UNIVERSITY OF BIRMINGHAM

THE EXPERIENCES OF TRAINING FOR TRAINEE CLINICAL PSYCHOLOGISTS WITH LIVED MENTAL HEALTH EXPERIENCE

by

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Thesis Overview

This thesis comprises of three chapters outlined below.

Chapter one: Systematic Literature Review

Chapter one consists of a meta-ethnography exploring the experiences of Psychological practitioners with lived experiences of mental health difficulties. A systematic search of four databases identified seven suitable papers. Six overarching themes across the papers were identified. The conclusions and clinical implications of the meta-ethnography are discussed in the review.

Chapter two: Empirical Paper

Part two consists of a qualitative empirical study which explores Trainee Clinical Psychologists' lived experiences of mental health difficulties. Semi-structured interviews were conducted with eight Tranee Clinical Psychologists. Interpretative Phenomenological Analysis (IPA) was utilised to find five overarching themes. The conclusions of the paper and implications for practice are reflected.

Chapter Three: Press Releases

Part three consists of two press releases for the meta-ethnography and empirical paper, respectively.

Dedication

This thesis is dedicated to my supportive husband, Rob. Your unconditional love and support especially through my darkest of days, allowed me to achieve what felt impossible.

And to all the aspiring, trainee, and qualified psychologists with lived experiences. I hope by sharing these narratives it helps to emphasise the benefits these experiences can bring to the field of psychology.

Acknowledgements

Firstly, I would like to thank all the individuals who took part in this research. Thank you for sharing your stories and trusting in me to share your narratives. I feel so grateful that you all chose to share your narratives with me, and without which this research would have not been possible.

I would like to thank my research supervisor Dr Owen Forster for helping me through this process. For providing me with a project in an area I am truly passionate about, and for encouraging research in this important area. Thank you for believing in me and keeping me grounded when I have needed it most. And thank you for sharing your knowledge, wisdom, and humour throughout. Thanks also Dr Andy Fox, for sharing his knowledge, skills, and enthusiasm about meta-ethnographies!

To my chosen family, thank you for supporting me through my whole journey of doctorate. For being there during my highs and lows and knowing how to help me blow off steam when needed (with long walks and terrible karaoke)! Thank you for always believing in me, especially when I was not able to believe in myself. For never questioning my ability, even when I doubted myself; and for being the positive inspiring role models I've needed.

Finally, I would like to thank my amazing husband, Rob. You have always been my constant and stability; my anchor in the storm. I do not have the words to fully express how grateful I am to have you in my life. Thank you for encouraging me to take risks and reminding me what I'm capable of. Thank you for your unwavering support and love.

Values statement

This thesis endeavours to acknowledge and embrace every individual's journey of mental health. It recognises the importance of each person's narrative, whilst highlighting the power of shared experiences. Acknowledging the prevalence of lived experiences is crucial, particularly within the mental health profession due to the potential challenges and barriers observed.

The term 'lived experience' is used throughout this thesis to capture experiences of psychosocial causal factors, context, and uniqueness of individual experiences of distress related to mental health difficulties (British Psychological Society, 2020). In order to not trivialise or diminish these experiences, the abbreviation 'LE' will not be used in any chapters of this thesis.

Reference:

British Psychological Society (2020). *Supporting and valuing lived experience of mental health difficulties in clinical psychology training*.

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CHAPTER ONE

Systematic Literature Review

Lived Experiences of Mental Health Difficulties amongst Psychological practitioners :

A Meta-ethnography

Abstract

Aims: This meta-ethnography aims to explore the lived experience of mental health difficulties amongst Psychological practitioners .

Background: Existing literature highlights the high prevalence of mental health difficulties amongst mental health professionals including psychologists and therapists. This review systematically evaluates the research published relating to lived experiences of psychologists and therapists.

Method: To systematically review the literature, four databases were searched in the autumn of 2023. All literature was measured against inclusion and exclusion criteria whereby only peer-reviewed and quantitative research was included. All research that met inclusion criteria was quality checked using the National Institute for Health and Care Excellence (NICE) qualitative quality appraisal checklist. In total seven publications were included with a total of 225 participants. Whilst the methodology of the studies was varied, all the studies explored experiences of lived experience of mental health practitioners. Using the seven steps of meta-ethnography as outlined by Noblit and Hare (1988), six themes relating to lived experiences were identified.

Results: Six overarching themes were found; stigma, discrimination, experiences of distress/lived experience, identity, disclosure, and support. According to this review experiences of stigmatisation were shared for practitioners, and negatively impacted disclosure and seeking support. Lived experience brought unique expertise for practitioners that are an asset within clinical work.

Conclusion: This meta-ethnography highlighted a need for future research to further understanding of the experiences and nuances of lived experience amongst Psychological practitioners ; and the need to improve the support offered by employers and colleagues.

Keywords

Mental health, lived experience, systematic literature review, mental health professionals, Psychological practitioners , meta-ethnography,

Note about the terms used throughout this thesis

The terms, 'lived experience', 'mental illness', 'mental health problem' and 'mental disorder' will be used interchangeably to refer to any disorder/condition that meets the DSM-V criteria for a mental health disorder. A mental disorder is a condition that causes clinically significant impacts on cognition, emotion regulation or behavioural dysfunction. Typically, mental disorders are associated with difficulties with social or occupational functioning or other important activities. It is important to note that a response to a common stressor or loss does not class as mental disorder e.g. bereavement.

Epistemology Position

The author of this systematic review adopted a critical realistic position.

Introduction

Background

Mental health difficulties within England are highly prevalent; with one in six people having experienced a common mental health difficulty within the past week (McManus et al., 2016). The findings from this survey provide valuable insights due to the large, representative sample that includes individuals without access to services. Mental health professionals are not immune to these experiences, as evidenced by significant prevalence rates among National Health Service (NHS) professionals (Williams, Michie & Pattani, 1998) and mental health practitioners (Grice et al., 2018; Harris et al., 2016; Sherring, 2019). Although Williams, Michie & Pattani (1998) provide foundational insights, the research is over two decades old, and the working conditions, have likely evolved significantly since then, the applicability of these findings to contemporary contexts may be limited.

Research suggests that mental health professionals are equally as likely to experience mental health difficulties as the general population (Edwards & Crisp, 2017; Harris et al., 2016). Lived experience may be a motivator for some professionals to pursue a career in mental health (Barnett, 2007). However, these studies may be seen as somewhat dated, as mental health trends can evolve over time due to various social, economic, and political factors. More recent research indicates persistently high prevalence rates, with 67% of trainee clinical psychologists (Grice et al., 2018) and two-thirds of qualified clinical psychologists (Tay et al., 2018) reporting experiences of mental health difficulties.

A recent study by Victor et al. (2022a) revealed that 82% of individuals involved in doctoral and internship programs in clinical, counselling, and school psychology, including faculty and students, reported experiencing mental health difficulties, with 48% indicating a diagnosable mental health condition. However, these figures could be underestimates due to stigma (Boyd et al., 2016). In contrast, these studies could be overestimating the prevalence amongst professions due to self-selection bias. As lived experience within the field of psychology is underdiscussed and with limited research, conclusions on prevalence are unable to be drawn (Victor et al., 2022b).

Defining Lived Experience

Lived experience of mental health difficulties is defined by the Group of Trainers in Clinical Psychology (GTiCP) as a "*range of mental health difficulties, regardless of whether the person has received a diagnosis or whether they have used public or private mental health services*" (BPS, 2020 p.7). As noted, this systematic review will use terms such as 'mental health difficulties' and 'lived experience' interchangeably. These terms in this context are being used to capture and acknowledge the complexities of psychological factors and uniqueness of distressing experiences (BPS DCP, 2013).

Clinicians who work within mental health services and have also accessed them have been called 'prosumers' (Manos, 1993). Use of the term 'prosumer' to describe these experiences within the mental health field is s is

becoming increasingly prominent in current literature (Bhattacharya, 2022; Boyd et al., 2016; López et al., 2023).

The unique position of prosumers means incidents of stigma and discrimination are a shared experience within the workplace, training environment and wider society. These experiences can often be a direct result of disclosure or due to witnessed incidents directed towards other colleagues or clients (Bennett, 2012; Burrell-Smith, 2013; López-Aybar & Gonzales, 2024). Deciding to disclose can be a difficult process for practitioners due to anticipated stigma and discrimination.

Stigma

Stigma is defined as "an attribute, behaviour, or reputation which is socially discrediting in a particular way" (Goffman, 1963, p. 3). Goffman also argues that stigma endures through the interactions between those who are stigmatized and those who engage in stigmatizing behaviours within society. Early labelling theories propose that stigma originates when society designates certain behaviours or characteristics as deviant. Once individuals are labelled, they may be treated according to this label, which can lead to self-fulfilling prophecies and perpetuate the stigma (Lemert, 1974). Additionally, Link and Phelan (2001) identify four stages that contribute to the formation of stigma: differentiating differences, viewing these characteristics as undesirable, labelling individuals as 'them' versus 'us', and experiencing negative consequences such as exclusion.

Individuals with mental health conditions are often perceived negatively: as unpredictable, aggressive, or even dangerous (Hinshaw & Stier, 2008). Even perceived stigma can result in individuals concealing mental health difficulties and not seeking support (Corrigan, 2005). Stigma negatively impacts individuals' quality of life by increasing psychological distress (Tsutsumi & Izutsu, 2010). Even anticipated stigma can result in disengagement from communities and activities (Perlick et al., 2001).

Mental health professionals and stigma

Experiences of stigma amongst NHS mental health professionals can vary, however individuals often reported fears of stigmatisation and discrimination (Waugh et al., 2017). Perceived stigma was more frequent than external or self-stigma for mental health professionals (Tay et al., 2018). Psychological practitioners also witnessed stigma within the workplace, training environment and greater society. Psychotherapists with a history of psychiatric conditions reported experiences of stigma and having their competency questioned (Adame, 2011). Similarly, clinical psychologists experienced varying levels of anticipated stigma often due to microaggressions (López-Aybar & Gonzales, 2024). These findings are not limited to psychologist professionals, as mental health professionals have been shown to have self-stigma and workplace stigma (Stuetzle, et al., 2023). However, these studies often rely on self-reported data which can introduce bias, as individuals may underreport or overreport their experiences due to social desirability or recall bias.

As indicated, stigma is prevalent within workplaces and training environments for mental health professionals despite efforts to reduce stigma and encourage lived experience within the workplace. Campaigns such as in2gr8mentalhealth (www.in2gr8mentalhealth.com) and the Time to Change programme (2011), have tried to combat stigma. Professional body support such as the 'Statement on clinical psychologists with lived experience of mental health difficulties' (Hogg & Kemp, 2020) and guidance 'Supporting and valuing lived experience of mental health difficulties in clinical psychology training' (BPS, 2020), recognise the value of clinicians with lived experience.

Mental health professionals themselves are not exempt from holding stigmatising beliefs. Whilst mental health professionals are less likely to discriminate against individuals with a mental health diagnosis, they are still susceptible to stigmatised views (Kopera et al., 2014; Stuber, et al., 2014). Trainee and qualified Clinical Psychologists may have lower levels of stigma compared to other professionals; however, stigmatising views may still be relatively high (Gonzales et al., 2021).

Discrimination

Experiences of discrimination due to mental health difficulties are witnessed within society (Maletta et al., 2023). Discriminatory behaviours stemming from negative beliefs can manifest in subtle forms, such as microaggressions or nonverbal disrespect (Sue, 2010). Whilst, Sue (2010) offers a foundational framework for understanding microaggressions, its broad scope may not capture

the nuanced experiences of specific professional groups. Furthermore, discrimination can have detrimental effects, as individuals with psychiatric conditions who anticipate or experience microaggressions will disengage from their communities (Gonzales et al., 2018). Within the field of clinical psychology, instances of both subtle and overt discrimination directed towards clients and professionals have been witnessed (López -Aybar & Gonzales, 2024).

Evidence suggests discrimination is present towards professionals with mental health difficulties (Joyce et al., 2012). Research by Glozier et al., (2006), reported higher levels of discrimination towards nurses with mental health difficulties compared to peers experiencing physical health problems.

Disclosure

The act of disclosure for mental health professionals with lived experience is complex and multifaceted. Given the stigma associated with lived experience and workplace cultures, the decision to disclose experience to a colleague or supervisor can be difficult. Professionals tend to be more inclined to disclose their lived experience within their personal social circles rather than in their workplace (Tay et al., 2018). This decision may be attributed, in part, to the pervasive stigma and culture surrounding mental health within the professional field (Boyd et al., 2016).

Workplace dynamics, including the prevalence of bullying, further influence the decision-making process, as clinicians may fear judgment if they reveal their mental health difficulties (Bryne et al., 2022; Harris et al., 2019; Harris et

al., 2022). Despite the challenges associated with disclosure, professionals who do decide to disclose their experiences to their clinical supervisor, often do this with the hope of receiving support (Joseph et al., 2022). However, deciding to disclose is not without its apprehensions; practitioners often express concerns about potential stigmatization and doubts around their competency (Adame, 2011; Harris et al., 2016; Huet & Holttum, 2016).

Identity

Constructing identities is a complex process, which some theories suggest are formed from our ingroups (Tajfel & Turner 1979) and the meaning we attach to the roles we occupy (Stryker, 1980/2002). As professionals who both experience mental health difficulties and work in the field, there is a notion of dual identity (Adame, 2011). Mental health professionals with lived experience may construct their identities as both a client and a professional, however these may be seen as separate (Richards et al., 2016). Despite having dual identities, some individuals may experience difficulties feeling fully accepted by either identity (Adame, 2011). Nevertheless, during periods of mental health distress these identities may be imposed on professionals rather than self-constructed (Joyce et al., 2007).

Psychological practitioners with lived experience occupy unique identities; being able to use their experiential knowledge to aid clinical practice and help with therapeutic alliance. These unique insights allow practitioners to

have deeper levels of empathy and understanding (Adame, 2014; Gelso & Hayes, 2007; Gilbert & Stickley, 2012).

Whilst there is high prevalence of lived experience reported amongst mental health professional (Grice et al., 2018; Harris et al., 2016; Sherring, 2019; Tay et al., 2018; Williams, et al., 1998; Victor et al., 2022), there is limited exploration of experiences amongst this population until recently. Previous research highlights shared experiences for practitioners and individuals with lived experience, however by synthesising research it can help to provide further insights into these experiences. Currently there is no systematic review of experiences of mental health difficulties amongst Psychological practitioners .

Aims

The aim of this systematic review is to synthesise Psychological practitioners ' experiences of mental health difficulties findings using a meta-ethnography. As this is the first review into this area, this review aims to gain an understanding of shared experiences within this population, with hopes to gain further insights into the lived experience of practitioners, to identify further areas of research and to inform practice.

The Current Review

The present systematic literature review was established following a broad scoping search of literature in 2023. The scoping search was completed

using online searches (i.e., Google Scholar), databases such as PsycInfo. This process highlighted the recent emergence of research and identified no existing literature reviews in this area.

Whilst the initial scoping search highlighted limited qualitative research given the importance and implications for the profession, a meta-ethnography at this early stage was necessary in order to summarise the current data and to help guide future research.

Method

Defining the Question

To help to define the parameters of the research question within this meta-ethnography, the SPIDER tool was utilised (Cooke et al., 2012).

Table 1.1.

SPIDER Tool for Qualitative Synthesis

Search Component	Description
Sample	Psychological practitioners (e.g. clinical psychologists, therapists, counselling psychologists, art therapists)
Phenomenon of Interest	Studies focusing on the 'Lived experience'
Design	Qualitative designs that use direct quotes from participants as data such as interviews, within the last 15 years
Evaluation	Studies that are related to experiences
Research type	Qualitative methodology, with rich data, or mixed designs but focusing on the qualitative data

Search Terms

Various key terms were identified from the initial scoping searches and through reading relevant literature. Additionally, search terms were explored within research supervision and discussions were had with the library services to help reduce non-relevant literature and ensure inclusion of relevant publications.

To ensure the publications could be understood by the researcher, searches were limited to papers written in "English". Whilst the search terms yield many irrelevant pieces of literature, it was deemed important to have the terms within "all" fields, as restrictions appeared to miss out key pieces of literature.

The phrasings used for the searches are shown below, however the phrasing and input of these terms varied depending on the database used. All the terms used are detailed in the table (Table 1.2) below:

Table 1.2.

Search Terms

Search Component	*Search Terms and Synonyms*
Sample	psycholog* OR "clinical psycholog*" OR therapist* or "art therapist*" or psychotherapist* or "psychodynamic therapist*"
Phenomenon of Interest	*Lived experience*" OR "mental health*" OR "psychological distress*" OR depress* OR anxi* OR "mental illness*" OR prosumer* OR "wounded healer*" OR "exp* mental disorders*" OR "exp* mental health*"
Design *Evaluation*	Interviews, questionnaires "Lived experience*" OR "mental health*" OR "psychological distress*" OR depress* OR anxi* OR "mental illness*" OR prosumer* OR "wounded healer*" OR "exp* mental disorders*" OR "exp* mental health*"
Research Type	Qualitative or mixed methods

Sources of literature

In order to yield the most publications, four databases were utilised for this meta-ethnography, which were selected based on their relevance and appropriateness to the topic. A systematic search strategy was applied to the four databases: Web of Science, Ovid which included PsycInfo and Medline; and CINAHL Plus through EBSCOhost. Searches on these databases were facilitated in Autumn 2023 and repeated in December 2023, to ensure inclusion of any new publications.

Given the search terms used and the topic being reviewed, to ensure experiences were reflective of the current context, the searches were limited to publications within the last fifteen years. To help to maximise the homogeneity between the papers and to ensure accurate data, searches across these databases were restricted to only include papers that were published in English.

Inclusion and Exclusion Criteria

Papers identified from the databases were screened against the inclusion and exclusion criteria, outlined in Table 1.3. The criteria for inclusion and exclusion were developed through discussions in research supervision and based on debates outlined by Meline (2006).

Table 1.3.

Inclusion and Exclusion Criterion for Papers Included in the Review

Inclusion Criteria	*Exclusion Criteria*
Publications which are available in the English language only	*Publications which are not available in English*
Publications exploring lived experience	*Publications which do not explore lived experience*
Publications dated within the time frame: January 2008-December 2023	*Publications are from outside of the time frame*
Primary studies	*Secondary studies (editorials, books, book chapters, reviews, meta-analysis)*
Therapeutic Practitioner- including psychologist, trainee (psychologists and therapists), therapists e.g. art therapist, cognitive behavioural therapist	*Participants are not Psychological practitioners or if the study includes other disciplines and the data for the Psychological practitioners cannot be separated*
Qualitative data	*Quantitative data*
Method of analysis needed e.g. IPA, grounded theory	*No analysis e.g. reflective accounts*
Peer reviewed	*Not peer reviewed*
	Grey studies or conference posters

Selection Strategy

During screening any duplicate journals were identified and removed. All remaining journals (20,899) were screened by their title and abstract against the inclusion and exclusion criteria. Following the initial screening 20,846 papers were excluded. A hand search of reference lists and search engines was conducted, which resulted in one additional paper being included. Full text reviews were completed on 53 papers (See Appendix A), full rationale for exclusions of papers at this stage can be seen in Figure 1. A total of seven papers were included in this systemic review. The process of the paper selection is outlined in Figure 1, which shows a PRISMA flow diagram.

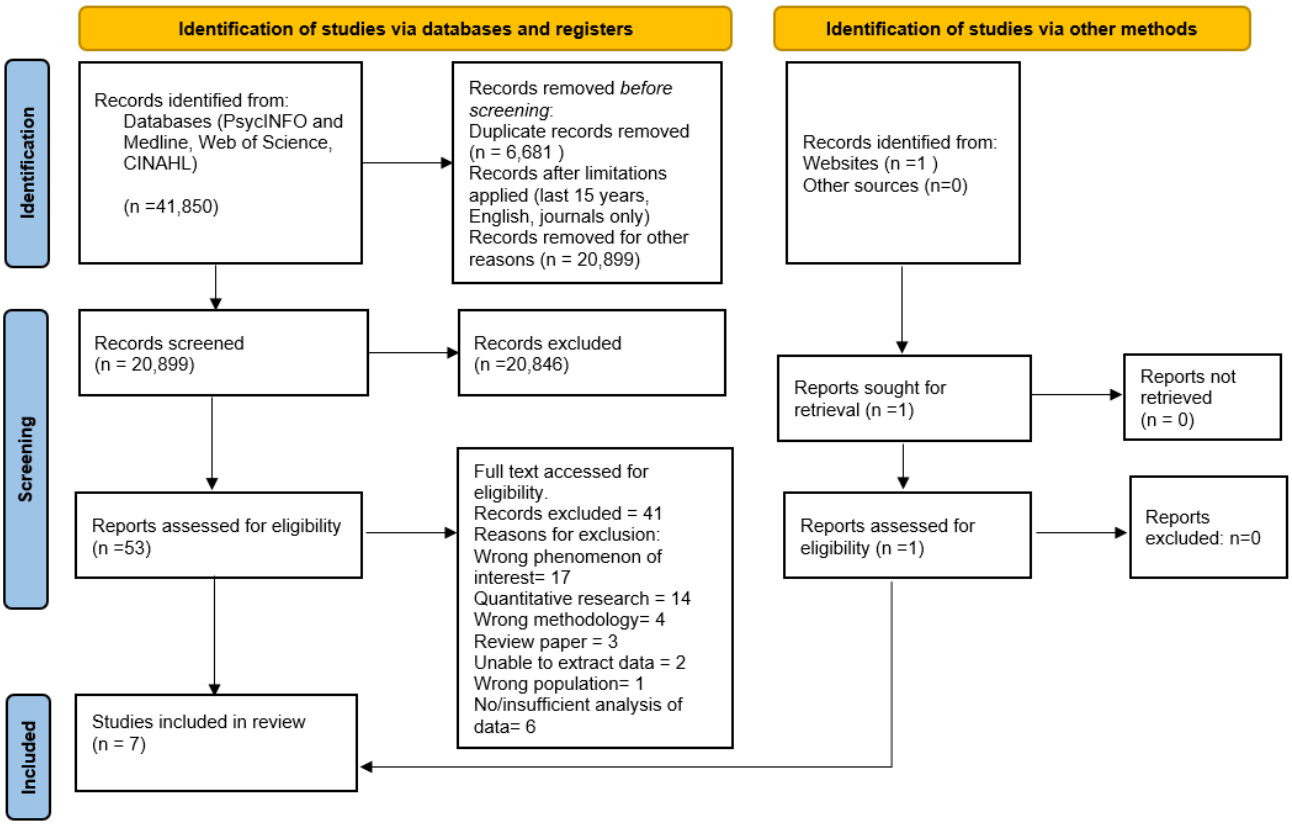

Figure 1. PRISMA flow diagram depicting the procedure of the systematic literature review

Quality Assessment

Seven publications met the inclusion criteria, which were quality checked using the National Institute for Health and Care Excellence (NICE) quality appraisal checklist for qualitative studies (NICE, 2012) (see Appendix B). The NICE checklist consists of 19 items which allows for evaluation for each paper on various areas including methodology, analysis, findings, and the value of the research. Each item requires an assessment to rate whether the studies are appropriate, inappropriate or if the information is unclear. This checklist was selected due to extensive items allowing for adequate consideration of the study's quality.

In addition to the NICE checklist items, the primary author added two items to assess whether the studies defined lived experience and if they stated the professional group of participants. One study (López-Aybar et al., 2023) utilised a mixed methodology, however for the purpose of this systematic review only the qualitative data was used and therefore this was quality checked with the same checklist.

To establish inter-rater reliability, two of the seven studies were randomly selected and rated by another researcher who was blind to the scores. There were minimal differences found between the author and researcher with a percentage agreement of 90.6%. Any discrepancies were discussed until an agreement was reached.

Due to the limited number of studies within this meta-ethnography the quality assessment was not deemed an appropriate exclusion criterion; however, it was an essential process of the synthesis. Moreover, there are no minimum quality thresholds for the inclusion of papers in a meta-ethnography. Instead, emphasis is on the conceptual richness within the studies to allow for data synthesis (Britten et al., 2002). Therefore, the quality checklist was not used for excluding papers but to provide a context of quality.

Meta-ethnography

Meta-ethnography was first proposed by Noblit and Hare (1988) which allows for interpretations of studies made by the meta-ethnographer (Noblit, 2020). Meta-ethnographies methodologies involve interpretive and inductive

synthesis of the studies (Atkins et al., 2008). The seven phases (steps) are outlined below (Table 1.4); it is important to note that these steps may run in parallel rather than independently. Meta-ethnography allows for the synthesis of qualitative research, to re-interpret the themes to gain new insights from third order constructs (Zimmer, 2006) and for conceptual models and theories (France et al., 2016). Furthermore, it allows for further understanding of factors that influence individuals' experience within the phenomenon explored in this systematic review (Grant & Booth, 2009).

Meta-ethnography is a well-established methodological approach that provides novel and comprehensive insights into individual experiences (Fernández-Basanta et al., 2021). This method is particularly effective in capturing the complexity and depth of experiences, allowing for a nuanced understanding of the perspectives of psychological practitioners. By translating and comparing concepts across different studies, meta-ethnography facilitates the development of new theoretical insights and the identification of themes that may not be apparent through other methods. Additionally, it allows for the consideration of the broader context and meanings of experiences, which is essential for capturing the full scope of the lived experiences of psychologists and therapists, often characterized by complex and multifaceted phenomena. In contrast, other methodologies such as narrative synthesis, while useful, may not provide the same level of theoretical insight and integration of concepts. Therefore, employing a meta-ethnographic approach is appropriate for exploring the lived experiences of psychological practitioners, as it enables a unique and profound understanding of their experiences.

Table 1.4

The Seven Phases of Meta-Ethnographic Approach (Noblit and Hare, 1988)

Phase	
1	Getting started
2	Deciding what is relevant to the initial study
3	Reading the studies
4	Determining how the studies are related
5	Translating the studies into one another
6	Synthesising the translation
7	Expressing the synthesis

Meta-ethnography approach

The meta-ethnography was led by the primary author with supervision from the primary supervisor and meta-ethnography workshops with peers under the supervision of the secondary supervisor. Support was received during all seven stages of the meta-ethnography, especially during interpretation, translation and constructing third order concepts.

The author of this systematic review adopted a critical realistic position. This epistemology approach is a branch of philosophy that distinguishes between the observable word and the real word. Critical realism suggests the world we know and understand is constructed from what is 'observable' by our experiences and perspectives, whereas the real world exists independently from perceptions or constructions. With critical realism, ontology reality is categorised by three levels, for the purposes of this systematic review the author focused on the empirical level. At the empirical level experiences are understood through individuals' interpretation (Fletcher, 2017). Thereby this position aids in

understanding of complex human experiences, enriching the following meta-ethnography.

