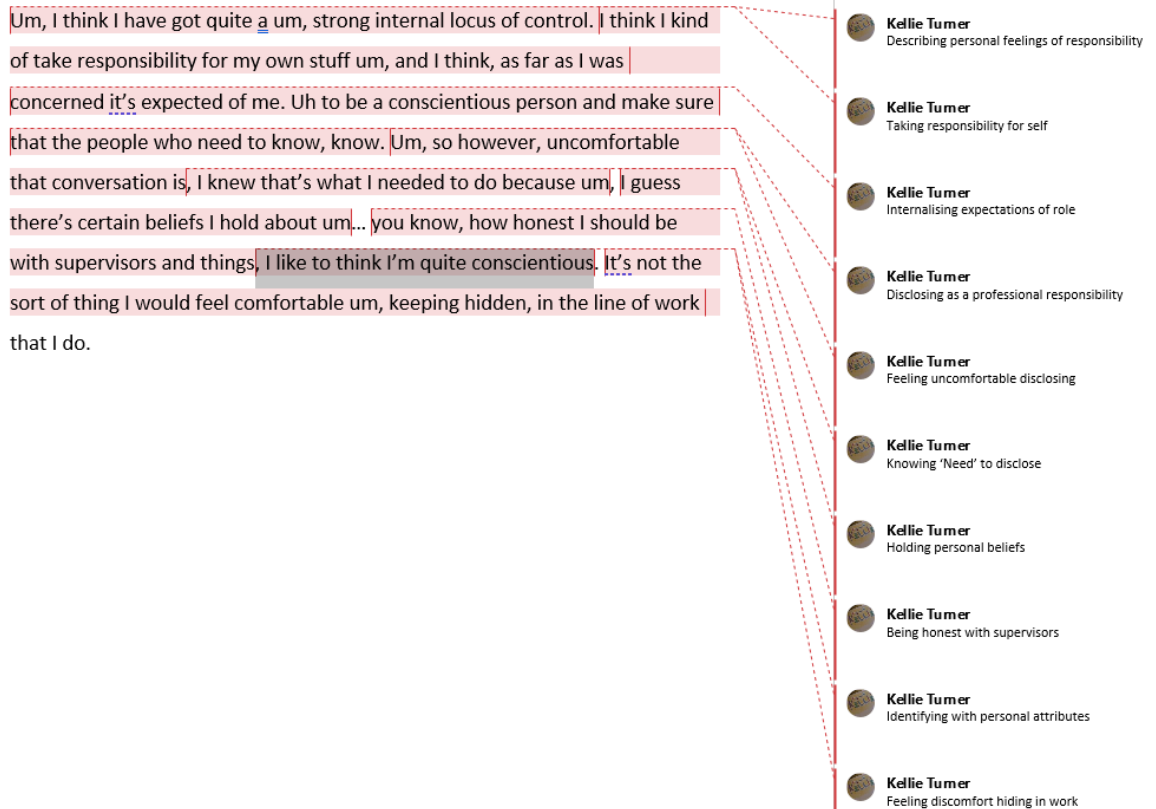Researcher Perspective Statement

The Researcher's Perspective

The researcher is a 30-year-old British trainee clinical psychologist from South West England. The researcher has worked in primary care mental health and learning disabilities services prior to training. The researcher has personal experience of mental health difficulties prior to training and has disclosed this at various points to some extent during training to supervisors, course tutors and peers which have been responded to in a variety of ways, generally supportively. The researcher's personal experiences of mental health difficulties have meant that the researcher aligns with ideas around being anti-diagnosis to a large extent and more systemic in understanding mental health than locating difficulties within individuals.

The researcher had experience of working with peer mentors in their adult mental health placement in year one and felt that having an individual in the team with lived experience who could discuss this openly was really invaluable for colleagues as well as service user and carers, creating more equal relationships with service users and opening conversations around well-being. It was then the researcher began to think more about lived experience of professionals being talked about more, and the researcher became more aware of colleagues and peers who had lived experience of trauma, adverse childhood experiences and mental health difficulties. At this point, the researcher was pursuing a thesis in learning disabilities, however that project became unfeasible and it was then that the researcher became familiar with some of the literature in the area of mental health of professionals (particularly in clinical psychology) and specifically developed interest in self-disclosure of lived experience. It was felt that this topic may be a good one for a thesis project to consider with regard to trainee clinical psychologists, who are generally a very engaged and reflective participant group and research shows often have lived experience of mental health difficulties. After considering some of the literature, it was felt a qualitative method would be most helpful to understand the process of disclosure during training and grounded theory methodology was felt to be most helpful in order to consider how and why disclosures of this nature happen on training. In particular, the researcher aligned with ideas around social constructivism and research being constructed with the researcher's perspective as part of this, so it was felt that Charmaz's (2000) approach would be most suitable. The researcher acknowledges that their past experiences influence their perspective (particularly considering views of mental health difficulties in professionals and stigma, and personal experiences of disclosing), and thus may influence the research process. The researcher also recognises that discussing these views with other researchers in the field and reflecting at each stage of the process will be vital in being able to identify biases and consider multiple perspectives in the data.