SEVEN PHASES

Phase One, Two and Three

Firstly, the author considered if a synthesis on the topic was required and the suitability of a meta-ethnography approach. Given the growing body of research into this area and the fact that there currently are no other meta-ethnography exploring this phenomenology indicated the need for this meta-ethnography. As this is an under-researched area all types of Psychological practitioners ' experiences were included (e.g. psychologists, cognitive behavioural therapists, psychiatrists who do therapy and trainees). Inclusion and exclusion criteria were followed. The NICE quality checklist was modified, and all papers were quality checked using this.

All studies were read thoroughly to allow the author to become familiar with themes and concepts. A data extraction table was completed (see Table 1.5).

Phase four: Determining how the studies are related

During this phase, the author created a list of themes extracted from each of the journals (see Appendix C). The author then reduced these themes into main categories observed across the papers (see Appendix D).

Phase five: Translating the studies into one another

An important step of a meta-ethnography is determining how the studies in the review are related to one another. As all the papers were sufficiently similar in terms of metaphors and concepts, this allowed for a reciprocal translation. Discussions about translation were had within research supervision and within the meta-ethnography workshops. A table was completed; summary definitions for the second order constructs were documented, this allowed for the similarities across the studies to be highlighted (See Appendix E).

Phase six: Synthesizing translations

As the studies were sufficiently similar it allowed for a reciprocal synthesis. A reciprocal translation was conducted for the first and second order constructs relating to lived experiences of Psychological practitioners . This allowed for the author to arrive at new interpretations and the shared themes across the studies were summarised within the table (see appendix F).

Phase seven: expressing the synthesis

The reporting of the meta-ethnography was completed using the eMERGe reporting guidance (France et al., 2019) to allow for clear and concise reporting of the processes.

Findings

Brief details about the articles

The current systematic literature review consists of seven studies between 2012 and 2023. Five of the studies used in-depth interviews; one study used structured meetings and one study used a survey with qualitative questions. In total the seven studies consisted of 225 participants, with a higher proportion of females reported. Five of the seven papers reported gender identities (Charlemagne-Odle, et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López -Aybar et al., 2023; Turner et al., 2021), with 210 participants' genders reported. A total of 144 female participants were reported, 52 males and 14 non-binary or genderqueer participants. Ages ranged from 26-58 years old across four of the papers which reported age ranges (Cleary & Armour, 2022; Elliott & Ragsdale, 2020; Hadjiosif, 2021;Turner et al., 2021). Some papers chose to limit demographic information to further protect anonymity.

The seven studies consisted of psychological practitioners including trainee clinical psychologists, clinical psychologists, counsellors, integrative therapists, and psychiatrists. See the table below for further information on the participants in the studies synthesised (Table 4). All 225 participants across the seven studies were involved in therapeutic work.

Two of the studies used IPA, two studies used grounded theory, one study used flexible coding, one study used narrative analysis and the final study utilised a collective autoethnography. The two studies that used grounded theory concluded new theories or added to current theories related to lived experiences

(Turner et al., 2020; López et al., 2023). Two studies used IPA to identify, analyse and interpret themes based on participants' experiences (Charlemagne-Odle et al. 2012; Cleary & Armour, 2022). Råbu and colleagues used a collective autoethnography to facilitate intensive exploration of experiences (Råbu et al., 2021). Elliott and Ragsdale used flexible coding for analytical coding of themes from the interviews (Elliott & Ragsdale, 2020). Hadjiosif (2021) adopted a narrative analysis approach to interpret individual stories about their experiences. For a full summary of the studies see Table 1.5.

Table 1.5.
Summary of Studies

Author (Date)	Title	Country	Study Aims	Participant Characteristics	Methodology, Design & Analysis	Key Themes	Key Findings
Charlemagne-Odle, S., Harmon, G., & Maltby, M. (2012)	*Clinical psychologists' experiences of personal significant distress.*	UK	To add to the existing knowledge of professional practice, by exploring experience of distress amongst psychologists	11 Clinical Psychologists (9 females, 2 males)	Qualitative Semi-structured Interviews Interpretative phenomenological analysis	Manifestation of distress Making sense of personal distress Role and effects of others Experiences of help/support Using experiences of distress	Participants conceptualised their personal distress by identifying external and internal causes. Participants also used their psychological knowledge to help them make sense of their distress. If distress is not seen as shaming or stigmatising, then clinicians are more inclined to access support.
Cleary, R., & Armour, C. (2022)	*Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy.*	UK	To explore the experiences of Psychological practitioners with lived experience of mental health issues	2 Counsellors and 1 Psychotherapist	Qualitative Semi-structured interviews Interpretative phenomenological analysis	Identity as a practitioner Self-disclosure as enhancing therapeutic relationships Importance of supervision Healing and recovery	Lived experience amongst practitioners can be important for enhancing therapeutic practice. Lived experience amongst professionals can be an important part of their identity, however there can be factors that prevent exploration of experiences due to stigma and cultures of non-disclosure.
Elliott, M., & Ragsdale, J. M. (2020).	*Mental health professionals with mental illnesses: A qualitative interview study.*	USA	To explore the experiences of mental health professionals who self-identify as having a mental health difficulty	12 Psychotherapists (9 females, 3 males)	Qualitative Semi-structured Interviews Flexible coding	Stigma in the workplace Discrimination and prejudice (indirect and direct) Revealing to coworkers Revealing to clients Concealing Asset or liability?	Stigma and prejudice were observed in other therapists when they made disparaging comments about other people with mental health disorders. Despite the prejudice and need to conceal their meant health problems at work, practitioners found having lived experience made them better at their job.
Hadjiosif, M. (2021).	*The ethos of the nourished wounded healer: A narrative inquiry.*	UK	To explore therapists' personal and professional development in terms of the concept 'wounded healer'	6 Psychological practitioners	Qualitative Interviews Narrative analysis	Entering a community of wounded healers Formulating the wounded healer Deconstructing the wounded healer	Some narratives found positives in being a part of a community and being surrounded by others who have gone through a similar process.

López-Aybar, L., Gonzales, L., & Kanani, A. (2023).	*Prosumers' experiences of stigma dimensions within the clinical psychology field.*	USA	To explore prosumers' experiences of stigma within clinical psychology	175 doctoral level clinical psychologist (including in training) prosumers of any given psychiatric diagnosis as defined in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). 135 cis women	Mixed Qualtrics Survey Grounded Theory	Anticipated Stigma Psychological Distress Over Pathologizing Psychologists as all-knowing)	This study explores the stigma psychologists face being a prosumer. The findings incident that stigma is present within the field in terms of views and attitudes. Participants reported experiences of witnessing colleagues acting on prejudice and stereotypes based on mental illness.
Råbu, M., McLeod, J., Haavind, H., Bernhardt, I. S., Nissen-Lie, H., & Moltu, C. (2021).	*How psychotherapists make use of their experiences from being a client: Lessons from a collective autoethnography.*	Norway	To look in more detail at therapists'˙ experiences of what and how they learn from and use their experiences as clients.	six therapists (4 women and 2 men)	Qualitative Collective autoethnography	Experience of being a client Therapist development Identity	These shared accounts explore how being a client can impact professional roles as therapist. Even if these experiences were positive or negative, therapists were able to draw on them to help them shape their practice.
Turner, K., Moses, J., & Neal, A. (2021).	*"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.*	UK	To investigate the process of self-disclosure of lived experience of mental health difficulties of trainees.	12 Trainee Clinical Psychologists	Qualitative Interviews Grounded Theory	Motivations Enablers Barriers Features of disclosure Impact	This study explores trainee clinical psychologists with lived experiences focusing on disclosure. The study highlights some of the experiences trainee clinical psychologists experience especially in terms of barriers and impact.

Quality of studies

Four of the studies were deemed to be good quality (Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; López-Aybar et al., 2023. Turner et al., 2021) and received a rating on '++ ' on the NICE checklist. Three of the studies received a slightly lower rating of '+' due to uncertainty around fulfilling items on the checklist (Elliott & Ragsdale,2020; Hadjiosif, 2021; Råbu, et al., 2021). Table 7 shows the ratings on the quality checklist and Table 1.6 shows the items of the NICE checklist, including the two additional items. Overall, the studies included in the synthesis had robust research designs, thorough analysis, and well-described methodologies.

Table 1.6.

Quality Check questions, based on the NICE (2012) Qualitative Checklist plus two additional items.

Number	Item	Number	Item
1	*Is a qualitative approach appropriate?*	10	*Is the data analysis sufficiently rigorous?*
2	*Is the study clear in what it seeks to do?*	11	*Is the data 'rich'?*
3	*How defensible/rigorous is the research design/methodology?*	12	*Is the analysis reliable?*
4	*Does the study define 'Lived experience' / mental illness?*	13	*Are the findings convincing?*
5	*Does the study include and define psychological practitioners?*	14	*Are the findings relevant to the aims of the study?*
6	*How well was the data collection carried out?*	15	*Is there adequate discussion of any limitations encountered?*
7	*Is the role of the researcher clearly described?*	16	*How clear and coherent is the reporting of ethics?*
8	*Is the role of the researcher clearly described?*	17	*Is the study relevant?*
9	*Were the methods reliable?*	18	*How well was the study conducted?*

Table 1.7.

Quality Checklist table based on the NICE Qualitative Checklist (2012).

	SECTION 1: Theoretical Approach		SECTION 2: Study Design			SECTION 3: Data Collection	SECTION 4: Trustworthiness			SECTION 5: Analysis						SECTION 5: Ethics	SECTION 7: Overall Assessment	
Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18.**
Charlemagne-Odle, et al (2012)	Appropriate	Clear	Defensible	yes	yes	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	not sure/not reported	Yes	++
Cleary, R., & Armour, C. (2022)	Appropriate	Clear	Defensible	yes	yes	Appropriately	Clearly described	Clear	Reliable	rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropriate	Yes	++
Elliott, M., & Ragsdale, J. M. (2020).	Appropriate	Clear	Defensible	yes	yes	Appropriately	unclear	Clear	Reliable	Rigorous	Not sure	Not sure	Convincing	Relevant	Adequate	Inappropriate	Yes	+
Hadjiosif, M. (2021).	Appropriate	Clear	Indefensible	Yes	Yes	Not sure	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	Yes	+
López-Aybar et al (2023).	Appropriate	Clear	Defensible	Yes	Yes	Appropriately	unclear	Clear	Reliable	Rigorous	Not sure	Reliable	Convincing	Relevant	Adequate	not sure/not reported	Yes	++
Råbu, et al. (2021).	Appropriate	Clear	Defensible	No	yes	Not sure	Clearly described	Not Sure	Not sure	Not rigorous	Not sure	Not sure	Convincing	Relevant	Adequate	Appropriate	Yes	+
Turner, et al. (2021).	Appropriate	Clear	Defensible	Yes	Yes	Appropriately	unclear	Clear	Reliable	Rigorous	Not sure	Reliable	Convincing	Relevant	Adequate	Appropriate	Yes	++

The major themes derived from the Synthesis

From the process of reciprocal translation six major themes and various subthemes were developed (see Table 1.8).

Table 1.8.

Overarching Themes, Subthemes and Papers within those Themes.

Overarching theme	Subtheme	Papers contributing
Stigma	Witnessed stigma Anticipated stigma Internalised stigma	Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023; Råbu et al., 2021; Turner et al., 2021
Discrimination	Discrimination at work or training Discrimination with clients	Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023
Experiences of Distress/ Lived Experience	Enhancing understanding Increasing compassion and empathy Seeing clients as human Reducing negative experiences Strain on mental health	Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; Hadjiosif, 2021; López-Aybar et al., 2023; Råbu et al., 2021; Turner et al., 2021
Identity	Dual identity Wounded Healer	Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; López-Aybar et al., 2023; Råbu et al., 2021; Turner et al., 2021
Disclosure	Disclosure to empower Rules of disclosure Fears and concerns regarding disclosure	Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; Hadjiosif, 2021; López-Aybar et al., 2023; Turner et al., 2021
Support	Available support Lack of support	Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023; Turner et al., 2021

Stigma

Stigma experiences are shared amongst professionals, either directed at themselves or through others, was an overarching theme across the majority of papers (Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023; Turner et al., 2021). Stigma was broken down into three subcategories.

Witnessed Stigma

Witnessed stigma refers to the phenomenon where individuals observe or become aware of the stigma directed toward others. This can involve seeing others being marginalized, discriminated against, or treated unfairly because of their perceived attributes, behaviours, or identities. Within these journals witnessed stigma relates to the professionals observing negative attitudes or beliefs towards colleagues or clients with mental health difficulties. Clinicians shared experiences of colleagues or teaching staff making negative assumptions based on a client's diagnosis (Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023).

López-Aybar et al., (2023) describes psychologists making generalisations based on diagnostic labels and assumptions made on clients' ability to function: *"I have heard various professionals indicate that simply because a patient is schizophrenic or has a disruptive behaviour disorder they will "never be able to get better" (*López-Aybar et al., 2023, p. 4).

Assumptions based on diagnostic labels appeared to be apparent in both workplace and training environments. These assumptions were also displayed by colleagues and trainers making jokes and comments at the expense of the individual or group of individuals. These negative views of others are transparent even pre-qualification during professional training.

"The professor teaching psychopathology class would turn the class into fun and unfortunately, some jokes would be about diagnoses "the last one you'd want to get

in personality disorders", "these people would make very entertaining friends", "the type of schizophrenia you don't want in your family"" (López-Aybar et al., 2023, p. 5).

Similarly, these negative attitudes were witnessed in the workplace as demonstrated in this quote:

"Dr. Baker, a psychologist who experiences intrusive thoughts associated with PO OCD, *described her reaction when she overheard a therapist making fun of exposure therapy in a mocking tone: "It was horrific. I was so pissed off. It's a good thing I was not actually in the room––I was on the phone calling in*"" (Elliott & Ragsdale, 2020, p. 681).

Witnessing stigma within training and workplace perpetuates biases and adds to a culture of not disclosing information. This appears to be a process that happens pre-qualification which can have implications regarding workplace culture, disclosure and help-seeking, as well as individuals' own internalised and anticipated stigma. This is further installed when professional leads are "condescending" towards clients sharing experiences as professionals (Cleary & Armour, 2022).

Anticipated Stigma

Anticipated stigma refers to the expectation and concern that others will hold negative views or beliefs based on an individual's identity, behaviour, or characteristics. In this systematic literature review, anticipated stigma is specifically examined in relation to the lived experiences of practitioners.

Elevated levels of anticipated stigma may affect clinicians' decisions regarding disclosure, seeking support, and the internalization of their professional identity.

Psychological practitioners had worries about "*not wanting to be seen to be weak, functioning less well than anybody else*" (Charlemagne-Odle et al., 2012, p. 245.). Similarly, trainees worried their lived experience would be viewed as weakness by others (Turner et al., 2021). This was further echoed as practitioners voiced fears of not wanting to be seen as incompetent (López-Aybar et al., 2023), or having their fitness to practice or clinical skills questioned (Cleary & Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023; Turner et al., 2021). Some clinicians even questioned that other professionals would query their worthiness in achieving their doctorate (López-Aybar et al., 2023); or if lived experience would impact their career; *"Not sure whether I'm inventing this but I suppose I might think that it would influence my career and that probably they would think less of me"* (Charlemagne-Odle et al., 2012, p. 245).

Professionals engaged in discussions surrounding fears of judgment and subsequently needing to conceal their own difficulties (López-Aybar et al., 2023), as illustrated in the following quote:

"I try really hard to mask it. I have made fun of me about being distracted or forgetful. So I overcompensate by trying to be extremely organized. Also, I have known friends being mistreated while having a panic attack. That has never happened to me but I'm afraid about it happening to me" (p.7).

This quote highlights anxiety induced by witnessing mistreatment and discrimination, further exacerbating professional personal worries.

Additionally, professionals had worries about being accepted by colleagues due to their lived experience (López-Aybar et al., 2023) and concerns about being viewed negatively (Charlemagne-Odle et al., 2012). Anticipated stigma plays a crucial role in disclosure, with professionals facing concerns about others finding out about their lived experience (Charlemagne-Odle et al., 2012) or being selective with their disclosure (Elliott & Ragsdale, 2020). Some diagnoses or traits associated with mental health difficulties were viewed as being more stigmatising.

Internalised stigma

Internalised stigma is the process by individuals absorb and adopt negative societal attitudes and beliefs about themselves, leading to self-criticism, diminished self-worth, and altered behaviours in response to those internalised negative perceptions. Internalised stigma is a process in which individuals from stigmatised groups believe the negative views that others have is true for them (López-Aybar et al., 2023).

Self-stigma is present within professional training (Turner et al., 2021) with trainees being aware of how their own stigma impacts disclosure. These stigmatising views of oneself do not dissolve once qualified; "*Louise had felt until then 'being a psychologist would somehow protect you'. Her distress shocked her 'I'm a psychologist how did this happen to me?'*" (Charlemagne-Odle et al., 2012, p. 243). Shame appeared to be a shared emotion linked to internalised stigma for professionals (López-Aybar et al., 2023; Charlemagne-Odle et al., 2014) and there

were experiences of shame attached to "*being a client themselves*" (Råbu et al., 2021, p. 119).

Perceived competence appears to be of great importance regarding stigma towards oneself. The pressure to behave and act in certain ways (López-Aybar et al., 2023; Turner et al., 2021) appeared to be fuelled by self-stigma, alongside anticipated stigma. Some professionals felt their profession would exempt them from mental health difficulties (Charlemagne-Odle et al., 2012) as further demonstrated in this quote;

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

Practitioners expressed worries and concerns relating to their own clinical practice; extending beyond self-perception and self-worries to apprehensions about causing potential harm to their clients (Elliott & Ragsdale, 2020), as echoed in the following sentiments: "What if I am not a good enough therapist for this person? What if I hurt him intentionally?" (p. 684). Furthermore, professionals expressed worries pertaining to their own clinical abilities and competencies. Practitioners' worries extended to feelings of ineffectiveness or inadequacy related to their clinical work (Charlemagne-Odle et al., 2012). Expanding on this, a practitioner stated;

"If the therapist thinks that they are always going to be wounded, on one level, I think that transmits a kind of despair to the client. If you actually

experience or believe that you can move beyond being wounded, it takes the work to a different therapeutic and healing dimension because this is where, in my mind, being informed by a bigger spiritual framework is really helpful because if you think of the transpersonal and the sense of being able to, as it were, go beyond itself" (Hadjiosif, 2021, p. 58).

This suggests that how practitioners view their lived experiences, can limit therapists' abilities, or even influence clients' feelings.

Professional competency beliefs are negatively influenced by internalised stigma. Some professionals report beliefs of not being capable within their profession (López-Aybar et al., 2023), or questioning their abilities (Charlemagne-Odle et al., 2012) or feelings of embarrassment due to difficulties (Turner et al., 2021). Internalised stigma not only impacts current beliefs about oneself but also beliefs about the future; "*Because I have received a mental illness diagnosis, I am less likely to succeed in my career as a clinical psychologist"* (López-Aybar et al., 2023, p. 6).

Discrimination

One key theme identified during the synthesis is discrimination; in which people with lived experience received prejudicial treatment. This theme is divided into two subthemes.

Discrimination at work or training

Workplace and training environments in mental health services often have occurrences of discrimination. Professionals with lived experience can face disadvantaged treatment from colleagues and management. This includes being denied promotions or experiencing poor treatment (Elliott & Ragsdale, 2020), with one professional finding another job due to treatment from a manager whilst others' shared experiences of invalidation due to witnessed attitudes, as well as experiences of being "othered" by colleagues (López-Aybar et al., 2023).

Professionals spoke about the invalidation and experiences of "gaslighting" within the workplace (López-Aybar et al., 2023). Practitioners shared stories of unfair or poor treatment at work; one participant shared their experience of a manager who "treated me really badly and knew about my condition", "so badly that she found a better job" (Elliott & Ragsdale, 2020, p. 681). Practitioners also discussed how stigmatised views lead to potential punishments for seeking help or speaking up (Cleary & Armour, 2022).

Discrimination with clients

Discrimination was not only observed towards other professionals but also directed towards clients within the services. Professionals reported hearing indirect discrimination from colleagues towards clients with certain diagnostic labels (Elliott & Ragsdale, 2020), and professional biases' influencing labelling clients with certain diagnoses; ""*a lot of times people [other therapists] just label*

people with borderline because they don't like them" (Elliott & Ragsdale, 2020, p. 681).

This was further echoed by colleagues not believing clients unless there was evidence to back their claims;

"*In one community mental health clinic where I did my practicum, my clinical supervisor made fun of patients, mocked them, and said he thought everything they said was a delusion unless proven otherwise. The possibility that they may be telling the truth was inconceivable to him*" (López-Aybar et al., 2023, p. 4).

By witnessing discrimination, it allowed professionals to have an awareness of mistreatment and dehumanisation of individuals with mental health difficulties within the field (López-Aybar et al., 2023).

Experiences of distress/Lived experience

Professionals related their lived experiences to impacting their therapeutic practice and clinical work. These experiences appeared to have many benefits related to the profession; however, there were also some difficulties associated with them. This theme is divided into eight subthemes.

Enhancing understanding

Increased understanding of clients and their experiences are a reported benefit of having lived experience (Charlemagne-Odle et al., 2012; Cleary

& Armour, 2022; Elliott & Ragsdale, 2020; López-Aybar et al., 2023; Råbu et al., 2021). Therapists are attuned to the concept of having a "very deep understanding" (Elliott & Ragsdale, 2020) due to their own lived experiences of mental health difficulties. By having this 'deeper understanding' it leads professionals to be 'richer psychologists' (Charlemagne-Odle et al., 2012), further highlighted in the following quote: *"probably one of the best things that could have ever happened to me in terms of my practice because I have a very deep understanding"* (Elliott & Ragsdale, 2020, p. 683).

Therapists discussed their experiences as an asset for aiding their understanding (Cleary & Armour, 2022). Additionally, more in-depth understanding was seen to add to "competence to treat certain populations" (Elliott & Ragsdale, 2020). Similarly, professionals saw this understanding as adding to their 'insight' and how without these experiences it would impact interventions (Råbu et al., 2021). By having these insights, it facilitated 'a special depth to their work' (Charlemagne-Odle et al., 2012). Professionals also expressed how going through the process of recovery "takes the work to a different therapeutic and healing dimension" (Hadjiosif, 2021, p. 58), further adding unique insights and understanding.

Increasing compassion and empathy

Professionals' own encounters with pain and adversity have been acknowledged as facilitating a deeper comprehension of their clients' suffering (Elliott & Ragsdale, 2020). Furthermore, empathy is an asset for helping clients

within therapeutic settings (Råbu et al., 2021). Practitioners are positioning themselves as being characterized by compassion and empathy due to their lived experiences, driven to encompassing the needs and narratives of their clients (Cleary & Armour, 2022). Increased empathy often emerges as a cornerstone of therapeutic engagement; allowing therapists to utilise this skill rather than relying on clinical training with clients; "*Francesca felt she was more comfortable with 'just being with the person in their situation and not feeling the pressure to come up with the answers'* "(Charlemagne-Odle et al., 2012, p. 247).

Whilst elucidating the potential benefits of increased compassion and empathy, without structured training and supportive supervision, the integration of lived experiences into clinical practice becomes challenging:

"I also think ignoring my lived experience restricts my potential as a future clinical psychologist. I think my experiences will make me more credible, authentic, and empathetic as a clinician, but without proper training and supervision that acknowledges and supports this, it's a lot harder to integrate into my work" (López-Aybar et al., 2023, p. 5)

The quote emphasizes the pivotal role of supportive frameworks and structured training in leveraging the empathetic and compassionate potential in practitioners' lived experiences. Practitioners discussed how alluding to their own experience is one of the ways they try to express empathy (Elliott & Ragsdale, 2020), and explained that empathy extends beyond mere empathic listening (Råbu et al., 2021).

These findings collectively emphasise the role of empathy and compassion, not only as facilitators of therapeutic efficacy but also as intrinsic components of the practitioners' professional identity and practice.

Seeing clients as humans

Professionals viewed '*having a mental illness helped them to see their clients as human beings with the potential to recover and be successful'* (Elliott & Ragsdale, 2020, p. 683). Adding to this, Charlemagne-Odle et al., (2012) reported one practitioner found their lived experience allowed them to more comfortable with "*just being with the person*" (p. 247). Likewise, another professional highlighted the importance of staying with the client;

"I always hold that in my mind, and I just try to ensure that I stay with the client no matter what they tell me, or where their story goes, so that they don't feel dismissed as I did that time" (Cleary & Armour, 2022, p. 1104).

This further supports the notion that lived experience for Psychological practitioners plays a crucial role in seeing clients as human beings, rather than as diagnostic labels.

Reducing Negative Experiences

Through the prism of their own negative experiences of services, practitioners gain insights that inform their professional practice, in hopes of

reducing the likelihood of clients undergoing similar experiences. This sentiment is captured in this observation;

"I want to do everything to make sure no one has a bad experience like I did in the hospital" which was "part of also why I decided I wanted to go into the world of behavioral health because I had such a supportive outpatient team and such a terrible team on inpatient" (Elliott & Ragsdale, 2020, p. 683).

This practitioner expressed their commitment to ensuring clients do not have similar experiences. These adverse experiences serve as motivators for professionals, drawing upon on their own experiences of being clients within mental health services. This not only enhances empathy but also adds deeper levels of insights, which professionals without lived experience would likely not have. This is further echoed bellow:

*"A lot of the clients that I would deal with are people who have had bad experiences with statutory mental health services. And therefore, as a person who has been a client of mental health services … that certainly resonates as well" (*Cleary & Armour, 2022, *p. 1104).*

Professionals can use negative experiences of individual therapeutic interventions to motivate their drive to reduce negative experiences for clients. Psychological practitioners may acknowledge negative aspects of their own personal therapy, which can enable them to cultivate heightened sensitivity towards clients' negative processes (Råbu et al., 2021). Due to lived experiences practitioners may find themselves "wanting to put right" when people are in unfair

situations and a desire of "*wanting people to feel free and to feel more fulfilled*" (Hadjiosif, 2021, p. 60-61).

Strain on Mental Health

Whilst practitioners with lived experience may have increased empathy, it is essential to acknowledge the potential negative ramifications of this phenomenon. Heightened empathy may precipitate a state of 'over-empathizing,' wherein professionals become exceedingly attuned to clients' emotions, to the extent that it impinges upon their own emotional equilibrium (Elliott & Ragsdale, 2020). This is emphasised in a practitioner quote:

"When I say I get it, I do get it. I really do get it. If anything, though, it sometimes has led me to falling in the well of despair with my clients because I over-empathize because I do get it" (Elliott & Ragsdale, 2020, p. 683).

Professionals can find themselves 'flooded' with emotions, which can feel overwhelming and potentially detrimental to their own mental well-being, or at times even triggering (Elliott & Ragsdale, 2020). This is further echoed as professionals reported how clinical work can negatively impact on emotions and increase anxiety (Charlemagne-Odle et al., 2012).

Moreover, professionals spoke about how working with clients with similar difficulties can negatively impact their own wellbeing, and the need to disclose this with supervisors to navigate through this effectively (Turner et al., 2021). López -Aybar et al., (2023) further demonstrated how experiences within

training settings can also impose strains on mental well-being, through witnessing discrimination.

Identity

Dual identity

Identity was an important theme discussed across multiple papers (Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Hadjiosif, 2021; Turner et al., 2021). Practitioners with lived experience suggested the idea of a dual identity, being both a practitioner and someone with lived experience, or the concept of identities being forged (Hadjiosif, 2021). This is the idea of being both the client and the therapist; and how they make sense of this. For some practitioners the identities encompass them whilst other times it may not be present, as echoed in this quote: *"You're always balancing this idea of being both a survivor and a practitioner…but in that moment, I don't know, it was like I was somehow both a survivor and practitioner and yet neither at the same time" (Cleary & Armour, 2022, p.1105).*

For some practitioners they found power in disclosing in terms of them better understanding their own identities, as shown in this quote:

"it's helped me to recognise my boundaries and this position that I take in terms of being a human and being a trainee and having the two together which I still I… feel like I'm still working through but, it's helped me to own it a lot more I think, and own my lived experience and how that helps me as a therapist, as a

psychologist. Um, rather than getting in the way of things" (Turner et al., 2021, p.739).

Wounded Healer

A key part of identity for practitioners involved the concept of being wounded or recognising the importance of their lived experiences. Hadjiosif (2021) suggest that being a wounded healer is a part of practitioners' identities. He further suggests that to deconstruct the wounded healer it's important to own the healing part of the identity. One participant discussed how the healing part of their identity was harder to connect with but emphasises the importance of doing this. This sentiment is further echoed in the following extract: "*Nobody is unwounded. So, there was a sense of yeah, I'm at home with this" (*Hadjiosif, 2021, p. 56).

Lived experience within identity can be a driving factor motivating people to pursue becoming a therapeutic practitioner (Hadjiosif, 2021). Professionals may also use their own positive therapeutic experiences as inspiring professionals to pursue a role as a therapist (Råbu et al., 2021). Suggesting that lived experience is not only an important aspect of identity but can also be a factor in motiving individuals to pursue careers and then adopt a dual identity encompassing both lived experience and professional.

Professionals also discussed the value in going through their own personal therapy, and how their lived experience is a part of their identity (Cleary & Armour, 2022). Whilst many practitioners were able to acknowledge their experiences were a crucial part of making their identity, some accepted their lived

experience was "inherent in their temperament or biological" (Charlemagne-Odle et al., 2012). Additionally, some practitioners felt the desire to conceal their wounded healer identities or expressed fears of having their identity reduced to their lived experience (López-Aybar et al., 2023).

Disclosure

Disclosing lived experience to other colleagues, supervisors or clients is another key theme across the studies. Disclosure is a wider overarching theme explored in the studies, with three subthemes; disclosure to empower; rules of disclosure and fears around disclosure.

Disclosure to Empower

Self-disclosure amongst professionals can facilitate empowerment for clients and others with similar experiences. It can be utilised to help show that it is "not a battle that is doomed" (López-Aybar et al., 2023). This can help to install hope for clients, as well to help clients (Elliott & Ragsdale, 2020). This is echoed in the form of this anecdote from a practitioner *"featuring her own experience as an example of how successful working professionals can live with serious mental illness when she lectured on the subject" (*Elliott & Ragsdale, 2020*, p.682).* This highlights the potential power in professionals sharing their experiences.

The utilisation of self-disclosure within the therapeutic environment, as noted by Cleary & Armour (2022), serves to foster a sense of reassurance for

clients, validating their experiences and allowing clients to be aware they are not alone. Self-disclosure, not only aids in the understanding of clients' perspectives but also helps the cultivation of meaningful therapeutic relationships. As illustrated in the following anecdote shared by a practitioner: *"That absolutely flipped the whole therapeutic relationship. The lad's hood came down, he sat back in the chair, and he began to open up, and it developed into an absolutely amazing therapeutic relationship where he has changed beyond recognition"* (Cleary & Armour, 2022, p. 1105).

Moreover, Elliott & Ragsdale (2020) highlights the therapeutic benefits of revealing lived experiences to clients, emphasizing its beneficial role in therapeutic alliance. This concept is further corroborated by López-Aybar et al., (2023), who highlight how experiences of mental health difficulties enable professionals to feel connected to their clients and in turn enhance therapeutic relationships. Collectively these insights emphasise the benefits of lived experience in enhancing therapeutic alliance and relationship development. Similarly, Hadjiosif 's (2021) study emphasises the importance of how practitioners view their lived experience; "*If you actually experience or believe that you can move beyond being wounded, it takes the work to a different therapeutic and healing dimension" (p. 58*), highlighting how lived experiences can enhance therapy and therapeutic relationship. Furthermore, the notion of disclosure can also allow practitioners to enter a 'community of wounded healers' (Hadjiosif, 2021). By entering this community, it can be empowering for the professional themselves and those colleagues with similar experiences. Professionals also touched on the point that helping (Elliott & Ragsale, 2020) and aiding understanding (Turner et al., 2021) are

important motivators and consequences of disclosure. These two concepts are basic foundations to empower others and oneself.

Rules of Disclosure

Alongside anecdotes and exploration of disclosure, professionals spoke about rules associated with their disclosure. These rules were sometimes guided by practice e.g. DBT rules (Elliott & Ragsdale, 2020). Other times these rules were associated with their own boundaries and for considerations about the reasons behind the disclosure, as shown in the following quote:

"I do have particular rules for myself, and also DBT has rules about self-disclosure. The first thing is why am I doing this? Am I sharing it for myself? Or am I sharing it as a way of modelling to the client of building additional rapport because maybe they're saying you don't get it . . . Am I saying it out of frustration because I really do get it, and I want them to understand. Then no, I don't share. Again, that's the self-serving part. If I'm doing it to model coping, to model success, to model the ability to be resilient and still live a life, even if there is a struggle, then that's something that I've done" (Elliott & Ragsdale, 2020, p. 683).

Similarly, professionals discussed the importance of understanding who the disclosure is for and to consider the appropriateness of self-disclosure;

"While Lisa worked through this disclosure to build a positive relationship with her client, she addresses the damage this may have caused to the therapeutic relationship: "That really did have the potential for a major rupture in the

relationship there." Lisa's account thus highlights the importance of consideration of the client's needs and self-reflection before self-disclosing" (Cleary & Armour, 2022, p. 1106).

Alongside this, there are suggested unwritten rules professionals may have when disclosing to colleagues or supervisors which involve consider the context of disclosure and whether the mental health difficulty is current or historic (López-Aybar et al., 2023).

Fears and Concerns Regarding Disclosure

Psychological practitioners had worries in regard to disclosure of their lived experience. Some practitioners had concerns they would be reduced to their diagnosis: "*they would always blame it on the condition and not just the situation*" (Elliott & Ragsdale, 2020, p. 682). Furthermore, practitioners were "*scared to death*" of being "outed" due to worries this would result in termination of career (Elliott & Ragsdale, 2020), adding insights into reasons why professionals may struggle to disclose or may choose not to disclose information. Feelings of fear and shame associated with self-disclosure could be contributing to this, as shown in the following extract: '*Ann reported being 'petrified' others would find out, and relieved her GP volunteered to write 'virus' on her sick form*' (Charlemagne-Odle et al., 2012, p. 245).

Professionals also expressed worries about how their disclosure would be received by other professionals, and fears "it wouldn't be well received"

(Charlemagne-Odle et al., 2012). This is further echoed in worries about potential loss of trust from colleagues based on disclosure (López-Aybar et al., 2023).

Professionals wanted to be seen as capable and competent, they appeared to have worries about how disclosure would negatively influence colleagues' views on them. Symptomology or types of diagnosis related directly to perceived levels of anticipated stigma. Some practitioners believed that certain type of diagnoses would hold less stigma as perceived severity and impact on functioning was low (Elliott & Ragsdale, 2020; López-Aybar et al., 2023). This is further echoed in the following quote; ""I *don't have a problem telling supervisors that I struggle with depression" because "there's not a ton of stigma around it. I would never want them to know about self-injury""* (Elliott & Ragsdale, 2020, p. 682).

Support

The final key theme that emerged from the meta-ethnography is support, which is broken down into two sub-themes: available support and lack of support. Support or the lack of it, appeared to be an important factor in professionals' experiences.

Available support

Support available appeared to vary, with the main types mentioned being medication and therapy; however, '*the use of medication elicited mixed responses'* (Charlemagne-Odle et al., 2012). There appeared to be some apprehension and ambivalence from some professionals towards the use of

medication for mental health difficulties. In order to access support, some professionals spoke about the need to disclose their lived experience (Turner at al., 2021).

Other forms of support included the use of supervisors to help provide insights into their 'inner world and an understanding of the ways in which client presentations may produce countertransference' (Cleary & Armour, 2022). Professionals were able to feel supported in their work environment in a variety of ways, such as 'managers being flexible about timekeeping and reducing pressure' (Charlemagne-Odle et al., 2012, p.247).

Self-help strategies were utilised by some practitioners to support their mental health difficulties (Charlemagne-Odle et al., 2012). Practitioners were able to use their own knowledge and clinician skills of therapeutic interventions to help with their own well-being as shown in the following extract: "*a lot of mindfulness-based cognitive therapy and DBT, and behavioural, in the process of helping my clients, I helped myself for sure*" (Elliott & Ragsdale, 2020, p. 684).

Lack of support

Whilst professionals spoke about support available and positive experiences of support, clinicians also had experiences where there was limited or no support available. Some clinicians were advised in "*concealing their identities as prosumers*" (López-Aybar et al., 2023). In some situations where professionals did disclose to their supervisors, they had experiences of being infantized and stigmatised (Cleary & Armour, 2022). Some of these unsupportive gestures

included ‘inflexibility’ and ‘lack of faith among colleagues’ (Charlemagne-Odle et al., 2012).

Professionals also discussed concerns over standards of support available, including the idea that due to their career they would need a more qualified therapist than what is typically offered (Charlemagne-Odle et al., 2012).

Quality of Papers and Themes

Overall highest quality papers contributed to all themes. Whilst there are fewer contributions from Hadjiosif (2021) and Råbu et al.’s (2021) papers, these are lower rated papers. The theme of discrimination has the lowest number of contributing papers, with three papers; however, these include two very high-quality rated papers. As all themes have a range of high-quality journal contributions, the findings should be reliable.

Discussion

Overview of Findings

The aim of this meta-ethnography was to examine and synthesise existing research exploring the lived experiences of mental health difficulties amongst Psychological practitioners , including psychologists, therapists, and trainees. The meta-ethnography identified six overarching themes across the papers, illuminating key shared experiences and understandings of Psychological practitioners with lived experiences. In total the meta-ethnography explored six

qualitative publications (Charlemagne-Odle, et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; Hadjiosif, 202; Råbu et al., 2021; Turner et al., 2021) and one mixed-methods publication (López-Aybar et al., 2023).

Stigma was a key overarching theme experienced by participants. Experiences of anticipated stigma influenced participants' disclosure due to fears of being judged, worries about prejudice or discrimination based on their mental health difficulties. The experiences of anticipated stigma described by participants are congruent with other research definitions (Earnshaw & Chaudoir, 2009). Similarly, practitioners experienced internalised stigma whereby they absorbed the negative perceptions and beliefs about mental health and applied it to themselves, which is congruent with other research's definitions (Corrigan & Watson, 2002). The findings from this review are in-line with other research, highlighting that stigma is an important factor influencing approaches to help-seeking (Klein et al., 2023; Yanos, 2018), can cause practitioners to devalue themselves (Corrigan, 2012) and acts as a barrier to disclosure (Tay et al., 2018).

Within this review participants reported limiting disclosure due to the stigma attached, worrying about judgment from others, not wanting to be seen as incompetent or having their fitness to practice questioned. Due to these factors, some participants made the decision to conceal or limit disclosure. Similarly, previous research suggests stigma and fears of judgement are important factors in disclosure for professionals (Bryne, et al., 2022; Dewa, et al., 2021; Grice et al., 2018; Mitchell, 2018; Waugh et al., 2017; Yanos, 2018). When choosing to disclose, participants had unwritten rules to reflect on their decisions. Participants reflected

on the appropriateness of disclosure, considering who the disclosure was for and having boundaries in place.

These finding agree with those from previous research, whereby individuals reported reluctance to disclose their lived experience to colleagues (Gras et al., 2015; Harris et al., 2016). However, this review highlights the importance of disclosure, with participants discussing times when disclosing their lived experience had been empowering. These themes suggest there is a wider systemic culture of stigma within workplaces and training environments which can be perpetuating beliefs around disclosing mental health difficulties. The findings also highlight when professionals may choose to conceal their lived experience, due to stigmatising views within the workplace. Research suggests that individuals with lived experience who must conceal part of their identity experience distress as result (Rüsch et al., 2014) and individuals have the desire to be their "authentic selves" within the workplace (Jones & King, 2013).

Whilst participants spoke about the many benefits of lived experience, they also reflected on the potential strain; this included over-empathising and feeling triggered. This further emphasises the need for workplace cultures to feel safe and non-stigmatising, so professionals feel able to disclose to supervisors and access support when needed.

Participants reported the benefits of their lived experience bringing skills that can be utilised within clinical practice. These skills included enhanced understanding of lived experience, increased compassion, and empathy with clients, enhancing therapeutic alliance and dedication in reducing negative

experiences. The unique insights and experiences provide an advantage over professionals without lived experience. Therefore, professionals with lived experience can be an asset to the workplace as they bring unique expertise. Given this, it would be important for workplaces and training settings to consider how they help support employees with lived experience and are able to utilise and learn from their skills. Recent research highlights how mental health professionals with lived experience can improve service users' experiences of care (King et al., 2020) and that practitioners with lived experience are perceived as more skilled by service users (Kaufman, 2016; Lewis-Holmes, 2016).

Strengths

The findings of this meta-ethnography are strengthened by several methodological factors. One strength is the quality of the publications as they were deemed good and high-quality papers. The quality assessment involved two different assessors with high inter-rater correlation. Additionally, in order to conduct a thorough search of the current literature, care was taken with generating the search terms identified within the SPIDER tool and robust search strategy was employed. Another strength of the methodology is the search terms utilised. Whilst these terms appear broad, it ensured relevant publications were not missed.

This review also benefited from having a homogeneous group, whilst participants had various professional titles, all completed therapeutic interventions with clients. As the participants across the publications have similarities this adds to the generalisability for applying these findings for Psychological practitioners .

Whilst the number of publications within this meta-ethnography is relevantly small, it brings together the data as a collective, allowing for identification of commonalities across the studies and highlighting gaps in knowledge (Samnani et al., 2017). The topic of this meta-ethnography is current and new, with six of the studies being published in the last five years, therefore, providing first insights into collective themes and shared experiences.

Limitations

The original aim of the meta-ethnography was to explore lived experience within clinical psychologists; however, due to the lack of available publications the review was expanded to focus on the therapeutic practitioner. Due to the limited sample size, it is important to recognise the implications on generalising these findings. Whilst the research is current, there are only seven publications included in this meta-ethnography with two of these publications not drawn upon as frequently as others; however, these papers were not as high-quality as others within the review. Therefore, any conclusions from this meta-ethnography may be limited and considerations are needed in generalising these conclusions.

As the initial search was limited to publications written in English, there was a lack of publications from non-English speaking countries. Out of the seven publications, four of the studies were from the UK, meaning there may be limited application to applying these findings to UK mental health training or workplace environments. As the review includes studies from other countries, it may impact on individuals' experiences within the workplace and training settings. Within these

countries there may be differences in workplace or training culture, which may in turn influence participants' beliefs, attitudes, and experiences.

Whilst not all participants' demographics were reported, those publications which reported their demographic information indicate that the majority of participants were white females. This has implications on generalising the findings.

Another limitation is the lack of exploration of intersectionality, social GRACES (Burnham, 2012) and other identities with lived experience. These other identities could add another lens to experiences within the workplace and education settings. Research indicates minoritized identities impact individuals' journeys into clinical psychology, their future hopes, experiences, and their sense of otherness (ACP-UK, 2022). These identities may have impacted participants' experiences of lived experience.

Finally, an important consideration is the potential author biases, despite efforts to limit this with the use of a reflective journal, supervision and meta-ethnography workshops. Biases could be due to the author's own ideas or experiences pertaining to the topic of the meta-ethnography; especially given the author is a trainee clinical psychologist with lived experience.

Implications for practice and research

Due to the shared experiences of stigma and discrimination for practitioners with lived experience, there is a need for non-stigmatising practices within the workplace and education settings. This could include having open conversations about lived experiences within the profession at training level to start normalising this experience, and then encouraging these conversations to continue within

workplace settings. It could also include managers and services thinking about how they make accommodations to support staff with lived experience such as flexible working. These practices could aid in challenging stigma and allow for learning from practitioners with lived experience. Additionally, changes to practice could dismantle harmful stigma and encourage practitioners to seek help.

These findings can be beneficial within workplace and educational settings; which may have implications for the theoretical understanding of lived experiences for Psychological practitioners in addition to clinical practice. Lived experience is evidently prevalent amongst Psychological practitioners and is a topic that is coming to light as more practitioners are publicly disclosing their stories and more research is being conducted. The themes within this meta-ethnography can help aid understanding and can be utilised by workplaces, colleagues, supervisors and training settings to help reduce stigma, increase help seeking and to create supportive environments so practitioners can use their experiences as an asset. By workplaces valuing lived experiences, having open conversations about mental health and managers thinking how to support their staff can all help to create a supportive environment for practitioners.

Future research

There is a need for future research exploring lived experiences amongst psychologists, trainee clinical psychologists and Psychological practitioners . It would be beneficial to have further research at different career points such as pre-training, on training, newly qualified and senior, especially for practitioners working

specifically within the UK and NHS. It would also be beneficial to explore intersectionality of multiple minority experience (e.g. LGBTQ+ or ethnic minorities) with lived experience. As practitioners with lived experience reported having assets such as increased empathy and benefits highlighted within the personal practice model (Bennett-Levy & Finlay-Jones, 2004), future research comparing these attributes within Psychological practitioners with lived experience and those without would be beneficial.

Conclusion

This meta-ethnography further highlights the experiences of Psychological practitioners with lived experience; outlines the strengths and limitations of research. This review identities the need for further research into experiences of practitioners, as they involve complex processes that need further investigation. The experiences of Psychological practitioners with lived experience are complex and vast. Key elements of experiences were found across the studies from experiences being seen as aiding therapeutic skills to rules around disclosure. Professionals experienced stigma and discrimination either directly or observed, which impacted on disclosure and worries and fears. These findings are congruent to previous research on experiences of mental health difficulties for Psychological practitioners . Work settings and education providers have an opportunity to learn from these experiences to help reduce stigma, discrimination and utilise the unique expertise lived experience brings.

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CHAPTER TWO

Empirical Research Paper

Exploring the experiences of trainee clinical psychologists with lived experiences of mental health difficulties

Abstract

Aims: This research aims to explore the lived experience of mental health difficulties amongst Trainee Clinical Psychologists.

Background: Previous research highlights the high prevalence of mental health difficulties amongst Trainee Clinical Psychologists. However, there is little research exploring what experiences of training are like for Trainees with lived experience.

Method: Semi-structured interviews were completed for eight Trainee Clinical Psychologists who identified as having lived experience. The interviews explored their experiences of training including teaching, assignments, research and placement. Transcripts were analysed using Interpretative Phenomenological Analysis.

Results: Five overarching themes were found; identity, safe spaces, disclosure, psycho-emotional experiences, and strengths. These themes captured the participants experiences of training and highlight the unique insights these trainees had with being both a professional in mental health services and accessing mental health services.

Conclusion: The experiences of Trainees with lived experience are complex. Whilst the experience can vary, there appeared to be shared experiences for trainees. From the findings of this study training courses need to encourage open conversations about mental health to help reduce barriers and stigma. Courses are recommended to facilitate peer reflective practice groups to create safe spaces for

Trainees to reflect on their experiences in the context of their professional role. Training for course staff, supervisors, and support systems is needed to enhance support for trainees. And finally, courses should utilise implementing disclosure frameworks.

Keywords: Trainee Clinical Psychologists, clinical psychology, lived experience, mental health difficulties.

Introduction

Background

Prevalence of mental health difficulties in the United Kingdom (UK) has increased since 1993, according to the most recent figures (House of Commons Library, 2013). Recent statistics indicate that 41% of adults encounter diagnosable mental health difficulties at some point in their lives, and 27.7% have received a diagnosis from a professional (Mental Health Foundation, 2016). However, these findings may be underestimating the prevalence as the data does not include those who did not seek support or those who sought private support. Individuals frequently reported barriers disclosing mental health difficulties due to stigma or barriers accessing support (Salaheddin & Mason, 2016). Mental health professionals are not exempt from mental health difficulties; with lived experience being prevalent amongst psychological professionals (Grice et al., 2018; Rao, et al., 2016; Tay et al., 2018). Lived experience may be a motivator for many mental health professionals to pursue such a career (American Psychological Association [APA], 2010; Smith & Moss, 2009). Whilst there is extensive research focusing on mental health difficulties within the general public, there is limited research exploring these experiences within professionals working in mental health services.

Defining lived experience

The British Psychology Society (BPS) defines Lived Experience of mental health difficulties as a "*range of mental health difficulties, regardless of whether the person has received a diagnosis or whether they have used public or private mental*

health services" (BPS, 2020 p.7).The terms 'lived experience' and 'mental health difficulties' will be used interchangeably to describe Trainees' experiences. These terms are used to describe the psychosocial factors, content and individualness of these experiences (BPS DCP, 2013).

Doctorate in Clinical Psychology Context

To become a qualified Clinical Psychologist in the UK, individuals must complete the Doctorate in Clinical Psychology (DclinPsy). The DclinPsy in the UK is a three-year doctoral programme, consisting of clinical, academic and research components. Trainee Clinical Psychologists (Trainees) on the programme are employed by trusts within the National Health Service (NHS). Over the last few years, the number of Trainees has gradually increased as a result of the increased funding from the NHS Long Term Plan, see Table 2.1.

Table 2.1

Table to show applicant rates from 2019-2023

Year	Places*	Applications*	Success Rate
2019	614	4,054	15%
2020	770	4,225	18%
2021	979	4,544	22%
2022	1,155	4,655	25%
2023	1,166	4,990	23%

From https://www.clearing-house.org.uk/about-us/number-places

*note these numbers do not include figures from two courses of candidates who do not require application via the clearing house.

The increased number of places on the DclinPsy is due the Psychological Professions Workforce Plan for England (NHS Health Education England, 2021), which aims to grow the psychological profession by 2024. This expansion of psychological professionals aims to support the NHS Long Term plan (NHS, 2019) by improving access to services, embracing new ways of working and to diversify the workforce.

Trainees are professional practitioners who must adhere to guidelines including the code of ethics of the BPS (BPS, 2021) and the Health and Care Professions Council (HPCP). Therefore, Trainees are bound to fitness to practice which is to ensure the safeguarding of their clients' wellbeing alongside side their own.

Trainees and Lived Experience

Trainees are equally or more likely to experience lived experiences of mental health difficulties than the general population (Brookes et al., 2002; Cushway, 1992; Pakenham & Stafford-Brown, 2012). Training can be a highly stressful experience for Trainees, with 59% of trainees scoring within the threshold for a mental health problem on the General Health Questionnaire (Cushway, 1992). While these studies provide valuable insights, their dated nature may not fully reflect current conditions. Trainees have shared that their experience of training has increased problems with depression and interpersonal difficulties (Kuyken et al., 2003). In a survey completed across 19 UK DclinPsy, 67% of the 348 Trainees reported having lived experience (Grice, et al., 2018), which is similar to the findings of qualified

clinical psychologists (Tay et al., 2018). Whilst these figures potentially overestimate the prevalence of lived experience due to selection bias, it highlights that these experiences are prevalent within Trainees.

Recently there has been increased recognition in the value of lived experience within mental health professional training, resulting in changes within teaching and reflective practice within training programmes (Health and Care Professions Council, 2017; in2gr8mentalhealth, 2020; The King's Fund, 2017). Recently the British Psychology Society (BPS) published guidance valuing lived experience amongst Trainees and suggesting how to best support them (BPS, 2020). Within the guidance the BPS acknowledges the unique expertise lived experience can bring within the profession and emphasises the value professionals with lived experience can bring into the field of psychology. However, even with recent publications, training course and policies designed to support trainees with lived experience are often inadequate (Victor, et al., 2022).

Unique Insights

As previously mentioned, experts by experience are often utilised within NHS services as their expertise means they have special insights and knowledge which is valuable within services (Ahuja & Williams, 2005). And whilst experts by experience's experiences are valued and their skills are utilised, there is currently less focus on the expertise of professionals with lived experience. Whilst there is limited research specifically on Trainees, conclusions can be drawn from research focusing on psychological practitioners due to similarities within their roles.

Practitioners with lived experience are in a unique position as they have their experiential knowledge, alongside their clinical knowledge to inform their practice and connect with clients (Cleary & Armour, 2022). These unique insights into their own suffering and distress allow for empathic, compassionate and deeply understanding practitioners (Adame, 2014; Gelso & Hayes, 2007; Gilbert & Stickley, 2012). In recent research, Trainees reported a deeper sense of empathy with their clients; allowing them to 'walk alongside' their clients (Reid, 2023). Lived experiences can also cultivate authenticity and increase resilience (Burks & Robbins, 2012; Gilbert & Stickley, 2012) and enhances their practice (Cleary & Armour, 2022) Due to their own experiences practitioners may challenge the medicalised approach to mental health (Adame, 2011; Byrne et al., 2016). These unique insights can be beneficial for services and clients by promoting recovery and aiding with therapeutic alliance.

Whilst practitioners may choose not to disclose to their clients, for some, knowing their therapists has recovered from mental health difficulties can increase their hope of recovery (Kottsieper, 2009). There can also be benefits from sharing experiences with clients as it helps to balance the power inequalities within the therapeutic relationship and can aid to normalise clients' experiences (Adame et al., 2017; Zerubavel & Wright, 2012). Whilst there are many benefits of lived experience, there is also the potential for practitioners to over-identify with their clients (Goldberg et al., 2015) and make assumptions on clients due to their own experiences (Zerubavel & Wright, 2012).