Appendix P

Coding and Memo Excerpts

Initial Coding Example 1

Um, I think I have got quite a um, strong internal locus of control. I think I kind
of take responsibility for my own stuff um, and I think, as far as I was
concerned it's expected of me. Uh to be a conscientious person and make sure
that the people who need to know, know. Um, so however, uncomfortable
that conversation is, I knew that's what I needed to do because um, I guess
there's certain beliefs I hold about um… you know, how honest I should be
with supervisors and things, I like to think I'm quite conscientious. It's not the
sort of thing I would feel comfortable um, keeping hidden, in the line of work
that I do.

Kellie Turner
Describing personal feelings of responsibility

Kellie Turner
Taking responsibility for self

Kellie Turner
Internalising expectations of role

Kellie Turner
Disclosing as a professional responsibility

Kellie Turner
Feeling uncomfortable disclosing

Kellie Turner
Knowing 'Need' to disclose

Kellie Turner
Holding personal beliefs

Kellie Turner
Being honest with supervisors

Kellie Turner
Identifying with personal attributes

Kellie Turner
Feeling discomfort hiding in work

Selective coding Example 1

Um, I think I have got quite a um, strong internal locus of control. I think I kind of take responsibility for my own stuff um, and I think, as far as I was concerned it's expected of me. Uh to be a conscientious person and make sure that the people who need to know, know. Um, so however, uncomfortable that conversation is, I knew that's what I needed to do because um, I guess there's certain beliefs I hold about um... you know, how honest I should be with supervisors and things, I like to think I'm quite conscientious. It's not the sort of thing I would feel comfortable um, keeping hidden, in the line of work that I do.

Kellie Turner
Feeling responsibility

Kellie Turner
Professional duty

Kellie Turner
'Needing' to disclose

Kellie Turner
Recognising Personal and professional values

Kellie Turner
Being honest with supervisors

Initial coding Example 2

Um, so again I think it's really different, so like it feels to me like when I've said there are some mental health problems that are OK to talk about and some that don't seem to be, um, or when it's talking about your family experiences than talking about your experience, again it's quite different, um. But I think when I've spoken about um, like difficulties with managing emotions and self-harming and things like that um…yeah, I think, I think it does quite, kind of shock people *laughter* but um, and um, I think you definitely get asked like, "but it's not still happening?" kind of thing um. Or you might get a response like, "oh I did that once" or *laughter* "that's something I struggled with once" and that is maybe a little bit invalidating? I don't know. I don't know how helpful that is but I can, I can understand why that might be their reaction. Um, so yeah I do think talking about self-harm and things like that, is, is quite, shocking for people, um to hear. Whereas anxiety may be less so, um.

Kellie Turner
Receiving different reactions

Kellie Turner
Differing stigmas for different difficulties

Kellie Turner
Speaking about others' lived experience

Kellie Turner
Noticing difference between speaking about_own and others experiences

Kellie Turner
Speaking about personal experience

Kellie Turner
Feeling disclosures 'shocking' people

Kellie Turner
Feeling others jumping to risk

Kellie Turner
Responders relating to own experience

Kellie Turner
Feeling invalidated by responses

Kellie Turner
Understanding others reactions

Kellie Turner
Certain difficulties 'shocking' responders

Kellie Turner
Differing responses to common MH difficulties

Selective coding Example 2

Um, so again I think it's really different, so like it feels to me like when I've said there are some mental health problems that are OK to talk about and some that don't seem to be, um, or when it's talking about your family experiences than talking about your experience, again it's quite different, um. But I think when I've spoken about um, like difficulties with managing emotions and self-harming and things like that um...yeah, I think, I think it does quite, kind of shock people *laughter* but um, and um, I think you definitely get asked like, "but it's not still happening?" kind of thing um. Or you might get a response like, "oh I did that once" or *laughter* "that's something I struggled with once" and that is maybe a little bit invalidating? I don't know. I don't know how helpful that is but I can, I can understand why that might be their reaction. Um, so yeah I do think talking about self-harm and things like that, is, is quite, shocking for people, um to hear. Whereas anxiety may be less so, um.

Kellie Turner
Describing different stigmas

Kellie Turner
Noticing 'us vs them' dynamic

Kellie Turner
Speaking about personal experience

Kellie Turner
Jumping to risk

Kellie Turner
Feeling invalidated by responses

Kellie Turner
Understanding reactions

Kellie Turner
Describing different stigmas

Memo Examples

Listening

Properties: About responders listening to disclosures and trainee feeling really 'heard' during disclosure event. Trainees appear to value this in disclosure responses and feel it is 'helpful' response to disclosing.

Definition: A response during disclosure. Trainees reported feeling 'listened to' or being 'heard'

Links to resisting urge to problem solve - trainees talk about feeling listened to, and the reverse of this being feeling responder 'jump' to problem solving, or risk.

Consequences: trainees feeling 'heard' and feeling supported. Able to disclose more and perception of improving relationship.

What does listening mean? - taking time, asking questions, using validation

Professional Duty and Values

Started as being about the conflict that arises from personal life and professional life - values, professionalism and mental health

But seems to fit more with thinking about Personal and professional values?

Properties: personal and professional values that align with disclosing - including, feeling it as a duty to look after others and provide quality care, not hinder care; being authentic and honest; believing in being open about mental health if we expect others to be.

Definition: a motivation to disclose - a reason why trainees decide to disclose. Trainees report feeling 'need' to disclose because of particular values or professional duty to be safe practitioner

Consequences: leads to disclosure, when considered alongside barriers and enablers.