As psychologists are role models for society, there is a need for practitioners with lived experiences to help to address stigma and normalise mental health, firstly within the professional community and then extended to the wider society (Victor et al., 2022).

Disclosure

Disclosure is the sharing of personal information with another person (Chaudoir & Fisher, 2010). Whilst there is an increased recognition in the value of lived experiences, professionals are still faced with the dilemma of whether to disclose their lived experience (Turner et al., 2021; Vally, 2018; Waugh et al., 2017). Moreso, ethical guidelines around disclosure can be ambiguous (Dunlop et al., 2022), making it difficult for practitioners to know how and when to disclose. Practitioners can have apprehensions towards disclosing due to fear of stigmatisation or having their competencies questioned (Harris et al., 2016; Huet & Holttum, 2016). Therefore, practitioners may choose to conceal their lived experiences or limit their disclosure. Clinical psychologists are more likely to disclose their experiences within their social circles rather than within workplaces (Tay et al., 2018), further highlighting the potential stigma within the profession.

Turner et al. (2021) identified various factors that are part of the decision making for disclosure for Trainees, these included enablers, barriers, and motivations. This emphasises the complex nature of disclosure for Trainees and factors that could increase or decrease the likelihood of self-disclosure. Further research exploring disclosure within supervisory relationships found four core

themes including 'setting the scene', 'using self-disclosure', 'the supervisory relationship' and 'reviewing outcomes of self-disclosure' (Spence et al., 2014). Similarly, research exploring disclosure by Trainees has highlighted the need for trusting supervisory relationships to facilitate disclosure (Lemoir, 2013; Mehr et al., 2010; Staples-Bradley et al., 2019).

Identity

Identity is the construct of how we understand ourselves or others with society, based on the roles we occupy or the social groups we are affiliated with. Social identity theory (Tajfel & Turner, 1979) suggests identities are constructed from in-and-out group connections whereas other theories suggest identity is constructed from the meaning we attach to our roles (Stryker, 1980/2002). Professionals with lived experience would be seen as being in both an outgroup with their mental health difficulties, and have certain meanings attached to their professional role, which would fit in with the notion of a dual identity (Adame, 2011) whereby, they have identities as both a professional and someone with mental health difficulties. However, whilst mental health professionals with lived experience may construct dual identities, these may never be seen as separate but will hide parts of their identity in certain contexts (Richards, et al., 2016). This is suggesting that Trainees with lived experience may see their identities as intertwined and both an important part of them. Professionals also spoke about not feeling accepted by either identity (Adame, 2011), which could relate to the stigma or perception around both identities.

Further adding to the dual identity, professionals often relate to the idea of the wounded healer (Hadjiosif, 2021), a concept originally from Greek mythology but is often used in within the psychological field. Wounded healers can use the power from healing their own wounds to help heal others. The concept of wounded healers means the practitioner can be both wounded and healer (Zerubavel & Wright, 2012).

Additionally, research exploring professional identity within doctorate level students suggested that transitions into new roles can lead to identity adapting into a new sense of self (Colbeck, 2008). The transition to a Trainee and then future transition into qualified Clinical Psychologist could be important factors into construction of identity, and lived experience could also influence sense of self.

Rationale and Aims of Research

Despite reported high prevalence of Trainees with lived experience, and increased recognition of valuing lived experience (BPS, 2020; Health and Care Professions Council, 2017; in2gr8mentalhealth, 2020), relatively little is known about experiences of training. There is limited research on lived experience amongst trainee psychotherapists (Byrne & Shufelt, 2014) and some exploring Trainee Counselling Psychologists (Kumary & Baker, 2008). Yet there is a dearth of research exploring experiences of Trainee Clinical Psychologists with lived experience. Trainees are in a unique position, whereby they are potentially attending teaching session on their mental health difficulties and potentially

working within mental health services whilst also having or having previously accessing them.

Overall, the current existing literature on Trainee Clinical Psychologists with lived experience is limited. Therefore, further exploration of the experience is important to gain insights and deeper understandings into these experiences across all aspects of training. In addition, further research will aid in highlighting the unique set of skills Trainees with lived experience have and try to normalise these experiences, in turn reducing stigmatising practices within training.

This study aims to answer the following research question: '*What is the experience of training on the DClin like for trainee psychologists with lived experiences of mental health difficulties*?' By addressing this question, the research seeks to gain comprehensive insights into the various facets of their training, including placement, research, and teaching. It will explore the unique challenges, coping mechanisms, and support structures that shape their experiences. This study not only aims to enhance understanding of these trainees' experiences but also to inform the development of more inclusive and supportive training environments within clinical psychology programs.

Method

Design

This research utilised a qualitative methodology via individual interviews and Interpretative Phenomenological Analysis (IPA) to explore how individuals make

sense of their experiences (Smith et al., 2022). IPA was most suitable for this research topic, due to its analysis of in-depth exploration of personal experiences and how people make sense of these (Larkin et al., 2006; Smith & Osborn, 2008). Additionally, IPA is useful as findings can be translated into meaningful recommendations, as it allows for theoretical underpinnings that link psychological and experiential constructs (Shinebourne, 2011). Foundations of IPA are based in philosophy; informed by phenomenology, ideography, and hermeneutics (Smith, 2011).

Ethical Considerations

Ethics is an important factor in research, providing guidance on basic conduct (Munhall, 1988). Ethics pertain but is not limited to; informed consent, confidentiality, protection from harm, deception (Guillemin & Guillemin, 2004). Ethical decisions on this research were informed by the British Psychological Society's (2021) Code of Human Research Ethics. The researcher and supervisor wanted to ensure all participants were treated with dignity and respect (Kraft, et al., 2020). This research gained ethical approval from the University of Birmingham (UoB) Research Ethics Committee (see Appendix G).

Individuals interested in the study were informed about the nature of the study, including the aims of the research. Fully informed consent was gained prior to the interviews, as participants signed a consent form (Appendix H). Participants were invited to select their own pseudonyms for the research and for those who chose not to select one, a random name generator was used. This was to allow

participants to feel empowered and consider a name that allows for meaningful narratives (Allen & Wiles, 2016). Identifiable characteristics such as geographical location, university, or specific unique details, were removed to ensure anonymity. One participant provided context to the interviewer but requested some details to be removed from the transcript to protect their anonymity.

Given the nature of the research, there was potential for participants to become distressed during the interview. Participants were informed of their right to withdraw at any time and that they were under no obligation to answer a question. At the start of the interview participants were reminded that they could have breaks at any point. During the interview the interviewer would check with participants that they were okay to continue. A full debrief was completed at the end of the interview and a debrief sheet with support contacts was sent via email following the interview (see Appendix I). Additionally, the researcher was mindful that their proximity to research could lead to potential distress. This was discussed in supervision and agreed that should this occur; the researcher would contact their supervisor.

All participants were informed and reminded of their right to withdraw at any stage, and reassured all data would be kept securely in line with UK Data Protection Act (2018) and in line with UoB data storage policies.

Sample and Recruitment

Participants were current Trainee Clinical Psychologists on a training programme within the UK and self-identified as having lived experience. Due to the timings of interviews, Trainees from their first year were excluded. This was to

ensure participants had adequate time on the course to talk about various aspects of training. Due to the personal nature of lived experience, a definition or list of definitions of accepted diagnoses or terms were not imposed. Instead, participants were asked to self-identify as having lived experience.

The recruitment took place between May 2023 and August 2023. Recruitment of participants relied on two approaches: through emailing the study details to the various DclinPsy training courses in the UK (Appendix J) and via social media advertisement (Appendix K). By emailing the courses directly through existing links with the University, it was felt this would help to maximise reach to potential participants. To reduce bias, participants could not be from researchers' university and partner institutions and none of the participants were directly known to the researcher. Adverts were posted within Trainee clinical psychologists' groups on social media, to further ensure that it reached potential participants, as emails were reliant on the training programmes disseminating it to their Trainees. These methods intended to ensure trainees from as many courses as possible were able to participate in the study if they wished.

Following initial contact with the researcher via direct email, the participants were sent further information about the study in the form of the information sheet (see Appendix L) and had the opportunity to ask any further questions. If participants still wanted to participate in the study, they were sent a consent form via email to complete (see Appendix H). Once the consent form was returned an interview was time was agreed. Due to time constraints, and due to the potential

long-distance, interviews were completed via Zoom. The inclusion and exclusion criteria for participants are outlined below in Table 2.2.

Table 2.2.

Participant Inclusion and Exclusion Criteria.

Inclusion Criteria	Exclusion Criteria
Trainee Clinical Psychologist currently on a clinical doctorate programme within the UK	Trainees are at the researcher's university or partner institutions
Trainees are in their second or third (or above) year of training	Trainees are in their first year of training
Trainees self-identify as having lived experience	Trainees do not identity as having lived experience themselves.
Trainees that are able to give informed consent	Trainees that are unable to give informed consent
	Trainees have a physical health condition, neurodevelopmental disorder or substance use disorder.

Procedure

Informed consent was obtained from participants and participants completed a brief demographic questionnaire (Appendix M). Interviews were arranged with participants and conducted via Zoom. Interviews consisted of semi-structured questions (see Appendix N), which allowed the interviewer the flexibility to ask additional questions to explore themes. Questions were broad and general

to allow the participants to not be biased by the researchers' understanding of lived experience (Smith, et al., 2009).

Prior to starting the interview, the researcher made the decision to disclose their lived experience identity, as there are many benefits with self-disclosure in research including enhancing rapport (Dickson-Swift et al., 2007).

Interviews lasted between 29 minutes and 79 minutes and were audio recorded on Zoom. All the interviews were completed on separate days to ensure the researcher could focus on each interview and to ensure content and processes did not merge (Rubin & Rubin, 2005). A full debrief was completed after the interviews, and a written debrief with sources of support listed was emailed to participants. Interviews were transcribed and anonymised, names and identifiable information, such as name of university, were removed.

Analysis

The data was analysed using IPA following the approach outline by Smith and Colleagues (2021). This approach consisted of the seven steps of IPA plus an additional step (step 6) of summarising the interview. This step was added to help aid transition to the next interview. These steps adapted from Smith et al., (2022) are outlined in the table below (Table 2.3).

Table 2.3.

Steps of IPA.

Step	*Description*
Step one	**Reading and Re-reading** *Getting familiar with the transcript.*
Step Two	**Exploratory Noting** Going through the text and making exploratory notes in the margins which are descriptive, linguistic or contextual.
Step Three	**Constructing Experiential Statements** Using the exploratory notes to help develop experiential statements.
Step Four	**Searching for connections across experiential statements** Mapping how the experimental statements fit together.
Step Five	**Development of Personal Experimental Themes (PETs)** Naming of the PETS.
Step Six	**Creating a Summary** Summarising the key parts of the interview and researchers' reflections.
Step Seven	**Continue Analysing other participants** Repeat the steps for all other participants.
Step Eight	**Development of Group Experiential Themes (GET's)** Look for patterns of similarities and differences across each of the individuals PETs to generate the GET's.

(Adapted from Smith et al., (2021), stages of IPA)

The author chose to manually analyse the data, thus did not require any computer software for this process. The researcher felt analysis by hand would be better suited to their learning needs and allow them to better familiarise themselves with themes and make connections more efficiently. Once the author was familiar with the transcripts and completed exploring noting and created

experiential statements, the author then formed the Personal Experiential Themes (PETs). PETs were formed by grouping together the experiential statements (see Appendix O) and were created to reflect the participants' sense-making at a broader level. A PET table was formed for each participant (see Appendix Q).

After all the PETs were formed for all participants, they were then used to find shared experiences across the participants and labelled with the Group Experiential themes (GETs) (see Appendix R). Once all the GETs and sub-themes were formed, this was compiled into a table with related participants' quotes. Throughout the analysis, these processes were discussed within supervision and regular IPA workshops with peers to help aid with checking credibility.

Epistemological stance

Consistent with Chapter One of this thesis, the epistemological stance for this empirical research was critical realism, which theoretically fits with an IPA methodology (Bhaskar, 1978). A reflective diary was used to maintain the author's epistemological stance.

Hermeneutics

Hermeneutics underpins IPA; allowing researchers to report meaningful findings and produce insightful interpretations of the experiences of the participants (Peat et al., 2018). Double hermeneutics is used within IPA, which is the process of the researcher making sense of the participants making sense of their

experiences (Smith & Osborn, 2007). Hermeneutics recognises that understanding individual experiences is a complex process involving participants' sense-making and the researcher's interpretation.

Reflexivity

IPA involves the researcher actively interpreting participants' sense-making of their experiences (Osborn & Smith, 1998), therefore, reflexibility is necessary to increase the researcher's awareness of their role within the analysis (Smith et al., 2009). The primary researcher is a 33-year-old, white British, female Trainee Clinical Psychologist who has lived experience. This experience could influence the interpretations of narratives and whilst the researcher had similarities with the participants, the researcher recognised this would not necessarily mean they would have the same perspectives or experiences. Especially given the researcher's proximity to the research topic, reflexivity was important to consider, and the researcher made use of a reflective journal for the process of interviews and analysis. The primary author also had regular supervision with a qualified Clinical Psychologist and attended regular IPA workshops with peers to discuss analysis.

The use of the reflective journal allowed the research to document thoughts, feelings and potential bias; allowing the researcher to identify instance where personal experience may have influence interpretations. Research supervision allowed for the researcher to have an external perspective. encouraged alternative interpretations and allows for reflections on assumptions. The workshops allowed for discussion of interpretations and critiques of analysis.

Results

Demographic information

The table below (Table 2.4) shows the demographic information of the participants. Five of the participants were female, one male, one non-binary and did not answer the question. All participants were white and were in the age range 26-35 years old. Lived experience was varied with labels such as anxiety, depression, post-traumatic stress disorder (PTSD) and psychosis. While the specific Dclin programs were not formally recorded to enhance anonymity and encourage participants to speak freely, the researcher inferred that participants were from different programs based on their university email addresses and the content of their discussions during interviews.

Table 2.4.

Demographic information of participants

Pseudonym	Age	Gender Identity	Ethnicity	Lived Experience
Nevena	26-30	Female	White British	Anxiety, depression, PTSD
Rowan	31-35	Non-Binary	White British	Bipolar II, psychosis, manic & depressive episodes
Aurbierre	26-30	Not answered	White British	Relational trauma, anxiety, depression
Niamh	26-30	Female	White British	Complex PTSD, Generalised Anxiety, Depression
Mariana	26-30	Female	White British	Trauma, feelings of depression and anxiety,
Gael	31-35	Male	White European	Depression and anxiety
Charlotte	31-35	Female	White British	Post-natal depression and anxiety
Matilda	36-40	Female	White British	Not disclosed

Group Experiential Themes

The analysis produced five GETs as shown below in Table 2.5. The GETs are presented in the table with sub-themes' evidences with participant quotes.

Table 2.5

Summary of GETs

		Number of participants contributing
GET	*A. Identity*	*8*
Subthemes	*Lived Experience is crucial part of identity:* "I'd say my lived experience and mental health is very important and central to my identity" [Rowan] *Identity is multi-faceted:* "there's so many different parts, you know, that make up self." [Nevena]	
GET	B. Disclosure	8
Subthemes	*Vulnerability of disclosure:* "I found it really difficult having to keep on changing course tutors, and having to re-explain my story all over again, because for me, I almost found that retraumatizing" [Aurbierre] *Psychological safeness needed for disclosure:* "...that was a relationship I could be safe to disclose in" [Mariana]	
GET	C. Strengths of Lived Experience	8
Subthemes	*Increased empathy & compassion:* "I also think that it means that I think I'm much more empathetic to clients than maybe people who don't have lived experience" [Niamh] *Unique insights shape practice:* "And I think it only enhances your you practice really, your work. and I don't think it sort of takes anything away from the work. I think it enhances it." [Gael]	
GET	D. Psycho-emotional experience of being a trainee with lived experience	7
	"Sometimes I just don't feel able to take on the people stuff. So, like the other day. I just kind of emotionally shut down." [Charlotte]	
GET	E. Safe spaces	8
	"And being part of that I was like, I kind of feel like I found my people. Because this is a group of people who will acknowledge it, and who will talk about it. yeah, and were acknowledging, not just having those experiences, but prepared to converse about that and tackle the complexities of." [Matilda]	

GET A: Identity

The first overarching GET captures how the participants shape their own identities in relation to being a trainee with lived experience. Some participants expressed conflicts in their identity, some participants felt their lived experience

was a big part of their identity whereas others felt this was not an important part of who they are or how they wanted to be seen by others. This highlights the complexities and individualistic nature associated with constructing identity.

Lived Experience as a Crucial Part of Identity

Many of the participants discussed how their lived experience is an intrinsic part of their identity, shaping who they are as a person and trainee. Lived experience plays an important role in trainees constructing their identity and shapes how they view the world around them. As emphasised in the following quote:

"It has a really big bearing on that construct of identity. and I think so for me. But I've had lifelong experiences with mental health difficulties. This didn't just like suddenly appear, it fundamentally changed the way I developed as a human. It changed the way my brain functioned; Change the way I perceive myself. It changed the way I perceive the world change the way that I perceive others."

[Matilda, p.5 line 177-183]

Matilda's lived experience appears to be intertwined with her sense of self and how she's developed as a person. Matilda later highlights that whilst she sees her lived experience as "*an integral part*" of her identity she sees it as an adaption that allowed her to survive rather than a "*deficit approach*" (Matilda, p.6, line 183).

Trainees expressed that their lived experience was seen as something long-standing, something that is carried throughout their lives, as Aurbierre highlighted:

"It's something that you carry with you". Further emphasising how trainees saw their lived experience is a part of them. Similarly, Nevena express how she "*very much identify as someone with lived experience*" (p6, line 183). This is further echoed by Rowan; "*I'd say my lived experience and mental health is very important and central to my identity" (p 5, line 152-153*). This highlights the key importance of lived experience identity, suggesting it is an integral part of identity. Niamh added to this suggesting that her lived experience *"takes up a big part of her identity as a trainee" (p2, line 71).*

Whilst Niamh felt her lived experience was a big part of her identity, she spoke about her struggles accepting this identity;

"So I feel as if it is quite a big part of my identity, and I think to be honest I've kinda of struggled with that quite a lot and tried, I've tried to have more of a positive outlook on it and kind of be like, okay, well, actually, it's really helpful for my identity" (p2, line 74-81)

The difficulty with Niamh's acceptance of this identity could be due to the stigma attached to mental health labels especially amongst the profession; further highlighting how trainees' journeys with identity can be complex; some trainees may not initially feel connected to this identity. Similarly, Aurbierre spoke about needing time to come to terms with this part of their identity; "*I almost have come to view it, as that's just a part of who I am.*" (p4, line 144). Whilst some trainees spoke about the idea that accepting this identity can take time, Mariana expressed that she was not *"going to pretend"* that this identity didn't exist (p2, line 51).

Lived experience being a part of their identity appeared to be shared experience amongst the participants, emphasising how deep-rooted and important mental health is in terms of constructing identity.

Identity is Multi-faceted

Many of the trainees discussed their experiences of identity being multifaceted, navigating their professional and lived experience identities. Rowan described conflictions around *"not wanting to be the psychologist with lived experience"* (p5, 159). Rowan did not want to be only defined by their lived experience as they had other facets to their identity and whilst they did not want to conceal this part of themselves, they did not want to have this identity at the *"forefront"* (p5, line 169). Similarly, Gael did not see his lived experience as a big part of his identity that defines him. He felt his identity was made up of more aspects than just his lived experience, as highlighted in the following quote:

"I think it is a big part of why I chose to do this work but there's so much more that defines me than mental health. That I don't think it's like the most important aspect of my identity, if that makes sense, as a psychologist" (p3, line 84-86).

Whilst Gael recognises that his lived experience is a part of his identity and a motivator in pursuing his career, he feels that there is more to his identity, indicating that some trainees may recognise their lived experience is a part of them but feel there is much more to their identity.

Furthermore, Nevena spoke about identity being made up of multiple parts; *"there's so many different parts, you know, that make up self."* (p7, line 203). Nevena also makes sense of her identity as not being separate; *"I think you know the part of me that's had that lived experience. I don't think it's completely separate to my identity as a trainee"* (p7, line 208). This suggests identities can be intertwined with one another rather than being deemed as separate. Mariana expressed difficulties initially connecting with her lived experience identity and suggested that the transient nature of identities changing from patient and professional depended on the context:

"So like someone with lived experience was definitely more of my identity than training clinical psychologist. But over time I think it's not that like being someone with lived experience has necessarily like diminished. But I'd say, being a trainee has kind of become more of my identity if that makes sense" (p 7, line 217-218)

Matilda discussed feeling compelled to try to separate her lived experience identity to "embody the psychology identity that is wanted of us" (p7, line 224). The presence of stigma within the profession meant Matilda deemed it necessary to try to conceal part of her identity and project another that would be considered as more accepted within the profession.

<u>GET B: Disclosure</u>

This group theme reflected trainees' experiences of disclosure, with many finding the disclosure puts them in a position of vulnerability due to the culture and stigma around being a professional with lived experiences. Trainees also discussed

the need to feel safe to allow for vulnerability of disclosure. Disclosure appeared to be a complex process that trainees had to navigate.

Vulnerability of disclosure

Aurbierre found her experiences of disclosure were "*exposing*", expressing how the retelling of her story was retraumatising: *"I found it really difficult having to keep on changing course tutors, and having to re-explain my story all over again, because for me, I almost found that retraumatizing" (p7, line 224). Highlighting the emotional impact disclosure, especially repeated disclosure can have on Trainees.*

Due to feelings of vulnerabilities around disclosure, Trainees spoke about limiting their disclosures. This is evidenced by Charlotte's reluctance to fully disclose due to feeling "*uncomfortable to do it."* (p9, line 285). Similarly, Nevena expressed confiding in only a select few individuals, underscoring the perceived vulnerability to disclosure. She also spoke about the fears of being "*too nervous*" to be the first one to open conversations about lived experiences in reflective spaces, further highlighting the exposing nature of disclosure. Niamh further limited her disclosure as she was "*not able to disclose certain things*" (p1, line 15). Some of her worries stemmed from stories of other trainees' disclosure not being well-received and she also recounted her own negative experiences; *"or when I do disclose certain things like people kind of look at you differently or treat you differently"* (p1, line 16).

Mariana shared the tendency towards vagueness in disclosure, due to apprehension toward potential reactions from others; *"I intentionally represent my*

experiences in like very vague ways, because of yeah, I guess the fear of how people react" (p 19, line 614-615).

Gael recounted his experiences of choosing to conceal his lived experience due to lack of support and the power imbalance between supervisors and trainees:" *I do have a sense that if you don't feel safe in supervision if you don't, if you feel that power imbalance is too steep, and you don't open up as much"* (p2, line 51-52). Furthermore, Mariana shared her difficult experience with her supervisor which made it feel too difficult to disclose her experience. However, these experiences of vulnerability of disclosure were not limited to supervisors or qualified psychologists, as Aurbierre felt unable to disclose to trainees.

Due to the stigma attached to her diagnostic label, Matilda chose not to disclose this: "Equally, the nature of my diagnosis is something that feels really risky to be out there" (p18, 407-408). This further emphasises the challenges of disclosure and how certain labels can put Trainees in a position of vulnerability.

Psychological Safeness Needed for Disclosure

As disclosure can be very vulnerable for Trainees, an important facilitator to help aid disclosure is the need for psychological safeness. Mariana highlighted her need to feel safe within the professional relationship to disclose. Aurbierre described a similar experience as needing to feel "*emotional safe*" (p5, line 246) to be able to disclose. Nevena also shared her need for feeling safe and comfortable within supervision, expressing the difficulty of sharing in larger groups due to the

lack of feeling safe. Nevena needed a *"secure, safe relationship"* to facilitate her disclosure.

Nevena further spoke about the importance of feeling safe within the supervisor relationship to allow for openness and discussion around lived experience. This openness allows for Trainees to bring discussions about difficulties or to process any transferences occurring and how this might interact with their lived experience:

"There's a lot of like kind of transferences and countertransference going on in the room that I bring back to supervision and kind of make sense with, and I think you have to be open about what that's bringing up in you. in that context. So luckily, I have quite a secure, safe relationship with her, and I'm able to explore that" (p6, 256-259).

For Mariana, she was able to anticipate her colleagues' reactions to her disclosure based on previous interactions with her and clients. This allowed her to feel safe and any negative potential reactions to be deemed low risk:

"Maybe I felt like I have more of an idea about how they might react to me like they wouldn't. You know, they wouldn't be disrespectful to me. They wouldn't like. you know, say horrible things about me, so I think that kind of gave me some kind of reassurance" (p 10, line 313-315).

Trainees spoke about disclosure being met with compassion (Charlotte) and having experiences validated and viewed as an asset (Niamh), allowing them to feel safe with disclosure. Gael shared the importance of having a good relationship to allow for feeling secure to share their experiences. He also expressed that

professionals sharing their own lived experience could help them feel like they were *"on equal playing fields"* (p9, 312); addressing the power imbalance. Aurbierre and Matilda further suggested that similar lived experiences with peers make it easier to feel safe. Whilst there were factors to help trainees feel psychologically safe in disclosing, feeling comfortable to do so can be a *"long road"* as described by Rowan.

GET C: Strengths of Lived Experience

Increased Empathy and Compassion

Having lived experience meant that trainees often shared similar experiences with clients. Nevena, Charlotte, Gael and Niamh discussed how their experiences increased their understandings which increased their empathy. Nevena further stated her lived experience facilitated *"true empathy"* and allowed for *"being real in the room".* Charlotte further echoed how her empathy increased her compassion to clients, especially those with similar experiences and allowed her to feel what her clients were feeling. Similarly, Rowan spoke about how their empathy allowed for therapeutic benefits and allowed them to understand their clients:

"*I think maybe a bit more understanding of people about who have had issues similar to mine, like I know what it feels like to hear voices. Erm, and I'm always conscious to be aware that my experience doesn't directly translate to anyone else's subjective lived experience. But I think it does give you a bit of insight and a bit of a window into what it might be like for them" (p9, line 272-280).*

Furthermore, Aurbierre shared how her experiences allowed her to not just empathise with clients but also to be truly with them during their recovery journey:

"And whilst I don't start off every session that I meet someone with and disclose my difficulties, I think It's allowed me to walk that road with them. Because I've been on the side of being in therapy, and I've been on the side of living with mental health difficulties and knowing that it's not as simple as it being like a light switch, so it's on and off. It's something that you carry with you and sometimes you might go through periods of life where it's better" Aurbierre (p8, line 262-268).

Aurbierre's experiences of mental health difficulties and therapy gave her unique empathy with her clients, something that someone without these experiences may not have. Similarly, Matilda discussed her awareness of both positions within therapy;

"I'm really aware of what it's like to sit in a therapy seat rather than a therapist's seat. So, I think that's really helpful. yeah. So, I think in the spaces where you're allowed to use it, or you can like subtly use it without having to acknowledge that that's what you're doing. It can be a real strength" (p10, line 344-347).

Trainees' lived experiences allowed them to be mindful of the client's experiences, resulting in increased empathy and compassion for their clients and their experiences.

Trainees also spoke about the more difficult aspects of their experiences, including the difficult feelings associated with their experiences. Nevena spoke about her understanding of a client's dark feelings, as this resonated with her previous experiences. Similarly, Mariana shared she knew what it was like to be in

the “depths of despair” and was able to hold this in mind when working with clients. Trainees were able to draw on these experiences to further empathise with their clients and their feelings.

Unique Insights Shape Practice

Experiences of mental health difficulties give trainees unique insights that those without these experiences would not have. Trainees had knowledge of what it was like to experience symptoms, be a client and accessing mental health services. Matilda echoed this by stating: *“I think it gives you a body of knowledge to draw on that isn't academic”* (p10, line 338); highlight how these experiences are beyond what can be learnt during training. Aubierre further expressed this emphasising how her experiences added to her professional knowledge and helped inform her on what kind of psychologist she wanted to be.

These unique insights also had benefits for trainees questioning systems with the interests of their clients in mind and encouraged them to advocate for clients. Mariana spoke about how her lived experience gave her unique insights into systems and services. Nevena expressed how her experiences allowed her to “question things a little bit more” (p11, line 330-332), including questioning the systems. Niamh’s insights motivated her to advocate for her clients;

“And I think also means that you advocate a lot more on behalf of people who do have experience, because, like, you know what it's like to be on the other side of it, and not experience good treatment” (p4, line 152-156).

Therefore, for Niamh, her experiences not only gave her unique insights but also impacted how she worked as a professional. For Rowan, he expressed how his experience gave him clinical tools to use, but for Charlotte she discussed how her experience made her reflect on her own prejudices. Trainees all spoke about how their experiences enhanced their practice, due to their unique insights. This is further demonstrated by Gael's account of how his experiences enhance his practice: *"And I think it only enhances your practice really, your work. and I don't think it sort of takes anything away from the work. I think it enhances it"* (p2, line 37-38).

GET D: Psycho-emotional Experience of Being a Trainee with Lived Experience

Whilst all the Trainees reported many benefits of their lived experience, for many of the trainees they found their experiences often came with emotional demands. Rowan discussed how initially they found some topics in therapy difficult, especially when trainees had similar experiences to the client as this often brought up difficult memories. He also compared how some situations within therapy can be more emotionally activating compared to peers without the same experiences:

"So anyone that's had ones where the delusional content or the voice content was similar to ones I've experienced was a little bit tricky just because it brought up memories. But I'd say, as the time on training has gone on from first to second year, and as the placements have gone on, I've become a bit more comfortable with that. But I would say that relative to my peers that was probably a bit more triggering for

me than it would have been for somebody that didn't have an experience which mapped onto the stuff that they were hearing" (p2, line 50-57).

Nevena also experienced similar feelings when she found some clients resonated with her which she found to be "*quite upsetting*" p12, line 368) indicating that sharing similar experiences with clients can evoke difficult emotions for Trainees. Mariana further added to this saying that even being in certain services can be emotively difficult:

"Obviously it didn't really work because you work in, you know, as in a psychiatric hospital. It's quite like a distressing environment for anybody, like let alone if you've actually maybe had some of the challenges that the people there have had" (p2, line 34-36).

For Mariana, she spoke about how her lived experience can make it "*a bit more heavy*" (p14, line 473), painting an image of how these experiences can make you feel weighed down and difficulty to carry. She also expressed caution with "*over identifying*" (p13, line 407) with clients, suggesting a potential for trainees to overemphasise when there are similarities which can be problematic. Gael also shared this experience feeling that more empathy "*can lead to more stress and more of that burn out*" (p6, line 204)., further highlighting the potential costs of increased empathy.

Trainees also found that their experiences made the course even more difficult due to various factors including the psych-social impact of training. Niamh found being a trainee is hard work, which was echoed by Charlotte who shared how lived experience makes the course more difficult. However, Gael expressed

concerns over the potential negative impact "*work sort of quite quickly*" (p6, line 201) if lived experiences are very active for a trainee, suggesting that the rawness of people's lived experience could potentially impact trainees in various aspects of their course.

Charlotte experienced feeling emotionally vulnerable in teaching and placements:

"I think another thing, I guess, is that sometimes I just don't feel able to take on the people stuff. So like the other day. I just kind of emotionally shut down. Which I do think that that meant that I was less present with the person in the room" (p10, line 363-366).

Here Charlotte shares how she felt unable to take on others' emotions, she also spoke of similar situations in teaching when she felt unable to engage or participate, suggesting that both placements and teaching can be emotionally activating for Trainees with lived experience. Similarly, Matilda spoke about teaching putting her out of her *"window of tolerance"(*p17, 592) and the difficulties surrounding these experiences.

GET E: Safe Spaces

Experiences of support varied for Trainees, however a common experience for trainees was the concept of safe spaces. Trainees spoke about the need for having safe spaces. For Nevena, her safe space was the counselling she accessed whilst on training. This gave her the space to explore which she found "helpful".

Gael expressed the importance of having a support network during training, to help navigate the complexities that come with being a Trainee with lived experiences. Nevena and Matilda both felt one important source of support was from being involved in small spaces for trainees with lived experiences. Matilda highlights the important of this group in the following extract:

"and being part of that I was like, I kind of feel like I found my people. Because this is a group of people who will acknowledge it, and who will talk about it. yeah, and were acknowledging, not just having those experiences, but prepared to converse about that and tackle the complexities of" (p8, line 276-279).

Charlotte and Matilda found safety with placement and teaching staff. Charlotte had experiences of supportive supervisors showing compassion and making her feel safe whereas Matilda found her conversations with the programme director as helpful. Gael expressed the need for having conversations about the "wounded healer" (p2, line 58), viewing them as helpful and potentially allowing for safety in opening these conversations within training. Adding to this, Mariana felt that there would be power in teaching staff talking about their lived experiences to further create this safeness within teaching.

In contrast trainees also had experiences of support that did not feel safe. Matilda spoke about her difficulties with occupational health due to the way they asked questions and approached mental health. Similarly, Niamh's experiences of occupational health were emotionally activating for her:

"I think occupational health are definitely more physical health orientated, I don't think that the people that I spoke to were very mental health aware. Which was

really challenging because the way that they asked questions was actually quite triggering. And they kind of didn't really have a lot of understanding, so I found that quite frustrating" (p5, line 187-192).

This highlights how systems of support for Trainees could be potentially damaging and evoke negative emotions. These instances show that trainees do not always feel safe in spaces and highlight the problematic nature of some support systems. Charlotte further highlighted how systems of support may actually not be helpful or create a safe space as intended. Charlotte referenced the buddy system which was an unhelpful experience due to the lack of guidance.

Discussion

Overview of the findings

The researcher aimed to explore the experiences of Trainees with lived experience of mental health difficulties. Eight Trainees participated in semi-structured interviews and the transcripts were analysed through IPA. Participants reflected on their experiences and drew meaning from these experiences. Through double hermeneutics (Smith et al., 2022), five GETs were identified: identity, disclosure, strengths of lived experiences, psycho-emotional experience of being a trainee with lived experience and safe spaces. These shared experiences amongst the participants highlighted the understandings, experiences, and meanings they made in terms of their role and mental health in the context of training.

Participants shared their need for psychological safeness when disclosing their lived experiences, as they viewed exposing their mental health as putting them into a potentially vulnerable position. Some participants spoke about limiting disclosure due to their own fears and worries of how their lived experience would be perceived. This is consistent with literature, with trainees being reluctant to share their lived experience with others due to worries around stigma (Grice, et al., 2018). These findings are also supportive of the study by Tay and colleagues (2018), whereby psychologists experienced higher levels of perceived stigma compared to external and self-stigma, highlighting that whilst psychologists are aware of the stigma attached to mental health difficulties, they are unlikely to stigmatise others. This finding was congruent with the results within this study, as the participants were very aware of potential stigma attached to their experiences, however, they did not hold those beliefs themselves.

Many participants viewed their lived experience identities as intrinsic deep-rooted parts of themselves. Participants also touched on the idea that identity is multi-faceted and made up of many parts, for some this consisted of being a professional and being a client. In line with other findings, some of the trainees saw their dual identities as separate (Richards et al., 2016), and would shift between identities (Goldberg et al., 2015). Participants also discussed the concept of 'wounded healer' identities as being a potential motivator for pursuing their career. This could suggest that motivation to becoming a psychologist is driven in part by identity.

Being a Trainee with lived experience was seen to be an asset to their clinical role, enhancing empathy and understanding whilst also adding unique insights that shaped practice. These current findings align with previous research, highlighting how Trainees with lived experience are in unique positions that can enhance clinical practice (Cleary & Armour, 2022). Participants viewed their lived experience as increasing their empathy and compassion as previously reported in existing literature (Adame, 2014; Cleary & Armour, 2022; Gelso & Hayes, 2007; Goldberg et al., 2015). Furthermore, research by Bennett-Levy & Finlay-Jones (2018) highlights the important role of self-experiential learning in the personal and professional developmental of therapists, supporting the notion that unique expertise based on experiential knowledge can be an assert within clinical practice.

Some of the Trainees shared that their lived experiences could sometimes result in emotional demands. Participants spoke about the potential for empathy to turn into over-identifying with clients and the potential of finding some experiences emotionally activating. This experience is similar to findings of professionals 'over-empathizing' (Elliott & Ragsdale, 2020), clinical work negatively impacting emotions (Charlemagne-Odle et al., 2012) and imposing further strains on wellbeing (López - Aybar et al., 2023).

Trainees discussed protective factors and the use of safe spaces to help them navigate the complexities of training with lived experiences. In line with other findings (Reid, 2023), all the Trainees spoke about the potential value peer-led reflective groups could have. This is further supported by previous research which

highlights the importance of trainees having spaces to talk (Cushway, 1992) and being a part of a community (Hadjiosif, 2021).

Stigma is often a shared experience amongst mental health professionals with lived experiences; with Clinical Psychologists experiencing anticipated stigma due to their lived experiences (Burrell-Smith, 2010; Tay et al., 2018). However, in this population stigma was not a shared group theme. For some of the participants stigma was an essential part of experience, however not all the participants discussed experiences of stigma and therefore this theme did not merit inclusion in the analysis. As previous research indicates high levels of stigma for professionals with lived experience (Adame, 2011; Charlemagne-Odle et al., 2012; Cleary & Armour, 2022; Elliott & Ragsdale, 2020; Harris et al., 2016; Huet & Holttum, 2016; López-Aybar et al., 2023; Turner et al., 2021), this contrast could potentially be due to stigma being less prevalent within this population compared to other studies, or because the participants, unlike previous research, were not specifically asked about experiences of stigma. Due to the nature of this empirical research, the questions were designed to get a broad sense of experiences and to see what topics naturally were discussed by participants.

The findings of this research significantly contribute to the existing literature by offering a nuanced understanding of the experiences of trainee clinical psychologists with lived experiences of mental health difficulties. Through semi-structured interviews and IPA, the study identified five key emergent themes. This research provides valuable insights into the complex interplay of identity, stigma, emotional demands, and support systems in the training experiences of clinical

psychology trainees with lived mental health challenges. It highlights the necessity for more inclusive and supportive training environments tailored to the unique needs of these individuals.

Strengths

This empirical study is one of the first to explore Trainee Clinical Psychologists' experiences of training. This research gives a narrative to the shared experiences of Trainees with lived experience, to gain better understanding and insight into their experiences. This empirical research allows for Trainees with lived experience to have a narrative which has previously been overlooked. Trainees from different DclinPsy courses across the UK participated within the study to allow for a variety and representative perspectives and to reduce biases of having accounts from a single training course. The findings of this course can help to inform training programmes and supervisors, on how to support Trainees with lived experiences and help to reduce stigma.

The study also benefits from being a homogenous sample, which is required for IPA (Smith et al., 2022). The analysis was also further strengthened by the researcher's use of a reflective journal, attending IPA workshops with peers and regular supervision to explore themes as well as potential biases.

To further validate the quality of this research, Yardley's (2000) four criteria were considered and are outlined in the table below (Table 2.6).

Table 2.6.

Application of Yardley's (2000) Four Criteria for Assessing Qualitative Research

Criteria	*Current Study*
Sensitivity to context	*The participants all contacted the researcher first and could choose to engage in the study. Ethical guidelines were adhered to, and participants were aware of their right to withdraw at any stage. The research took care with interpretations during the analysis and utilised a reflective diary, supervision, and qualitative support groups to monitor judgements, biases and practice.*
Commitment and rigour	The focus of lived experience within psychological practitioners was maintained through both chapters of this thesis; this was to allow the author to immerse themselves in the relevant research on the topic. The analysis of the data took place over several weeks to allow the researcher adequate time to rigorously explore the material, alongside attending IPA support groups to discuss processes with peers. The researcher also attended regular supervision, with these processes in place to ensure high standards were maintained. .
Transparency and coherence	The researcher documented all stages of the study (Smith et al., 2022), and utilised a reflective diary to show transparency on the processes the researcher made on their interpretations (Chan et al., 2015). The researcher also used supervision and the IPA support groups as a space to reflect on their processes and interpretations.
Impact and importance	The findings of this study highlight the shared experiences of Trainees with lived experiences. The findings also emphasise the need for changes within the DclinPsy training programmes and wider profession, to ensure Trainees feel safe, supported, and valued. This study shows that trainees with lived experience have many assets from their unique positions and expertise, it is therefore important that course staff think about how they can value lived experiences within the teaching programme.

Limitations

IPA relies on the researcher making sense of participants' sense-making (Smith & Osborn, 2008) and is therefore subject to the researcher's bias. To help reduce this bias, the researcher used a reflective journal, regularly attended IPA workshops with peers and had regular research supervision with a qualified Clinical Psychologist.

Participants were self-selected volunteers, and they may have had motivations or interests for engaging in the study. It could also mean not all experiences were expressed and therefore some voices were missed. As the study relied on participants' own reports and recollection of experiences, responses could be subject to error or bias (Jobe & Mingay, 1991). Another important consideration is the potential limits due to the small exploratory sample. As the study consisted of eight participants and the primary focus was not on recommendations it could mean participants' suggestions on changes may be somewhat limited.

The study faced several limitations regarding the sample. Participants were not directly asked whether their lived experiences were current or historical, either during the interviews or in the pre-interview questionnaires. This omission could be considered a limitation, as theoretically, if the lived experiences were not current during their training, they might not have influenced their experiences of the DClin program. However, based on the discussions within the interviews, it was apparent that the lived experiences were current for most, if not all, participants. Additionally, participants were not specifically asked about their engagement with pharmacological or psychological therapy. While some participants freely discussed these aspects during the interviews, this factor could be important to consider for a more comprehensive understanding of their experiences.

While the author used IPA workshops with peers to ensure the credibility of the analysis throughout the process, member checking was not utilized, which may be considered a limitation. However, IPA strongly advises against member checking

(Smith et al., 2009), so the involvement of participants would need to be carefully considered in future research.

It is important to consider the potential limited richness of data due to interviews being conducted remotely (Seitz, 2016). However, participants reported finding remote interviews as comfortable and preferable. Also, remote ways of working and communication have increased in recent years due to the implications of COVID-19 and it would therefore suggest people would be comfortable with remote methods.

Implications for Clinical Psychology Training

Overall, the findings in this research provide a sense that DClinPsy training values lived experience but does not provide an encouraging environment for Trainees with lived experiences. Through the interviews with Trainees, it was clear there were variations in support available and teaching within universities. Given the HCPC standards of proficiency outlining the importance of wellbeing, it is crucial for training programmes to acknowledge the value and challenges of being a trainee with lived experience. Training programmes and occupation health staff should have co-produced training to encourage supportive responses to disclosure and explore how to best support Trainees. Co-production would be beneficial as it can allow for Trainees with these experiences to have a voice and input on the content of this training.

Disclosure was a core theme that appeared throughout the interviews for all the participants. For many their apprehensions around disclosing their experiences

were especially due to worries about their competencies or fitness to practice being questioned. In line with other research, Trainees shared the importance of supportive responses to their disclosure (Brouwers et al., 2020). Trainees expressed the need for feeling safe to disclose their experiences. To help cultivate feelings of safety within training, teaching programmes should include open discussions within training (Waugh et al., 2015) and include teaching sessions on being a practitioner with lived experiences. Supervisors, teaching staff, academic tutors and professional mentors should also follow disclosure frameworks, such as Dunlop et al., (2022) or Turner et al., (2021). Dunlop and colleagues' Shared Lived Experiences Framework (SLEF) (2022) provides a structure for sharing lived experiences within clinical settings and could be applied to use within training settings. The SLEF identified six key areas for reflection including preparedness, confidence, relevance, comfort, supervision and competence. Turner and colleagues (2021) model identifies' core categories such as enablers, motivations and barriers which can all increase or decrease the likelihood of self-disclosure. These frameworks can aid in positive disclosures for trainees and help to reduce stigma within the professional field, it can also help to encourage Trainees seek any support required

Most of the participants expressed the value in a reflective peer-support group for trainees with lived experiences. Some of the Trainees were already assessing these groups within their courses with reported benefits of talking to a community of peers. Peer reflective practice groups was the most requested recommendation within this research, as Trainees saw the value in having a safe space with others to reflect and make sense of their experiences. This aligns with

literature which discovered Trainees most frequently managed their stress by talking to other trainees (Cushway, 1992) and the importance of being in a community of other professionals with lived experiences (Hadjiosif, 2021). Therefore, it would be beneficial for DclinPsy Training programmes to facilitate peer-led reflective practice groups for Trainees with lived experience (Vally, 2018).

Future Research

Over 70% of the successful applicants for the DclinPsy identity as white females (CHPCCP, 2022), and as all participants were white, the current research could be missing the voices of minoritised Trainees. Trainees with lived experiences who also have other varied identities from the elements of the social GRACES framework (Burnham, 2012), may have different experiences of training and assumptions cannot be made about their experiences. Future research would be beneficial to explore intersectionality of multiple minority experience (e.g. ethnic minorities or LGBTQ+) with lived experience.

Considering that stigma did not emerge as a theme for all participants in this study, despite previous research indicating it is often a common experience, future research may benefit from incorporating more targeted questions about stigma. It may also be beneficial to confirm that participants' lived experiences are current and to explore their engagement with pharmacological or psychological therapy in more detail.

Since this study focuses on the experiences of trainees, future research could explore experiences at different career stages, such as pre-training, newly qualified,

and several years post-qualification. These stages could be examined individually, compared across different stages, or studied longitudinally to observe how experiences evolve over time.

It would also be beneficial for future research to explore experiences of peer-led reflective groups in order to have better insights and understanding of the benefits of these groups for Trainees with lived experiences, and to highlight any potential barriers. Furthermore, research exploring the interaction between lived experiences and the development of competencies would be beneficial. This would allow trainees and courses to have a better understanding of the development of the competencies required in training and to think about the contributions of lived experiences.

Conclusions

Overall, this study sheds light on the nuanced experiences of Trainees with lived experience of mental health difficulties; highlighting the key experiences including the importance of identity, disclosure, and the value of safe spaces in navigating clinical training. While there is potential stigma and emotional demands associated with lived experience, the findings emphasise the unique strengths that these experiences bring to clinical practice. Moving forward, it is important for clinical psychology training programmes to create supportive environments that embrace and empower Trainees with lived experiences, providing frameworks for positive disclosures and opportunities for peer support. With the recommendations outlined, training courses and supervisors can facilitate inclusive practices that

honour the narratives of those with lived experiences within the field of clinical psychology and value the unique expertise these experiences can bring.

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Press Release One

Compassionate yet stigmatised: Latest research explores the experiences of therapeutic practitioner with mental health difficulties.

One in six adults will have experienced a common mental health problem in the past week (McManus at al., 2016). Mental health professionals are not exempt from experiencing mental health difficulties, with mental health practitioners are just as likely to experience them (Edwards & Crisp, 2017; Harris et al., 2016).

A new review has investigated the experiences of Psychological practitioners with lived experiences of mental health difficulties. Psychological practitioners are mental health professionals who worked in mental health services and provided therapeutic inventions, such as psychologists, trainees, and therapists. This review aimed to gain further insights and understandings into the lived experiences of practitioners and to identity further areas of research.

The review collated research that explored the experiences of Psychological practitioners with lived experience of mental health difficulties. Seven appropriate papers were identified. The papers included all had qualitative data, whereby the participants were able to discuss their experience either by interviews, a survey allowing free text or a collective discussion. The data from these papers were then analysed to find shared experiences, themes, and metaphors.

The findings from this review identified six key shared experiences:

- Stigma
- Discrimination
- Experiences of distress/lived experience
- Identity
- Disclosure
- Support

One shared experience for professionals was viewing their mental health difficulties as aiding their therapeutic skills. Highlighting the benefits these experiences can have within clinical practice, as many practitioners felt their experiences enhanced their empathy and compassion. One participant shared "*I think my experiences will make me more credible, authentic, and empathetic as a clinician".* Lived experiences were seen to be an asset within their roles due to their unique expertise, sometimes from being both a professional and a client.

Another important theme across the papers was experiences of stigma. Stigma is the negative views of a person due to their characteristics or behaviours being seen as inferior to societal norms (Dudley, 2000). Often people with mental health difficulties are seen negatively by others, as unpredictable or even aggressive (Hinshaw & Stier, 2008). One practitioner had worries about "*not wanting to be seen to be weak, functioning less well than anybody else*". These findings alongside experiences of discrimination and unhelpful experiences of support; emphasise the need for changes within workplaces and training settings to better support employees. These experiences also highlight the need for these

settings to think about ways to reduce stigma and encourage healthy workplace cultures.

The findings within this review align with other research and allow for workplaces and educational settings an opportunity to utilise these results to help reduce stigma and discrimination whilst also encouraging the unique expertise practitioners with lived experiences bring. Non-stigmatising practices within workplace and educational settings is essential. This could include having open conversations about mental health difficulties at training level, to encourage these conversations throughout the profession. Managers and supervisors also need to reflect on how to best support staff with mental health difficulties. Whilst the findings of the reviewed aids in better understanding experiences of Psychological practitioners with lived experiences; it also highlights the need for further research into the experiences of therapeutic practitioner, to shine further light onto these experiences. For instance, further research exploring mental health difficulties experiences at different career points would be beneficial, e.g. pre training, training and qualified. It would also be beneficial for research to focus on mental health difficulties within psychological professionals who also have other minoritised identities e.g. LGBTQ+ or ethnic minorities; this would help to ensure all voices are heard and provide deeper understandings of these experiences.

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Press Release Two

"We're all human at the end of the day": Lessons learned from the experiences of Trainee Clinical Psychologists with mental health difficulties

Previous research indicates that Trainee Clinical Psychologists are equally or more likely to experience mental health difficulties (Brookes et al., 2002; Cushway, 1992; Pakenham & Stafford-Brown, 2012). One survey found that 67% of Trainees identified as having a mental health difficulty (Grice er al., 2018). Whilst mental health difficulties are highly prevalent for Trainees often this is something that is not spoken about due to fears of stigma within the profession, meaning trainees with these experiences can often feel like they are in the minority.

Trainees with lived experiences of mental health difficulties are situated in unique positions, as there is the potential of them attending teaching about their own experiences, working in services they have accessed or working with clients with similar presentations. Currently there is very little research on trainees with lived experiences of mental health difficulties. The limited research that is available focuses on specific aspects such as stigma or disclosure. To date there is no published research exploring experiences of training. Therefore, the aim of this research was to gain insights and deeper understandings into the experiences across all aspects of training. This research hopes to normalise these experiences, reduce stigma within training and provide recommendations for courses.

This study recruited eight participants, who all identified as having mental health difficulties and were current Trainees on a Doctorate in Clinical Psychology course within in the UK. Participants were invited to discuss and make sense of their

experiences of training, including placements, research, assignments, and teaching. This study revealed five key shared experiences for the participants. One of the biggest shared themes was disclosure which naturally came up for participants throughout the interview. Some trainees shared their experiences of the vulnerability of disclosure, due to the stigma within the profession. Trainees emphasised the importance of psychological safeness needed for disclosure; whereby the trainees needed to feel comfortable with their supervisors or staff member to feel able to share their experiences. Even when trainees felt safe, they at times would limit their disclosure due to worries about how they would be seen or having their competencies questioned.

All participants discussed the strengths of their lived experiences, seeing them as an asset that gave them unique insights that shaped their practice. One participant shared "*I'm really aware of what it's like to sit in a therapy seat rather than a therapist's seat".* Trainees' experiences allowed them to really empathise with clients and gain deeper insights compared to peers without those experiences.

Whilst participants spoke about the positives they drew from their experiences, some also mentioned the emotional difficulties these experiences can occasionally bring especially when teaching sessions or clients share similarities with their experiences. For most participants, safe spaces were vital for helping with their own stigma, worries and maintaining their wellbeing. Most trainees expressed a need for having peer-led reflective groups. One participants shared: "*I kind of feel like I found my people. Because this is a group of people who will acknowledge it,*

and who will talk about it. yeah, and were acknowledging, not just having those experiences, but prepared to converse about that and tackle the complexities of."

In light of the findings, clinical recommendations were made to better support Trainees with lived experiences. Training courses need to have open and honest conversations about mental health to help reduce barriers around disclosure and to reduce stigma. Courses are recommended to facilitate peer reflective practice groups to increase the sense of community and to allow Trainees to reflect on their experiences in the context of their professional role. Further co-produced training for course staff, supervisors, and support systems such as occupational health is needed to think about how to best support trainees and approach disclosure.

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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

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

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Appendices

Appendix A- Literature search- full journals accessed and reasons for exclusion

Author	Reference	Country	Study Aims	Participant Characteristics	Methodology and Measures	Design and Analysis	Exclude	if yes, why?
Anonymous	The "Healing Healer"? A Psychologist's Personal Narrative of Psychosis and Early Intervention. (2018). *Schizophrenia Bulletin*, *44*(6), 1173–1174. https://doi.org/10.1093/schbul/sbx188	UK	personal account	psychologists	personal account	personal account	YES	Wrong phenomenon of interest
Anonymous	Anonymous. (2022). A psychologist's experience of the clinician's illusion in the face of familial mental illness. Psychological Services, 19(1), 66–68. https://doi.org/10.1037/ser0000532	USA	to describe the complexities and experiences facing psychologists who family members are experiencing mental health symptoms.	psychologist	qualitive	personal reflection/ account	YES	Wrong phenomenon of interest
Aafjes-Van Doorn, et al	Aafjes-Van Doorn, K., Békés, V., Luo, X., Prout, T. A., & Hoffman, L. (2021). What Do Therapist Défense Mechanisms Have to Do With Their Experience of Professional Self-Doubt and Vicarious Trauma During the COVID-19 Pandemic? *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.647503	USA	to look at defence mechanisms	psychotherapists	quantitative	online surveys	YES	Wrong phenomenon of interest
Akbari et al	The role of psychological, skill level and demographic variables in information-seeking behaviours in mental health professionals. (2022). *Journal of Information Science*, 016555152210923-016555152210923. https://doi.org/10.1177/01655515221092363		to identify the variables that can potentially affect information-seeking behaviour in mental health service providers	mental health professionals	mixed	quasi-experimental research design	YES	Wrong phenomenon of interest
Bhattacharya	Bhattacharya, P. (2020). "And now I know how you feel . . .": Lived experience of surviving mental illness as a prosumer.. Psychological Services. https://doi.org/10.1037/ser0000484	India	reflections of a psychologist experience of clinical depression	psychologist	qualitive	reflective account	Yes	first person account and no analysis
Bike	Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training*, *46*(1), 19–31. https://doi.org/10.1037/a0015139	USA	To explore the process and outcomes of therapists' personal therapy	psychotherapists	quantitative	survey	YES	Quantitative
Barre, Boer & Guarnaccia	Barre, K., De Boer, S., & Guarnaccia, C. (2023). Vicarious trauma and posttraumatic growth among victim support professionals. Current Psychology. https://doi.org/10.1007/s12144-023-04523-2	France	to explore if professionals who work with trauma clients experience vicarious trauma and if they experience post-traumatic growth.	163 participants. legal practitioners and psychologists	quantitative	online questionnaire	YES	Quantitative

Bearse, McMinn, Seegobin & Free	Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. Professional Psychology: Research and Practice, 44(3), 150–157. https://doi.org/10.1037/a0031182	USA	To investigate the stressors that impact psychologists and barriers to seeking mental health services.	260 psychologists	quantitative	questionnaire	YES	Quantitative
Boyd, et al.	Boyd, J. E., Zeiss, A., Reddy, S., & Skinner, S. (2016). Accomplishments of 77 VA mental health professionals with a lived experience of mental illness. *American Journal of Orthopsychiatry*, *86*(6), 610–619. https://doi.org/10.1037/ort0000208	USA	to document the existence of competently functioning mental health providers with lived experience of mental illness (prosumers) and to begin exploration of their contributions and their point of view, in an effort to shape future work	psychologists, psychiatrists, social workers, and nurses	mixed	survey	yes	Wrong concept-professional group and unable to extract psychology data only
Burrows, Warner, Heath and Keville	Burrows, A., Warner, C., Heath, J., & Keville, S. (2022). Mental health, stigma and psychologists' lived experience of caring. The Journal of Mental Health Training, Education and Practice. https://doi.org/10.1108/jmhtep-03-2022-0018	UK	an exploration of psychologist's experiences of caring for loved ones with mental health conditions and the impact on practice	11 psychologists with experience of caring for a loved one with mental health conditions/distress	qualitive	Semi-structured interviews and thematic analysis	YES	Wrong phenomenon of interest
Byrne, Roennfeldt, Davidson, Miller & Bellamy	Byrne, L., Roennfeldt, H., Davidson, L., Miller, R., & Bellamy, C. (2021). To disclose or not to disclose? Peer workers impact on a culture of safe disclosure for mental health professionals with lived experience. Psychological Services. https://doi.org/10.1037/ser0000555	USA	to investigate the potential impact of disclosure for mental health professionals.	132 participants-32 mental health professionals, 47 managers, 7 in peer-designated leadership positions, 38 in peer-designated positions, 8 unspecified	qualitive	semi-structured interviews	YES	Does not specify the professional job titles
Charlemagne-Odle, Harmon & Maltby	Charlemagne-Odle, S., Harmon, G., & Maltby, M. (2012). Clinical psychologists' experiences of personal significant distress. Psychology and Psychotherapy: Theory, Research and Practice, 87(2), 237–252. https://doi.org/10.1111/j.2044-8341.2012.02070.x	UK	To add to the existing knowledge of professional practice, by exploring experience of distress amongst psychologists	11 clinical psychologists	qualitative	interview and IPA	NO	
Davies, Rushworth and Fisher	Davies, S., Rushworth, I., & Fisher, P. (2023). "Being human": A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees. https://doi.org/10.1002/capr.12648	UK	To explore the factors and process involved in disclosure of mental health conditions to trainees.	nine participants-all clinical psychologist training on a course	qualitative	interviews	maybe	focus is disclosure?

DelTosta	DelTosta, J. E., Ellis, M. V., & McNamara, M. L. (2019). Trainee vicarious traumatization: Examining supervisory working alliance and trainee empathy. *Training and Education in Professional Psychology*. https://doi.org/10.1037/tep0000232	USA	To investigate characteristics as risk factors of vicarious trauma in trainee therapists, and to explore if these risks reduce with alliance with supervisors	206 mental health trainees	quantitative	survey	YES	Wrong phenomenon of interest
Davendorf	Devendorf, A. R., Victor, S. E., Rottenberg, J., Miller, R., Lewis, S. P., Muehlenkamp, J. J., & Stage, D. L. (2023). Stigmatizing Our Own: Self-Relevant Research (Me-Search) Is Common but Frowned Upon in Clinical Psychological Science. *Clinical Psychological Science*, 216770262211416. https://doi.org/10.1177/21677026221141655	USA	to investigate self-relevant research and attitudes towards this	1,776 faculty, graduate students and others affiliated with doctorate programs in clinical, counselling and school psychology	quantitative	survey	YES	quantitative
Devilly	Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373–385. https://doi.org/10.1080/00048670902721079	Australia	To explore vicarious trauma, secondary traumatic and burnout in Australian mental health professionals.	152 mental health professionals	quantitative	questionnaire	yes	quantitative
Di Bnedetto	Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. Psychology, Health & Medicine, 19(6), 705–715. https://doi.org/10.1080/13548506.2013.861602	Australia	to investigate the relationships among burnout in Australian psychologists.	167 psychologists	quantitative	survey	yes	quantitative
Dunlop	Dunlop, B. J., Woods, B., Lovell, J., O'Connell, A., Rawcliffe-Foo, S., & Hinsby, K. (2021). Sharing Lived Experiences Framework (SLEF): a framework for mental health practitioners when making disclosure decisions. *Journal of Social Work Practice*, *36*(1), 1–15. https://doi.org/10.1080/02650533.2021.1922367	USA	to present a comprehensive framework to assist mental health practitioners when choosing to disclose		framework	framework	yes	wrong methodology-framework
Edmonds	Edmonds, C. (2019). The entwined narratives of the wounded healer. *Social Work with Groups*, *43*(1-2), 126–130. https://doi.org/10.1080/01609513.2019.1639102	USA	to share personal account of working in a cancer service with a diagnosis of cancer	psychotherapist	qualitative	personal account	yes	Wrong phenomenon of interest
Ege & Lannin	Ege, S. M., & Lannin, D. G. (2021). Deciding to disclose: The role of identity when "coming out proud".. Stigma and Health. https://doi.org/10.1037/sah0000298	USA	To examine the theoretical idea that there is a reduction in stigma related to being out and proud	364 students	quantitative	Qualtrics	yes	Quantitative

Elliott	Elliott, M., & Ragsdale, J. M. (2020). Mental health professionals with mental illnesses: A qualitative interview study. *American Journal of Orthopsychiatry*, *90*(6). https://doi.org/10.1037/ort0000499	USA	explore the experiences of mental health professionals who self-identify as having a mental illness by analysing how they describe their experiences in their own words	12 therapists	qualitative	interviews	No	
Finan	Finan, S., McMahon, A., & Russell, S. (2021). "At What Cost Am I Doing This?" An Interpretative Phenomenological Analysis of the Experience of Burnout among Private Practitioner Psychotherapists. *Counselling and Psychotherapy Research*, *22*(1). https://doi.org/10.1002/capr.12483	Ireland	explore burnout in psychotherapists working in private practice	8 psychotherapists	qualitative	interviews	YES	Wrong phenomenon of interest
Ford	Ford, E., George, N., Holland, E., Maher, S., Maree, L., Naylor, K., Rossel, K., & Wake, J. (2021). Seven lived experience stories of making meaning using art therapy. *International Journal of Art Therapy*, *26*(1-2), 65–72. https://doi.org/10.1080/17454832.2021.1893771	Australia	To explore experiences of people attending art therapy	clients and art therapists	qualitative	personal stories	YEs	Wrong participant group- focus is clients
Grice, Alcock & Scior	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	UK	to explore the potential factors associated with disclosure for trainees.	348 Trainees- 67% reported lived experience	quantitative	web based survey	yes	quantitative
Hadjiosif	Hadjiosif, M. (2021). The ethos of the nourished wounded healer: A narrative inquiry. *European Journal of Psychotherapy & Counselling*, *23*(1), 1–27. https://doi.org/10.1080/13642537.2021.1881137	UK	This paper takes the 'wounded healer' into the research arena by approaching it reflexively as an analytic tool to explore therapists' personal and professional development	5 Psychological practitioners	qualitative	interviews	No	
Hammer	Hammer, D. E. (2020). The lived experience of a psychologist activist. *Psychotherapy and Politics International*, *18*(2). https://doi.org/10.1002/ppi.1536	USA	reflects upon the role of activism for psychologists in these times and future decades	psychologist	personal reflection	personal reflection/ account	YES	Wrong phenomenon of interest
Hammersley	Hammersley, D. (2021). Wanderer to warrior. *Counselling Psychology Review*, *36*(1), 55–62. https://doi.org/10.53841/bpscpr.2021.36.1.55	UK	to explore the journey of wounder healers	therapist	personal reflection	personal reflection/ account	YES	Wrong phenomenon of interest
Harris	Harris, J. I., Leskela, J., & Hoffman-Konn, L. (2016). Provider lived experience and stigma. *American Journal of Orthopsychiatry*, *86*(6), 604–609.	USA	to explore lived experience and stigma of mental health professionals	psychiatrists,41 psychologists, 16 social workers, 23 nurses, and 6	quantitative	survey	yes	quantitative

	https://doi.org/10.1037/ort0000179			respondents from other disciplines.				
Hobaica	Hobaica, S., Szkody, E., Owens, S. A., Boland, J. K., Washburn, J. J., & Bell, D. J. (2021). Mental health concerns and barriers to care among future clinical psychologists. Journal of Clinical Psychology, 77(11), 2473–2490. https://doi.org/10.1002/jclp.23198	USA	to explore the mental health of clinical psychology doctorate students	trainees	quantitative	survey	yes	quantitative
Huet	Huet, V., & Holttum, S. (2016). Art therapists with experience of mental distress: Implications for art therapy training and practice. *International Journal of Art Therapy*, *21*(3), 95–103. https://doi.org/10.1080/17454832.2016.1219755	UK	to explore trainee art therapists experience of mental distress	trainee art therapist	qualitative	cross sectional survey with open ended questions	NO	
Ivey	Ivey, G., & Partington, T. (2012). Psychological Woundedness and its Evaluation in Applications for Clinical Psychology Training. *Clinical Psychology & Psychotherapy*, *21*(2), 166–177. https://doi.org/10.1002/cpp.1816		investigating clinical psychology programme selectors' perceptions of psychological 'woundedness' in the autobiographical narratives of applicants for clinical psychology training	psychologists	qualitative	interviews	yes	Wrong phenomenon of interest
Jones & Hutson	Jones, S., & Hutson, A. (2020). Should therapists self-disclose their own mental health in the public domain? *Psychotherapy and Politics International*, *18*(2). https://doi.org/10.1002/ppi.1530	UK	to debate if it appropriate for psychological professionals to self-disclose within the public domain.	psychological professionals	debate	debate	yes	Debate
Kleespies et al	Kleespies, P., Orden, K., Bongar, B., Bridgeman, D., Bufka, L., Galper, D., Hillbrand, M., & Yufit, R. (2011). Psychology Service (116 B), VA Boston Healthcare System, 150 South Huntington Ave. *Prof Psychol Res Pr*, *42*(3), 244–251. https://doi.org/10.1037/a0022805	USA	to investigate the incidence of psychologist suicide and its impact on colleagues, students or interns, patients or clients, and the profession.	psychologists	review	review	yes	review
Linnerooth et al	Linnerooth, P. J., Mrdjenovich, A. J., & Moore, B. A. (2011). Professional burnout in clinical military psychologists: Recommendations before, during, and after deployment. *Professional Psychology: Research and Practice*, *42*(1), 87–93. https://doi.org/10.1037/a0022295	USA	discussion of professional burnout in clinical military psychologists and recommendations	clinical military psychologists	review	review	YES	review
Lopez-Aybar, Gonzales & Kanani	López-Aybar, L., Gonzales, L., & Kanani, A. (2023). Prosumers' experiences of stigma dimensions within the clinical psychology field. https://doi.org/10.1037/ser0000765	USA	explore prosumers experiences of stigma within clinical psychology	175 doctoral level clinical psychologist (including in training) prosumers	mixed	Qualtrics	No	

Patmore	Patmore, J. (2019). Therapist self-disclosure in the treatment of eating disorders: A personal perspective. *Journal of Clinical Psychology*, *76*(2), 266–276. https://doi.org/10.1002/jclp.22893	USA	provide a personal account of the experience of the author struggling with a serious eating disorder in young adolescence	therapist	personal account	personal account	yes	PERSONAL ACCOUNT
Phiri	Phiri, P., Rathod, S., Gobbi, M., Carr, H., & Kingdon, D. (2019). Culture and therapist self-disclosure. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/s1754470x19000102	UK	to explore one of these themes in greater detail, i.e. client-initiated therapist self-disclosure	patients, CBT therapists and mental health practitioners	qualitative	interviews - thematic analysis	yes	Wrong phenomenon of interest
Rabu et al	Råbu, M., McLeod, J., Haavind, H., Bernhardt, I. S., Nissen-Lie, H., & Moltu, C. (2019). How psychotherapists make use of their experiences from being a client: Lessons from a collective autoethnography. *Counselling Psychology Quarterly*, *34*(1), 1–20. https://doi.org/10.1080/09515070.2019.1671319	Norway	to look in more detail at therapists´ experiences of what and how they learn from and use their experiences as clients.	six therapists	qualitative	collective autoethnography	NO	
Richard	Richard, A. (2012). The Wounded Healer: Can We Do Better Than Survive as Therapist? *International Journal of Psychoanalytic Self Psychology*, *7*(1), 131–138. https://doi.org/10.1080/15551024.2011.606967	Canada	to share account of being a wounder healer	therapist	qualitative	personal reflection/ account	YES	Wrong phenomenon of interest
Richardson	Richardson, C. M. E., Trusty, W. T., & George, K. A. (2018). Trainee wellness: self-critical perfectionism, self-compassion, depression, and burnout among doctoral trainees in psychology. *Counselling Psychology Quarterly*, *33*(2), 1–12. https://doi.org/10.1080/09515070.2018.1509839	USA	to address these gaps in the literature by examining the associations between self-critical perfectionism, depression, and burnout among doc-toral trainees in psychology, investigating the mediating role of self-compassion	119 students in clinical/counsellin g psychology doctoral programs	quantitative	online surveys	yes	quantitative
Sciberras & Pilkington	Sciberras, A., & Pilkington, L. (2018). The lived experience of psychologists working in mental health services: An exhausting and exasperating journey. *Professional Psychology: Research and Practice*, *49*(2), 151–158. https://doi.org/10.1037/pro0000184	Malta	settings, specific research is still lacking. This study attempted to explore some specific issues encountered by these psychologists such as working with this specific set of clients and working in an MDT where the leading treatment philosophy is based on the MM.	7 psychologists	qualitative	interviews- IPA	YES	Wrong phenomenon of interest
Spence et al	Spence, N., Fox, J. R. E., Golding, L., & Daiches, A. (2012). Supervisee Self-disclosure: A Clinical Psychology Perspective. *Clinical Psychology &*	UK	to investigate qualified UK clinical psychology supervisees' use of voluntary	10 psychologists	qualitative	interviews	YES	Wrong phenomenon of interest

	Psychotherapy, *21*(2), 178–192. https://doi.org/10.1002/cpp.1829		self-disclosure in supervision throughout their careers to develop a theoretical understanding of supervisees 'self-disclosure process					
Stromme et al	Strømme, H., & Gullestad, S. E. (2012). Disclosure or non-disclosure? *The Scandinavian Psychoanalytic Review*, *35*(2), 105–115. https://doi.org/10.1080/01062301.2012.10662648	Norway	to explore the disclosure within therapy	student therapists	qualitative	case studies	Yes	Wrong phenomenon of interest
Tay, Alcock & Scior	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	UK	To assess the prevalence of personal experiences of mental health problems among clinical psychologists, external, perceived, and self-stigma among them, and stigma-related concerns relating to disclosure and help-seeking	678 Clinical Psychologists	quantitative	web survey	YES	quantitative
Turner Moses & Neal	Turner, K., Moses, J., & Neal, A. (2021). "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. Clinical Psychology & Psychotherapy. https://doi.org/10.1002/cpp.2667	UK	to investigate the process of self-disclosure of lived experience of mental health difficulties of trainees.	12 Trainee Clinical Psychologists	qualitative	interviews and grounded theory	No	
Victor et al	Victor, S. E., Devendorf, A. R., Lewis, S. P., Rottenberg, J., Muehlenkamp, J. J., Stage, D. L., & Miller, R. H. (2022). Only Human: Mental-Health Difficulties Among Clinical, Counseling, and School Psychology Faculty and Trainees. *Perspectives on Psychological Science*, 174569162110710. https://doi.org/10.1177/17456916211071079	USA	to obtain representative data on experiences of mental health difficulties	1692 faculty, graduate students and other affiliated with accredited doctoral programs	quantitative	survey	YES	quantitative
Victor et al	Victor, S. E., Lewis, S. P., & Muehlenkamp, J. J. (2021). Psychologists with lived experience of non-suicidal self-injury: Priorities, obstacles, and recommendations for inclusion. *Psychological Services*. https://doi.org/10.1037/ser0000510	USA	to explore and make recommendations for inclusion for psychologists with lived experience	psychologists	commentary and recommendations	commentary	yes	wrong methodology
Victor, Schleider, Ammerma, Bradford, Devendorf & Gruber	Victor, S. E., Schleider, J. L., Ammerman, B. A., Bradford, D. E., Devendorf, A. R., Gruber, J., Gunaydin, L. A., Hallion, L. S., Kaufman, E. A., Lewis, S. P., & Stage, D. L. (2022). Leveraging the Strengths of Psychologists With Lived Experience of Psychopathology. Perspectives on Psychological Science, 17(6), 1624–1632. https://doi.org/10.1177/17456916211072826	USA	To discuss lived experiences of professionals.	psychologists	commentary	commentary	YES	commentary

Vierthaler & Elliot	Vierthaler, J. M., & Elliott, E. C. (2020). A shared lived experience of a psychologist battling a mental health crisis. Psychological Services. https://doi.org/10.1037/ser0000489	USA	to share experience as a prosumer	psychologist	qualitative	first person narrative	Yes	first person account and no analysis use
Whitten	Whitten, L. (2020). Stigma matters: An African American psychology professor comes out of the mental illness closet. Psychological Services. https://doi.org/10.1037/ser0000486	USA	to share experiences living with bipolar disorder	psychology professor	qualitative	reflections	Yes	first person account and no analysis use
Williams et al	Williams, A. M., Reed, B., Self, M. M., Robiner, W. N., & Ward, W. L. (2019). Psychologists' Practices, Stressors, and Wellness in Academic Health Centers. *Journal of Clinical Psychology in Medical Settings*. https://doi.org/10.1007/s10880-019-09678-4	USA	to review the literature investigating professional wellness, sources of stress, and burnout in practicing psychologists.	healthcare professionals	quantitative	survey	yes	quantitative
Zerubavel et al	Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482–491. https://doi.org/10.1037/a0027824	USA	to review literature of wounded healers	psychologists	review	review	yes	review
GOOGLE SCHOLAR								
Cleary	Cleary, R., & Armour, C. (2022). Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy. *Counselling and Psychotherapy Research*, *22*(4). https://doi.org/10.1002/capr.12569	UK	to explore the experiences of counsellors and psychotherapists with lived experience of mental health issues	2 counsellors and 1 psychotherapist	qualitative IPA	Interview and IPA	NO	

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

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

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

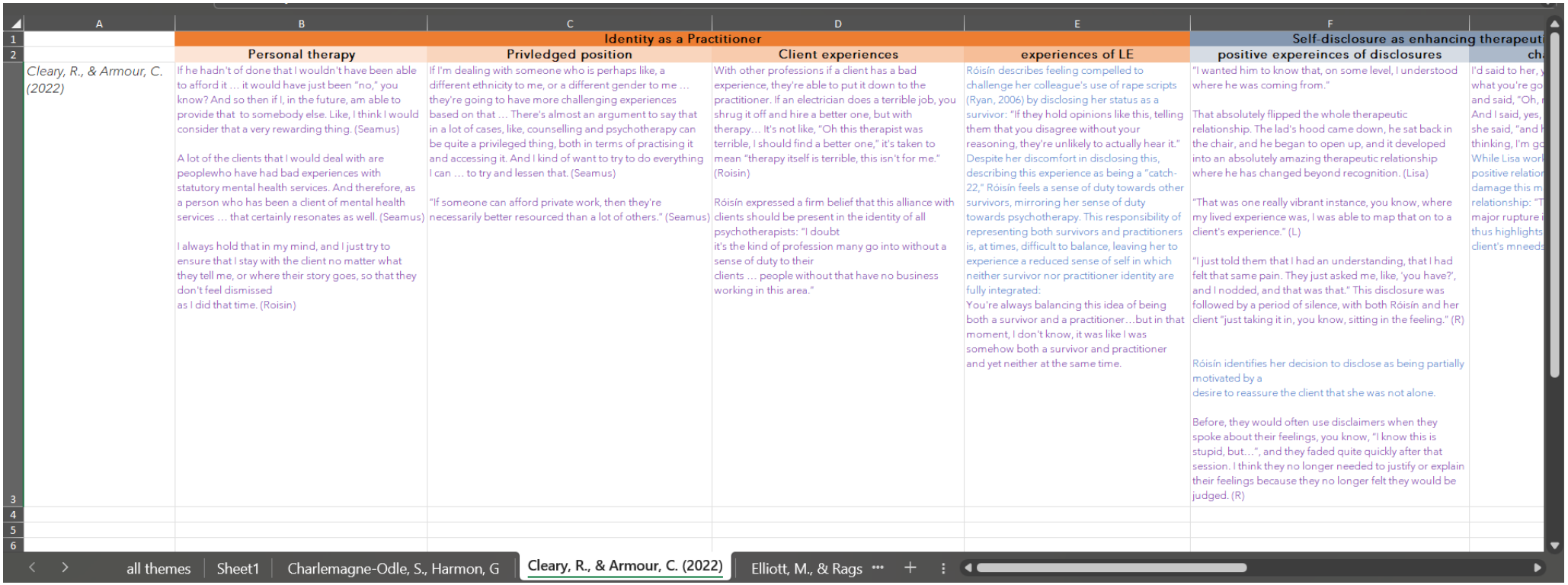
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was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

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

12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		

As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix C- example of themes for a paper



	A	B	C	D	E	F	
1		Identity as a Practitioner				Self-disclosure as enhancing therapeuti	
2		Personal therapy	Privledged position	Client experiences	experiences of LE	positive expereinces of disclosures	ch
3	*Cleary, R., & Armour, C. (2022)*	If he hadn't of done that I wouldn't have been able to afford it … it would have just been "no," you know? And so then if I, in the future, am able to provide that to somebody else. Like, I think I would consider that a very rewarding thing. (Seamus) A lot of the clients that I would deal with are peoplewho have had bad experiences with statutory mental health services. And therefore, as a person who has been a client of mental health services … that certainly resonates as well. (Seamus) I always hold that in my mind, and I just try to ensure that I stay with the client no matter what they tell me, or where their story goes, so that they don't feel dismissed as I did that time. (Roisin)	If I'm dealing with someone who is perhaps like, a different ethnicity to me, or a different gender to me … they're going to have more challenging experiences based on that … There's almost an argument to say that in a lot of cases, like, counselling and psychotherapy can be quite a privileged thing, both in terms of practising it and accessing it. And I kind of want to try to do everything I can … to try and lessen that. (Seamus) "If someone can afford private work, then they're necessarily better resourced than a lot of others." (Seamus)	With other professions if a client has a bad experience, they're able to put it down to the practitioner. If an electrician does a terrible job, you shrug it off and hire a better one, but with therapy… It's not like, "Oh this therapist was terrible, I should find a better one," it's taken to mean "therapy itself is terrible, this isn't for me." (Roisin) Róisín expressed a firm belief that this alliance with clients should be present in the identity of all psychotherapists: "I doubt it's the kind of profession many go into without a sense of duty to their clients … people without that have no business working in this area."	Róisín describes feeling compelled to challenge her colleague's use of rape scripts (Ryan, 2006) by disclosing her status as a survivor: "If they hold opinions like this, telling them that you disagree without your reasoning, they're unlikely to actually hear it." Despite her discomfort in disclosing this, describing this experience as being a "catch-22," Róisín feels a sense of duty towards other survivors, mirroring her sense of duty towards psychotherapy. This responsibility of representing both survivors and practitioners is, at times, difficult to balance, leaving her to experience a reduced sense of self in which neither survivor nor practitioner identity are fully integrated: You're always balancing this idea of being both a survivor and a practitioner…but in that moment, I don't know, it was like I was somehow both a survivor and practitioner and yet neither at the same time.	"I wanted him to know that, on some level, I understood where he was coming from." That absolutely flipped the whole therapeutic relationship. The lad's hood came down, he sat back in the chair, and he began to open up, and it developed into an absolutely amazing therapeutic relationship where he has changed beyond recognition. (Lisa) "That was one really vibrant instance, you know, where my lived experience was, I was able to map that on to a client's experience." (L) "I just told them that I had an understanding, that I had felt that same pain. They just asked me, like, 'you have?', and I nodded, and that was that." This disclosure was followed by a period of silence, with both Róisín and her client "just taking it in, you know, sitting in the feeling." (R) Róisín identifies her decision to disclose as being partially motivated by a desire to reassure the client that she was not alone. Before, they would often use disclaimers when they spoke about their feelings, you know, "I know this is stupid, but…", and they faded quite quickly after that session. I think they no longer needed to justify or explain their feelings because they no longer felt they would be judged. (R)	I'd said to her, y what you're go and said, "Oh, r And I said, yes, she said, "and I thinking, I'm go While Lisa work positive relation damage this m relationship: "T major rupture i thus highlights client's mneeds
4							
5							
6							

all themes | Sheet1 | Charlemagne-Odle, S., Harmon, G | Cleary, R., & Armour, C. (2022) | Elliott, M., & Rags

Appendix D- Themes across each paper

Themes/Concepts from each paper

Charlemagne-Odle, S., Harmon, G., & Maltby, M. (2012)

- Manifestations of Distress
    - Personal Indications
    - Impact of distress
    - Impact of distress on managing workplace
- Making Sense of Personal Distress
    - Job-specific difficulties
    - Multiple/accumulated stressors
    - Professional knowledge
    - It's me
- Role & affect of others
    - Disclosure
    - Being a psychologist
    - Comparisons to others
- Experience of help/support
    - Accepting the need for help
    - Attitudes to help available
    - Experiences that help
    - Unsupportive messages
- Using experiences of distress
    - Type of clinician
    - Personal/professional life balance
    - Self-monitoring
    - Less Harsh to self

Cleary, R., & Armour, C. (2022)

- Identity as a Practitioner
    - Personal Therapy
    - Privileged position
    - Client experiences
    - Experiences of LE
- Self-disclosure as enhancing therapeutic relationships
    - Positive experience of disclosures
    - Challenges to disclosure
- Importance of supervision
    - Positive experiences
    - limitations
- Healing and Recovery
    - Therapy
    - Within work
    - Knowledge
    - Self-reflection

Elliott, M., & Ragsdale, J. M. (2020)

- Stigma in the workplace
    - Indirect prejudice & discrimination
    - Direct prejudice
- Revealing vs concealing on the job
    - With coworkers and supervisiors
    - With clients
- Asset or Liability
    - LE as an asset
    - Difficulties of LE
    - Benefits of being a therapist

Hadjiosif, M. (2021)

- Entering a community of wounded healers
- Formulating the wounded healer
- Relating to clients
- Deconstructing the wounder healer
    - Problematic fusion
    - Owning the healer

López-Aybar, L., Gonzales, L., & Kanani, A. (2023)

- Witnessed Discrimination
    - Invalidation
    - Over pathologizing
    - Clinical Psychologists as “all-knowing”
    - Training as a breeding ground for stigma
- Witnessed Discrimination Affect
    - Psychological Distress
    - Negative feelings related to the field of psychology
- Anticipated Stigma
    - Agency and induvial rejection
    - Degree of acceptance
- Internalised Stigma
    - Social desirability
    - Perceived competence
    - Cause
- Stigma Resistance
    - Academia in action
    - Engaging communities
- Engaging in stigma resistance
    - Comes with a risk
    - Is it worthwhile?

Råbu, M., McLeod, J., Haavind, H., Bernhardt, I. S., Nissen-Lie, H., & Moltu, C. (2019)

- Being helped by a therapist before I had an idea of becoming a therapist
- Exploring fantasises and realities in client work as result of working through complex personal issues
- Transforming negative experiences from personal therapy into knowledge as a professional therapist
- Powerful positive experience in personal therapy as a central aspect of professional practice

Turner, K., Moses, J., & Neal, A. (2021)

- Motivations
    - Feeling the struggle and needing support
    - Being understood
    - Professional values and duty
    - Influencing narratives
- Enablers
    - Trusting relationships
    - Feeling safe
    - Having an 'in-road'
- Barriers
    - Worrying about the impact on training
    - Voicing the unspoken
    - Internalising stigma
- Features of disclosure
    - Being selective
    - 'spilling out' verus 'controlled disclosures'
    - Testing the waters
- Responses
    - Listening versus 'jumping in the fix'
    - Exploring versus lack of curiosity
- Impact
    - Making it 'easier' to be open
    - Growing connections
    - Finding the right support
    - Clarifying positions

Appendix E- Reducing themes into main categories

Key

Master theme
Subtheme

Reducing themes into relevant categories

Stigma

- Stigma in the workplace: *indirect prejudice & discrimination* (Elliot & Ragsdale, 2020)
    - *Indirect prejudice & discrimination-* hearing coworkers talk about clients/presentations. Publications which stigmatize groups of people. Giving labels to those clients they did not like. Avoid client with certain labels. Concerns over therapists' abilities with BPD diagnosis.
    - *Direct prejudice-* being treated badly by managers, being denied promotions, being required to see psychiatrists to assess fitness to practice. Being selective who to share information with due to fears of discrimination.
- Discrimination: *Invalidation, over pathologizing, clinical psychologists as "all-knowing", Training as a breeding ground for stigma* (López-Aybar L., et al. 2023)
    - *Invalidation-* mental illness perceived as a weakness, and need to get over it, witnessing others not being believed, gaslighting, mocking patients and not believe them.
    - *Over pathologizing-* psychologists making generalisation about diagnosis, assumptions being made about functioning.
    - *Clinical psychologists as all knowing-* witnessing patronising or condescending behaviour, othering, taking away autonomy.
    - *Training as a breeding ground for stigma-* places where psychologists gathered were filled with stigma. colleagues who identified any distress had competencies and abilities questions. Fear of colleagues with LE due to cautions from other colleagues. Being advised to hide LE.
- Anticipated stigma: *agency and induvial identity rejected, degree of acceptance* (López-Aybar L., et al. 2023)
    - *Agency and induvial identity rejected-* seen as incompetent, warned to proceed with curation, fear of retaliation, exposure to patronising attitudes, fear of identity being reduced to diagnosis. Worries about others seeing them as incapable and incompetent to do their clinical role. Fear of being treated differently or pitied.
    - *Degree of acceptance-* unconditionally accepted and celebrated, acceptance dependent on assigned diagnosis. Stigma being associated with certain labels.
- Internalised stigma: *Social desirability, perceived competence* (López-Aybar L., et al. 2023)
    - *Social desirability-* pressure of acting/behaving in certain ways and being critical of self. Not like others, unlikeable, never being functional enough. Mixed emotion from proud to ashamed.
    - *perceived competence-* internalised beliefs about competency and impact of LE- not competent enough or more competent.
- Stigma resistance: *Academia in action, engaging communities* (López-Aybar L., et al. 2023)

    - *Academia in action*- organisational efforts, educational efforts, scholarship. Fighting stigma, using teaching to challenge attitudes.
    - *Engaging communities*- challenging stigma by working directly with communities- challenging misinformation, outreach, testimony
- Engaging in stigma resistance: *comes with a risk, is it worthwhile?* (López-Aybar L., et al. 2023)
    - *Comes with a risk*- compensating, impacts to academics, loosing faith in mental health systems,
    - *Is it worthwhile*- feeling proud, strong, connected to others, motivated to help others, empowering, insights, reflections (e.g. on those without as much privilege), more understanding and compassionate with clients

Experiences of distress/LE

- Identity as a practitioner: *experiences of LE* (Cleary & Armour, 2022)
- Manifestations of distress: *personal indications, impact of distress, impact of distress on managing workplace* (Charlemagne-Odle et al., 2012)
    - *Self-monitoring:* four participants had learned to recognize and respond to their distress earlier.
    - *Less harsh to self:* people spoke about ways they were no longer judgemental and rigid towards themselves, one mentioned how important it was not to associate his experience with failure.
- Making sense of personal distress: *job-specific difficulties, multiple/accumulated stressors, professional knowledge, it's me* (Charlemagne-Odle et al., 2012)
    - *Impact on client work:* participants spoke about several ways their clinical work was affected e.g. negative emotions, increased level of empathy with clients. Feelings of uselessness, helplessness and indifference.
    - *Impact of distress on managing workplace:* participants spoke about not wanting to be at work. Some took sick leave but felt guilt or pressure to return.
- Healing and recovery: *self reflection* (Cleary & Armour, 2022)
    - *Self reflection:* reflection during training can expose you to parts of yourself that you may not see positively. Importance of dealing with own issues.

Positives of LE

- Asset of Liability: *LE as an asset,* (Elliot & Ragsdale, 2020)
    - *LE as an asset-* seeing clients as human beings with the potential to recover and be successful, having a deeper understanding, made them compassionate, idea that pain and suffering makes them the therapist they are. Wanting others to have good experiences unlike them [kaller]
- Impact of distress on client work – increased level of empathy with clients
- Using experiences of distress: *type of clinician* (Charlemagne-Odle et al., 2012)
    - Five participants spoke about gaining deeper understanding of their clients making them a richer psychologists. Two spoke about the unique insights added a special depth to their work.

- Identity as a practitioner: *Personal therapy* (Cleary & Armour, 2022)
    - *Personal therapy: being a client of mental health services, when someone has bad experiences it resonates with them [Seamus] , not wanting clients to have same negative experiences they experienced as client [Roisin]*
- Self-disclosure as enhancing therapeutic relationships: *positive experiences of disclosure* (Cleary & Armour, 2022)
    - *positive experiences of disclosure-* can reassure client is not alone, understanding clients, development of therapeutic relationships.
- Formulating the wounded healer (Hadjiosif, 2021) participants gave accounts of how they relate to clients,
- Internalised stigma: *perceived competence,* (López-Aybar L., et al. 2023) being more competent then colleagues due to more empathy. Having a deeper understanding.
- Engaging in stigma resistance: *is it worthwhile?* (López-Aybar L., et al. 2023)
    - *Is it worthwhile-* feeling proud, strong, connected to others, motivated to help others, empowering, insights, reflections (e.g. on those without as much privilege), more understanding and compassionate with clients
- Being helped by a therapist (Råbu, et al., 2019) one person reports they would never have became a therapist without experience of therapy as something powerful and meaningful. Another found that therapy earlier in their life motiaved them to go into psychology.
- Exploring fantasises and realities in client work (Råbu, et al., 2019) having similar experiences added to ability to assist and help clients. Insight and impact of treatment. Experience from personal therapy guide therapists.
- Transforming negative experiences (Råbu, et al., 2019) having experiences of therapy allowed the therapists to be aware of what was helpful and unhelpful within therapy.
- Barriers: *worrying about the impact of training, voicing the unspoken, internalising the stigma* (Turner, K., Moses, J., & Neal, A. (2021).)
    - *Worrying about the impact of training-* worries about fitness to practice being questioned, if they fail or have to stop training
    - *Voicing the unspoken-* lived experience was not spoken about much and so uncertainty about if it was 'acceptable' to discuss it
    - *Internalising stigma-* being hindered in disclosing due to feelings of internalised stigma e.g. feeling embarrassed and anxious to disclose, worries of being seen as 'weak'.

<u>Difficulties of LE</u>

- Asset or Liability: *Difficulties of LE* Elliot & Ragsdale, 2020)
    - *Difficulties of LE-* impact of clients trauma history and potential triggers. Feeling deeper leading to being overwhelmed. Over empathizinf resulting in "failing in the well of despair". Self concept being linked to work performance. Worries about hurting a client.
- Deconstructing the Wounded healer (Hadjiosif, 2021) having problematic fusion with the wounded healer and promte usion with states of suffering.
- Engaging in stigma resistance: *comes with a risk,* (López-Aybar L., et al. 2023)

    - *Comes with a risk*- compensating, impacts to academics, loosing faith in mental health systems,
- Powerful positive experience (Råbu, et al., 2019) shame with being a client themselves, and how this had to be exposed t be shared and explored. And some difficulties with shame and wanting to be invisible.

Identity

- Identity as a practitioner: *personal therapy, client experience, experiences of LE* (Cleary & Armour, 2022)
    - *Client experiences:* one participant expressed a belief that an alliance with clients should be present in the identity of all psychotherapist.
    - *Experiences of LE:* being both a survivor ad practitioner [roisin] – dual identity
- Entering a community of wounded healers (Hadjiosif, 2021) coming to terms with their wounds and being accepted within a certain community. Idea that being wounded is part of identity.
- Role and affect of others: *Being a psychologist* (Charlemagne-Odle et al., 2012) quotes suggesting what a psychologist is expected to be like [Francesca] and what they did not want seen as weak [Ann].
- Making sense of personal distress: *Its me* (Charlemagne-Odle et al., 2012) some accepted their difficulties as inherent in their temperament or biological.
- Deconstructing the Wounded healer (Hadjiosif, 2021) owning the healer.

Disclosure

- Revealing vs concealing on the job: *with coworkers and supervisors, with clients* (Elliot & Ragsdale, 2020)
    - *With coworkers and supervisors-*
      →*AGAINST* fear of being "outed" and career begin over [Dr Hart]. Blame being on diagnosis not situation. Fearing stigma and discrimination, worries over competence being questioned. Worries how it could bias perceptions
      →FOR wanting to share to educate, sharing with trusted colleagues, view that some things are more okay to be shared e.g. depression but not self injury.
    - *With clients-* focus should be on the clients truama, not intruding with own experiences [Gabriel]. How clients have found disclosure helpful and helps them face their own situation. When to use [Lake].
- Role and affect of others: *disclosure, being a psychologist* (Charlemagne-Odle et al., 2012)
    - *disclosure* - positive experience, however also reports of fear and shame with sharing. Also need to maintain pretence.
    - *being a psychologist-* negative consequences anticipated from disclosure as a psychologists, not wanting to be seen as weak.
- Self-disclosure as enhancing therapeutic relationships; positive experiences, challenges to disclosure (Cleary & Armour, 2022)

    - positive experiences- can reassure client is not alone, understanding clients, development of therapeutic relationships.
    - Challenges to disclosure- potential damage it may cause to the relationship
    - Being a psychologist: some participants anticipated negative consequences from open disclosure.
- motivations: *feeling the struggle and needing support, being understood, professional values and duty, influencing narratives* (Turner, K., Moses, J., & Neal, A. (2021)
    - *feeling the struggle and needing support-* needing to disclose for support
    - *being understood-* disclosure is helpful to see that "side" of the person and be better understood and prevent people misattributing difficulties to personality flaws or negative attirubutes
    - *professional values and duty-* people were motivated to disclosure in line with professional values e.g. to be a safe professional
    - *influencing narratives-* wanting to disclose to influence conversations around mental health- being open with colleagues.
- Enablers: *trusting relationships, feeling safe, having an 'in-road'* (Turner, K., Moses, J., & Neal, A. (2021).)
    - *Trusting relationships-* finding it easier to disclose when they hace a good relationship- trusting the person will be empathetic and containing.
    - *Feeling safe-* how disclosure was enabled depended on how safe the trainee felt, interpersonally and contextually.
    - *Having an in-road-* more able to disclose when disclosure had some relevance to conversation
- Features of disclosure *: being selective, spilling out vs controlled disclosures, testing the waters (*Turner et al., 2021)
    - *Being selective –* others not knowing the full story, disclosing to those they trusted gradually
    - *Spilling out vs controlled disclosure-* many spoke about planned disclosures that were less emotion laden
    - *Testing the waters-* gauging responses as to weather to disclose
- Responses *: listening vs jumping to fix, exploring vs lack of curiosity (*Turner et al., 2021)
    - *Listening vs jumping in–* positive experiences when person had listened, been pen and accepting rather then trying to 'fix it;. Some said person was invalidating or appeared to jump to questions about risk or solutions.
    - *Exploring vs lack of curiosity-* appreciating people taking time to explore disclosure with curiosity.
- Impact *: making it easier to be open, growing connections, finding the right support, clarifying positions (*Turner et al., 2021)
    - *Making it easier to be open–*easier when person was supportive and others had experiences that was not supportive so this would prevent them from disclosing again.
    - *Growing connections-* relationships were perceived to change from disclosure, many felt disclosure made them stronger or deeper.
    - *Finding the right support-* disclosure functioned as a pathway for some to support when needed. Practical and emotional support e.g. extensions, adaptations, accessing personal therapy.

- *Clarifying positions-* how to encourage other to disclose safely to people they trust, rather than keeping it hidden.

Support/Help

- Experience of help/support; accepting the ned for help, attitudes to help available, experiences that help, unsupportive messages (Charlemagne-Odle et al., 2012)
  - *Accepting the need for help:* for some the point they accepted need for help was straightforward e.g. advice from people they trusted, seek professional help, made aware of support available. For others they struggled some time before they recognised a need for professional help. Most frequent mentioned help was medication and therapy.
  - *Attitudes to help available*: one reported an ambivalence to medication, two reported former unhelpful experience of therapy put them off. Three were concerned about the level of support they would get through the NHS. Idea of needing someone more qualified when a psychologist is distressed [Francesca]. Some spoke positively about therapy but spoke about challenges to the process e.g. taking time to be persuaded, judgments, trust, challenges admitting
  - *Experience that help*: various self-help strategies with varying success. Two spoke about it as an opportunity to re-build their sense of value. People spoke about various ways they felt supported by colleagues e.g. managers being flexible with timekeeping and reducing pressures, offering protection for other colleagues, also contact calls/texts/letters during sick leave.
  - *Unsupportive messages*: inflexibility in the job, lack of faith in their work by colleagues, discouraging messages that it was unacceptable to need personal support as a psychologist.
- Importance of supervision: *positive experiences, limitations* (Cleary & Armour, 2022)
  - *Positive experiences:* being able to share experience openly provides supervisor with insights into inner world.
  - *Limitations:* potential of being unable to reflect on lived experience or request support. Supervisor might question abilities or punish them for speaking up.
- Healing and recovery: *therapy* (Cleary & Armour, 2022)
  - *Therapy- benefits of personal therapy e.g. managing countertransference.*
- Asset of Liability: *benefits of being a therapists* (Elliot & Ragsdale, 2020)
  - *Benefits of being a therapist-* how skills helped themselves, helping others helps them and forces them to take care of themselves.
- Discrimination: *Training as a breeding ground for stigma* (López-Aybar L., et al. 2023)
  - *Training as a breeding ground for stigma-* Being advised to hide LE.
- motivations: *feeling the struggle and needing support* (Turner, K., Moses, J., & Neal, A, 2021)
  - *feeling the struggle and needing support-* needing to disclose because they support to manage active difficulties e.g. needing to talk, access support, prompt change

Appendix F- Sample of the themes master table

Major theme	Second order construct (sub-theme)	Journals- authors comments	First order constructs
STIGMA	Witnessed Stigma	**indirect prejudice** (E&R) hearing coworkers talk about clients/presentations, publications, described situations in which another mental health professional put down people who shared their diagnosis without realizing they were speaking to someone dealing with the very same condition.	Dr .Anderson, described how one of her coworkers said she never works with clients who are depressed because they were "bad for her energy." Dr Baker with OCD, described her reaction when she overheard a therapist making fun of exposure therapy in a mocking tone: "It was horrific. I was so pissed off. It's a good thing I was not actually in the room—I was on the phone calling in." Ms. Dodd, a dialectical behavioral therapist (DBT) with BPD, was so outraged by a publication on people with BPD that she wrote the journal editor and told them "how the stigmatization is actually preventing people . . . from getting help. It's also affecting how clinicians treat them, so knock it off everyone!" Dr. Carlin,, heard so much negativity toward people with BPD that she figured "a lot of times people [other therapists] just label people with borderline because they don't like them."
		over pathologizing (L et al) psychologists making generalisations about diagnosis, assumptions being made about functioning.	I have heard various professionals indicate that simply because a patient is schizophrenic or has a disruptive behavior disorder they will "never be able to get better" etc. Very frequently equating symptoms to diagnosis ("if they're doing ___, it's because they have ___").
		Training as breeding ground for stigma (Lopez et al) Prosumers described that within clinical psychology, others described or treated individuals with lived experiences as morally undesirable (e.g., dangerous, manipulative, and others), which	The professor teaching psychopathology class would turn the class into fun and unfortunately, some jokes would be about diagnoses: "the last one you'd want to get in personality disorders", "these people would make very entertaining friends", "the type of schizophrenia

		resulted in others mocking, ignoring, denying services, and generally dehumanizing them. stigma where psychologists are together, having competencies questioned, being advised to hide LE Prosumers observed that whenever another colleague expressed any type of psychological distress, they were subjected to having their competency, ability, skills, and talents questioned in favor of achieving a higher level of performance.	you don't want in your family." My dct once said that we try to screen out people with personality disorders at our program interviews.
		being a psychologist (C et al) distress seen as 'hidden' and 'taboo' within healthcare profession. having affirming responses "a depressed psychologist".	'Not wanting to be seen to be weak, functioning less well than anybody else . . . a fear that other people may see me as not being able to do my job as well'. (Frncessca) 'The doctor patted me on the head and said "oooh a depressed psychologist now that's not very good is it?"' (Ann).
		importance of supervision (C & A) observing stigmatising and infantilising beliefs towards certain client presentations- This observation led Róisín to understand her internal supervisor as expecting her to be devoid of weakness, suggesting that they may view perceived woundedness as a liability.	There was a sort of perceived fragility to the clients, and of course if you're hearing your clinical lead be dismissive or condescending towards clients with whom you have similar experiences, you know, the message you're coming away with is that they will also perceive you as being fragile. (Rosini)
	Own stigma	Indirect prejudice (E&R) the two therapists who spontaneously expressed prejudices of their own spoke exclusively about BPD, voicing concerns over whether therapists with BPD should be treating clients who also had the condition	Dr. Edwards, went so far as to say that if she knew a therapist had BPD, "I would be really hesitant about referring someone to them." Dr Anderson expressed that it's "a little terrifying to think that person [with BPD] is a therapist."
		Training as breeding ground for stigma (Lopez et al Additionally, some prosumers expressed having started to fear individuals with lived experiences because they were cautioned to stay away from them by other colleagues, creating a contagion effect surrounding stigmatizing beliefs and attitudes.	No direct quotes

Appendix G- Ethical approval

UNIVERSITY OF BIRMINGHAM

Dear Owen Forster and Candice Valentine

RE: Exploring the experiences of clinical training for trainee clinical psychologists who identify as having lived mental health experience: a qualitative study

Application for Ethical Review: ERN_0673-Apr2023

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Committee.

On behalf of the Committee, I confirm that this study now has ethical approval.

Any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards,

The Co-Chairs of the Science, Technology, Engineering and Mathematics Committee

E-mail: ethics-queries@contacts.bham.ac.uk

Appendix H- Consent form

Title of study: Exploring the experiences of clinical training for trainee clinical psychologists who identify as having lived mental health experience: a qualitative study

University: University of Birmingham, as part as the Doctorate in Clinical Psychology

Researcher: Candice Valentine Contact details: [redacted]

Supervisor: Dr Owen Forster Contact details: [redacted]

You have been invited to participate in the study outlined above. Please read the following information carefully. If you consent to the terms detailed on this consent form, please write your initials in each box and sign your name at the bottom of this

page.

I acknowledge that the details of the study that I will be participating in have been explained to me by the researcher and I have been given the opportunity to ask questions. [initials]

I have been informed that my participation in the interview is voluntary and that any data included in the research project will be confidential. [initials]

I understand that my interview will be audio-recorded so that the researchers have an accurate record of what I say. [initials]

I understand that my name will not be included in any reports or publications about the study being conducted. Any quotations used will not identify me personally or the university course I attended. [initials]

I understand that I have the right to withdraw my data up to one month following the interview, without any obligation to explain my reasons for withdrawing. If I withdraw from the study, I understand that any data collected from me will be destroyed [initials]

immediately.

If I do not withdraw my data from the study, I understand that my data may be used

for analysis and publication. [initials]

If I do not withdraw my data from the study, I understand that my data will be stored

in a safe and secure location, only accessible to the researcher and the academic

supervisor. [initials]

I consent to the above terms and wish to participate in the interview.

Signed: _____ Date: _____

When the research project is finished, I would like to be informed about the results of the

study (delete as appropriate) Yes No

If yes, please provide your email address below:

_____

Appendix I- Debrief form

Debriefing Sheet

Thank you so much for taking the time to talk to me and participating in our research.

What happens next?

Your interview will be typed into a transcript. I will then analyse the data by looking for themes across the interviews with other trainee clinical psychologists who took part in the research.

If you would like, I will also send you a summary of my main findings. Please let me know where you want me to send you this.

If you have any questions about the research, you can contact me at the following email address: [redacted] or the academic supervisor, Dr Owen Forster: [redacted] .

Where can I get information and support?

If you would like further information or support due to issues raised within our conversations, you may wish to discuss this with your course tutors, individual tutor, university wellbeing team, personal advisor and/or course director.

Below are several external organisations which can provide information or support:

1. Samaritans

www.samaritans.org

Free and confidential emotional support via telephone (call 116 123) or email (jo@samaritans.org)

2. Mind

www.mind.org.uk

Infoline provides information and signposting service call 0300 123 3393 or email infro@mind.org.uk

3. Mental Health Innovations

Text "SHOUT" to 85258 for free to be connected to a volunteer for an anonymous conversation via text.

4. NHS urgent mental health helplines

To find your local urgent NHS helpline use https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

5. You can also contact your GP for further support.

Appendix J- Recruitment email

Recruitment Email to Courses

To whom it may concern,

My name is Candice Valentine and I am contacting you today regarding a study that I am conducting.

I am a Trainee Clinical Psychologist completing a Doctorate in Clinical Psychology at the University of Birmingham. For my research project, I will be conducting online interviews with current trainees with lived experience of mental health, exploring their experiences of training on the doctorate. The aim of the study is to gain an insight into the experiences for trainees with lived experience, break down the stigma and potentially help guide future support during training.

I would appreciate it if you could circulate this email to your second and third year trainees, I have also attached a poster with all the details outlined. It is important to highlight that any information relating the trainee's identity or their university will be fully anonymised and will remain confidential in the write-up of the study.

If you have any questions about the research or wish to find out more about the study, you can contact me at the following email address: [redacted] or the academic supervisor, Dr Owen Forster: [redacted] .

I appreciate you taking the time to read this email and I hope to hear from you soon.

Kind Regards,

Candice Valentine

Lead Researcher and Trainee Clinical Psychologist

University of Birmingham

Appendix K- Study advert for social media

UNIVERSITY OF BIRMINGHAM

Are you a Trainee Clinical Psychologist with lived experience of mental health difficulties?

- **Are you a current Trainee Clinical Psychologist studying within the UK?**
- **Are you in your second or third year of study?**
- **Do you identify as having lived experience of mental health difficulties (diagnosed or undiagnosed)?**

Exclusion Criteria:

- Studying at the University of Birmingham or University of Coventry and Warwick
- Have a physical health condition
- Have a neurodevelopmental disorder
- Identify or diagnosis of substance use disorder
- In your first year of study

I am conducting research into how individuals with lived experience of mental health difficulties, experience training on the Doctorate of Clinical Psychology .

This study hopes to gain an insight into the experience of training for clinical psychology trainees with lived experience. This could potentially influence future support available and guide training courses and supervisors.

If you would like to take part in this study, you will need to attend an **online interview**, which will last approximately 60 minutes.

If you are interested in participating in this study or would like further information please contact me:

Candice Valentine on [redacted]

or my Academic Supervisor Dr Owen Forster on [redacted]

Appendix L- Information sheet

Information Sheet

Thank you for your interest in participating in the study. You are invited to participate in a research project about trainee clinical psychologists with current or previous history of mental health difficulties, whilst on clinical training. Prior to the interview commences, it is important to understand the purpose of this study and what participation involves.

Please take your time to read the information, and if you have any questions please ask the researcher.

Why is this study being conducted?

This study aims to explore experiences of clinical training for trainee clinical psychologist who identify as having lived experience with mental health difficulties. This research hopes to gain an insight of the experience of training for clinical psychology trainees and thereby influence future support available and potential guide training courses and supervisors.

What will the study entail?

If you wish to participate in the study, you will be asked to attend an interview which will be approximately 60 minutes long. The interview will be facilitated online. During the interview you will be asked about your experience of clinical training as a trainee with lived experience. Prior to completing the online interview, you will need to complete some documents including a consent form and demographics information form.

Do I have to participate in the study?

Participation in the study is entirely voluntary. If you would like to participate in the study, you will be sent a consent form. Once you have received the consent form you will need to read this carefully and if you still wish to participate you will need to sign and date the form.

You will then provided with a participant number which will be used to identify your transcript if you should wish to withdraw at a later date. You are able to withdraw from the study up to one month following your interview. To withdraw your data please email the researcher with your participant number. If you wish to withdraw during the interview, please tell the researcher and they will end the interview immediately.

On the consent form, there is also an option to receive information about the findings of the study. Please indicate on the form if you wish to receive a summary of the findings.

Will the information I provide during the interview be confidential?

All interview data will be anonymised so that the information provided in participant interviews will remain confidential. Names and other forms of identifiable information will not be included in reports or write ups. It is important to note that all interviews will be audio recorded so that the researchers have an accurate record of what has been said. However, only the researcher and the academic supervisor will have access to the audio-recording and any quotations will be fully anonymised. The Ethics Committee at the University of Birmingham have reviewed and approved this research project.

What if I have further questions about the study?

If you require further information about the study, please do not hesitate to contact the researcher, Candice Valentine, or academic supervisor, Dr Owen Forster. You can contact Candice at the following email address: [redacted] and you can contact Dr Owen Forster at the following email address: [redacted] .

Thank you for showing an interest in the study. I hope the information provided in this document has been useful to you. Please do not hesitate to ask the researcher about any further questions that you might have about the study.

Appendix M- Demographic form

Demographic information Form

Title of study: Exploring the experiences of clinical training for trainee clinical psychologists who identify as having lived mental health experience: a qualitative study

University: University of Birmingham, as part as the Doctorate in Clinical Psychology

Researcher: Candice Valentine Contact details: [redacted]

Supervisor: Dr Owen Forster Contact details: [redacted]

Please complete the questions below. If you have any questions, please ask the researcher.

Gender: Choose an item.

Age: ☐ 20-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46+

Ethnicity: Click or tap here to enter text.

Year of study: ☐ Second year ☐ Third year ☐ Fourth year or beyond

What mental health difficulty/difficulties do you identity as having: Click or tap here to enter text.
Do you have a formal diagnosis for any mental health difficulties listed above: Click or tap here to enter text.

Appendix N- Interview questions

Interview schedule

Introductions and engagement

- Introduce self
- Go through information sheet and consent form
- Re-iterate confidentiality and right to withdraw, reschedule etc
- Collect demographic data if not already sent

1. Before we start, how do you prefer to refer to "lived experience" e.g. specific condition, mental health condition, etc

2. What is it like being a trainee with [preferred term]?

3. Tell me about your experiences with [preferred term] on training:
   - teaching
   - placement
   -research
   -being assessed

4. How does living with effect your identity as being a trainee?

5. Have you disclosed this?

6. Are there any specific strengths that come with being a trainee living with [preferred term]?

7. Are there any limitations or dilemmas that come with being a trainee living with [preferred term]?

8. Can you tell me about any support that you've accessed whilst on training in relation to being a trainee living with [preferred term]?
   Occupational health, university disability and wellbeing service, formal adjustments, support from course staff?
   Mentorship, psychologists with lived experience, other students with lived experience?
   Other?
   What helpful/ unhelpful/ would be better?
   What support systems would you like to be available?

9. What advice would you give to other trainee clinical psychologists with lived experience?

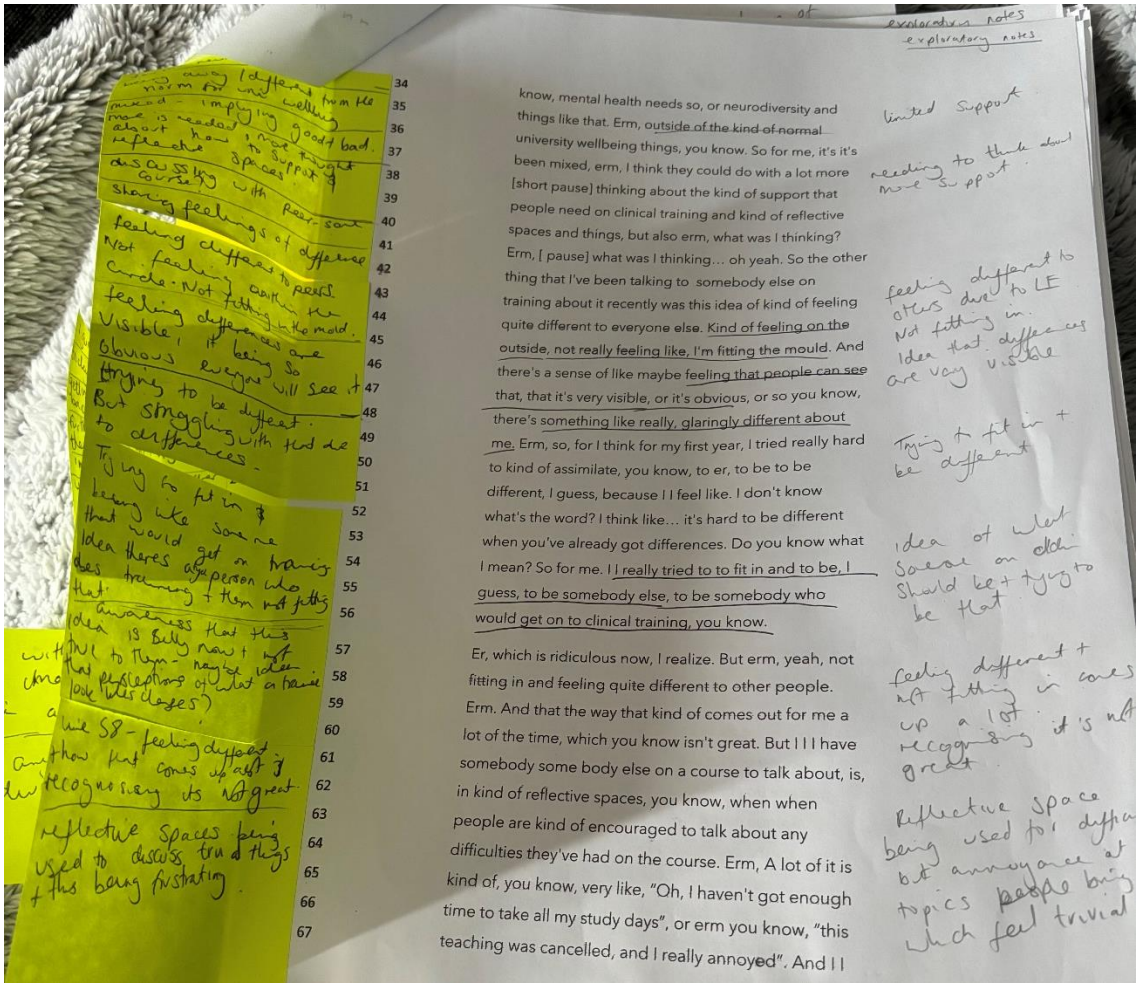
10. What advice would you like to give to training programmes in relation to trainees with lived experience?

    lastly, is there anything I haven't asked about that you would like to tell me?

Debriefing

- How do you feel about the conversation we just had? Is there anything that bothered you? Do you have any questions? You can contact me if you think of any questions later
- Here are some contact details for more support if you'd like to talk to someone

Appendix O- Transcript with initial noting and experiential statements

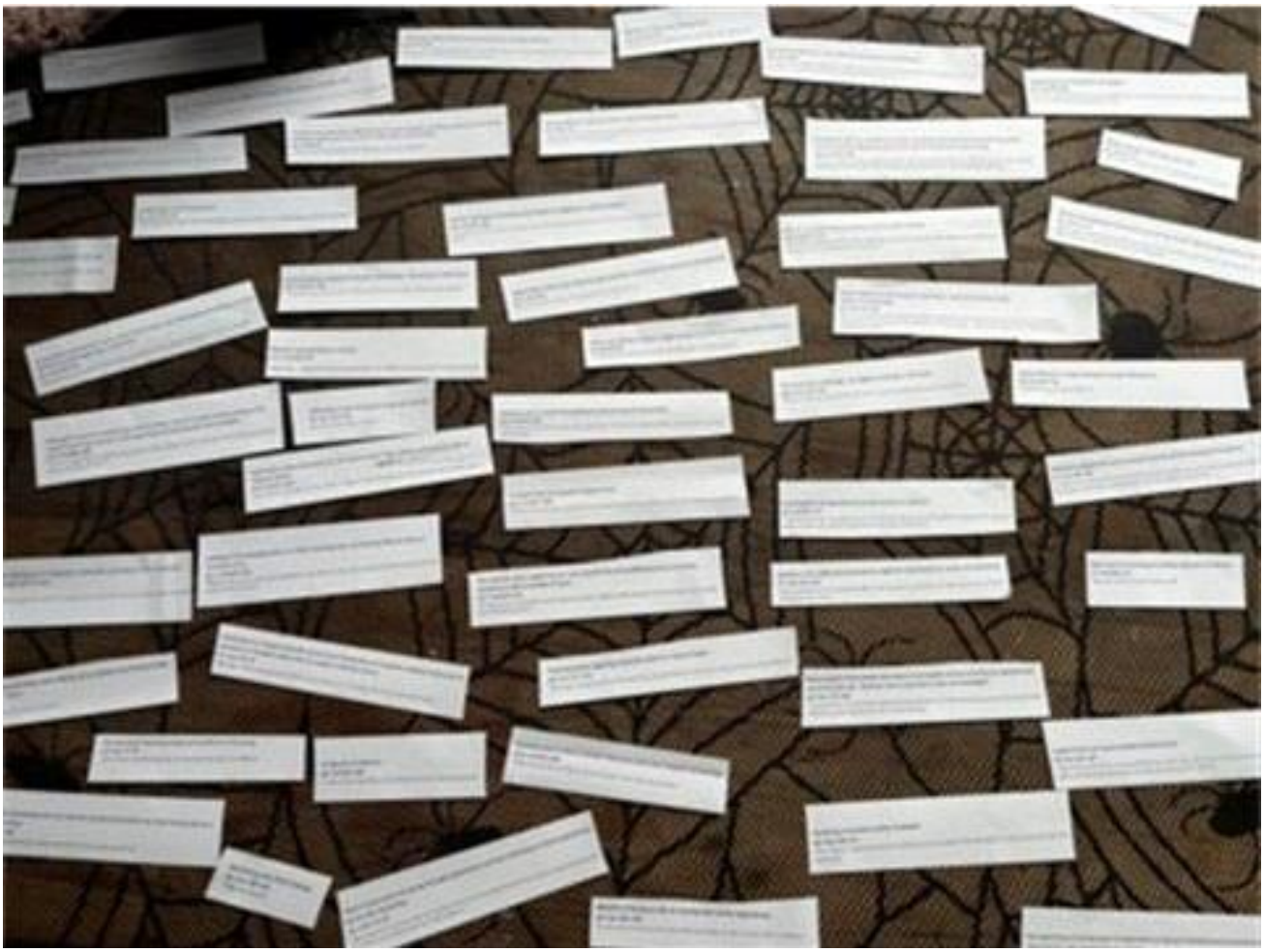


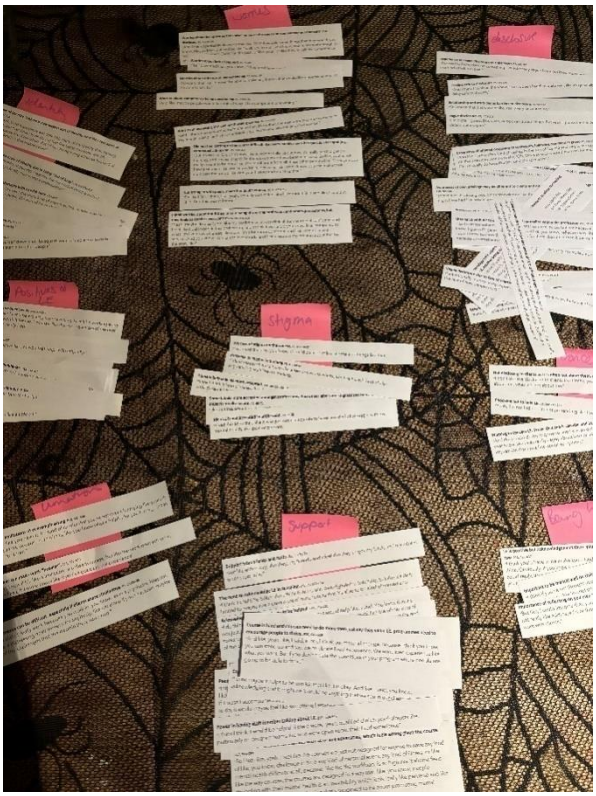
know, mental health needs so, or neurodiversity and things like that. Erm, outside of the kind of normal university wellbeing things, you know. So for me, it's it's been mixed, erm, I think they could do with a lot more [short pause] thinking about the kind of support that people need on clinical training and kind of reflective spaces and things, but also erm, what was I thinking? Erm, [pause] what was I thinking… oh yeah. So the other thing that I've been talking to somebody else on training about it recently was this idea of kind of feeling quite different to everyone else. Kind of feeling on the outside, not really feeling like, I'm fitting the mould. And there's a sense of like maybe feeling that people can see that, that it's very visible, or it's obvious, or so you know, there's something like really, glaringly different about me. Erm, so, for I think for my first year, I tried really hard to kind of assimilate, you know, to er, to be to be different, I guess, because I I feel like. I don't know what's the word? I think like… it's hard to be different when you've already got differences. Do you know what I mean? So for me. I I really tried to to fit in and to be, I guess, to be somebody else, to be somebody who would get on to clinical training, you know.

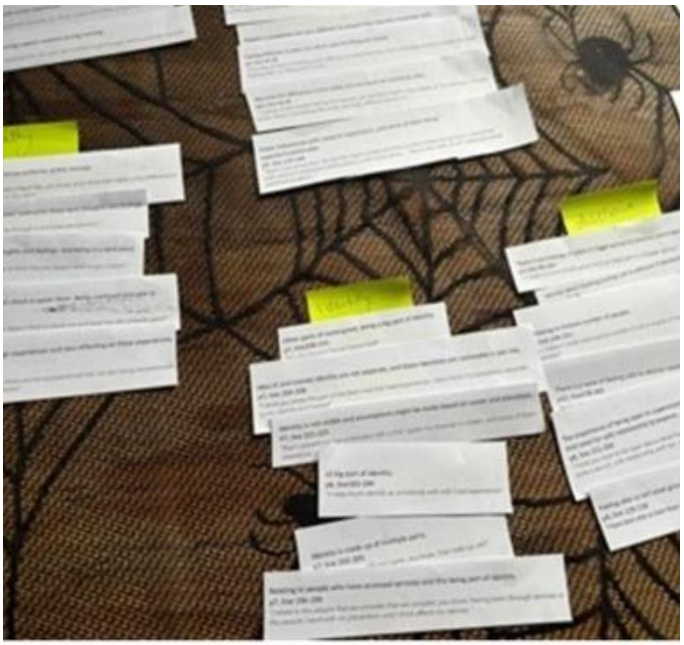
Er, which is ridiculous now, I realize. But erm, yeah, not fitting in and feeling quite different to other people. Erm. And that the way that kind of comes out for me a lot of the time, which you know isn't great. But I I I have somebody some body else on a course to talk about, is, in kind of reflective spaces, you know, when when people are kind of encouraged to talk about any difficulties they've had on the course. Erm, A lot of it is kind of, you know, very like, "Oh, I haven't got enough time to take all my study days", or erm you know, "this teaching was cancelled, and I really annoyed". And I I

Experiential Statements		
Own belief that shes shouldn't be unwell because of her profession. P5, 152-153	149	Interviewer: Yeah. so how does having lived experience affect your identity as a
	150	training.
	151	
	152	P7: I think there's definitely this feeling for me of I shouldn't be poorly because
Feeling like a freud, extra impoter syndrome due to LE. P5, 155-161	153	I'm in psychology. I know what I should do, you know. Like I'm I'm telling things to
	154	my clients and things that should help them for the same, the exact, same things
	155	I'm going through. So I guess imagine, for like a bit of a fraud particularly since
Assumptions from others that psychologists won't be mentally unwell. P5, 166-168	156	I'm still teachin… like learning. So I'm already in that position of life, feeling like
	157	I'm maybe not the most competent, because I'm still finding my way, and I'm not
	158	getting quite right all the time not to completely confident in my processes, which
	159	is to be expected to trainee level. But then there's this added dealing for me. I
Feels a resposnbility that should be seen as well to others. P5, L173-175	160	think of feel like a bit of a fraud, because I can't. I'm telling people to do things or
	161	suggesting I do things people in that. I can't even do it myself. So it was like this. I
	162	don't know, I guess, like, maybe this extra imposter syndrome. I'm obviously not
Difficult being a trainee with LE. P5, L176-177	163	even practicing what I preach, so why should these people listening to me? I think
	164	it's also difficult, because, like my my dad has made a comment before as well
	165	about when I first had, when I had my first child, so I had two whilst I'm on the
Increased understanding and empathy. P5, L 182-185	166	course. When I had my first child he He said to me, 'oh, at least we don't have to
	167	worry about you getting post natal depression because you're a psychologist'. he

Appendix P- Grouping of PET's







Appendix Q- Example of participants PET's

Personal Experiential Themes for participant 1

Empathy

Understanding of client's thoughts and feelings

- Understanding of negative thoughts and feelings. And being in a dark place.
  p10, line297-304
  "I really do and I know what it's like to think that you haven't kind of got a future"

- Knowing what its like to recover/ overcome these dark thoughts and feelings.
  p10, line303-306
  "And I know what it's like to come through it and have perspective."

Allowing for authenticity

- Genuine empathy allows for being authentic within therapy. p10, line307-314
  "but I genuinely know what it, what it feels like, you know, and I think that makes a big difference in being authentic and being real in the room."

Allows for positive responses

- Experiences mean disclosures do not shock or panic them. Being unphased and able to respond calmly. p10, line315-325
  "and I think a strength *for me. is that I it doesn't kind of shock me and send me into a frantic panic"*
- Experiences mean they know how to respond, due to empathy. p 10, line 310-313
  "And you know the way that you can maybe respond to things you know, with with just true empathy, like true understanding"

Benefits of LE (alongside empathy)

- LE means they can question systems more. p11, line327-338
  "I think it also benefits, and like kind of questioning things a little bit more like questioning systems."

- There is hard work into going through experiences and also reflecting on these experiences, but its also rewarding. p1, Line 15-20
  "I get quite a lot out of not only having been there and having experienced that, but also having recovered and put a lot of, a lot of work into kind of self-reflection"

Sense of community/ belonging to group

Positives of experiences of community

- Benefits of having an ally on training with similar experiences. p9, line 285-290
  "So we kind of look out for each other and keep an eye on each other a little bit,"
- Identifying with other trainees. p6, line 189-190
  "they, my people."

Connecting with people with similar experiences

- idea you gravitate to people with similar experiences. p3, line91-93
  "people kind of gravitate towards erm towards, you know, certain friendship groups and things like that"

Others not understanding

- Being a part of a community and others not understanding or being aware. p6, line185-189
  "Why do you see them so often? Why do you join these groups?"

Perception of differences

Feeling different to peers

- Feelings of being different comes out a lot. p2, line57-60
  "not fitting in and feeling quite different to other people. Erm. And that the way that kind of comes out for me a lot of the time"
- feeling different is a big challenge & always feeling that. p4, line126-129
  "that feeling of being different"
- Feeling different to peers on cohort, and not fitting the mould. p2, line 43-45
  "this idea of kind of feeling quite different to everyone else. Kind of feeling on the outside, not really feeling like, I'm fitting the mould."

Difference is noticeable by others

- Idea that this difference is very visible and very easily be noticed by other. pg2, line 46-49
  " a sense of like maybe feeling that people can see that, that it's very visible, or it's obvious, or so you know, there's something like really, glaringly different about me."

Feeling others are different

- Power imbalances with research supervisors, and sense of them being superior/unattainable. p5, line 159-166
  "And I I, you know that I do feel like there's a little bit of this power imbalance going on sometimes with research supervisors where there's a bit of you know… they're the really smart, highly educated, qualified academic."

- People in academia are very different to people they typically associate with. p5, line153-157 *" I find that the you know, people in academia are very different to people I know in in my normal life"*

Identity

Identity is made up of multiple aspects

- Identity is made up of multiple parts. p7, line 202-203 *"there's so many different parts, you know, that make up self."*
- Idea LE and trainee identity are not separate, and these identities are noticeable in job role.p7, line 204-208 *"I think you know the part of me that's had that lived experience. I don't think it's completely separate to my identity as a trainee"*
- Other parts of social grace, being a big part of identity. p7, line208-215 *"like the Normal Social Graces stuff"*

LE makes up a big part of Identity

- LE big part of identity. p6, line183-184 *"I I very much identify as somebody with with lived experience"*
- Relating to people who have accessed services and this being part of identity. p7, line 196-199 *"I relate to the people that we consider that we consider, you know, having been through services or the people I work with on placement. and I think affects my identity."*

Identity is not always visible

- Identity is not visible and assumptions might be made based on career and education. P7, line 215-225 *"that's something I've contended with is that I guess my diversity is unseen, and some of that's intentional, you know"*

Disclosure

Factors needed to disclose

- There is a need of feeling safe to discuss upsetting experiences with clients. p12, line378-383 "And I I think for me, I only really feel comfortable going there when I feel safe and like, I won't ruminate and feel really anxious."
- Feeling able to tell small groups. p4, line 129-136 *"I have been able to have those conversations honest, you know, in a smaller group, or all the supervisors."*

Importance of disclosure

- The importance of being open in supervision to discuss transference & countertransference. And need for safe relationship to explore. p8, line 251-260 *"I think you have to be open about what that's bringing up in you. in that context. So luckily, I have quite a secure, safe relationship with her, and I'm able to explore that"*

Experiences of disclosure

- Disclosing to limited number of people. p8, line 248-251
  "No, I haven't really told anyone outside of just a couple of trainees who I'm really close with and one supervisor"

Factors limiting disclosure

- There is less feelings of safety in bigger groups to disclose, and it being harder to open up. p3, line 99-104 *"it's hard to kind of talk about that and feel safe in a bigger group"*
- Vulnerability of placement due to short time frame, and challenging of building a trusting relationship with supervisor in that time. p12, line344-351
  "You don't have an awful lot of time to build that trusting relationship. And it's very vulnerable"

Normalising/ talking about Lived experience

Power in sharing LE

- *Lecturers or supervisors sharing LE or challenges is powerful, and helps to feel connected knowing that psychologist with LE exist.* *p16, line 509-520 "And that actually, I found that really good, because I thought, Gosh, you know, we are out there. We just hardly ever talk about it."*

Courses/profession needing to normalise LE

- Talks about struggles within the profession at the beginning of training may encourage people to open up and use reflective spaces. p15, line459-468
  "I mean, maybe if we had that from the beginning, I might feel a little bit more inclined to open up in those reflective spaces instead of sitting back and feeling, quite scared."
- Courses needing to normalise psychologists struggling or needing support. p16, line505-508
  "a lot more normalizing around struggling just generally and seeking support as a clinical psychologist or as a trainee"
- Need to normalise LE within the professional on the course to help break down stigma. p14, line452-456 *"just building into the course a lot more normalizing and just kind of breaking down that stigma about clinical psychologists having struggled with something or struggling with something"*

Difficulties for psychologists being unvoiced

- No one is talking about psychologist leaving due to burn out. Or about struggles. p15, line456-465 *"there's not an awful lot of acknowledgment that actually, you know, a lot of us do struggle"*

Experiences of training/ profession being difficult

Difficulties as a trainee

- Being a trainee is hard work and 'a lot'. p1, Line 12-15
  "I think there's, there's lots of ways to answer that question"

- Difficulties is part of reasons to go into training P4, line 122-124 *"But that's also why I'm here."*

Feeling difficulties are bigger then others

- Having to stay silent about difficulties due to others problems not being as big and worries at her problems will be seen as too much or make others uncomfortable. p3, line68-78
  "If this is your vulnerability, then like fuck, I can't say anything."
- Although its easy to compare yourself to others, there is a need to know being on the course means you can do it. The importance of working with own strengths p15, line484-500
  "that it's really easy to compare yourself to other people. but just the fact that we here, you know, means that we can do it."

Experiences of helpful support

- Support plans are limited but are helpful. p13, line394-405
  "but that's helpful that they put that together for me, because it's kind of it's my little you know, cards that I can wave when things get too much."
- Benefit of having counselling as a space to explore. p13, line390-394
  "To be honest, it really was helpful to have that space"
- Importance of having a small group to focus of LE. p13, line420-424
  "it's been helpful to have that small small, you know, group of people to to talk to about. You know, specifically lived experience things"
- Importance of maintaining support systems during training. p15, line474-484
  "that's been incredibly important for me, and I don't think I'd get through without maintaining that"

Reflective spaces

Spaces not being utilised

- Frustrations with use of reflective spaces not being used how they assumed they would. And the need for reflective spaces to be used for emotional impact of role. p14, line425-432 *"But it's usually, I mean, actually, not even usually it's always more of a reflective space to think about people's frustrations with various things on the course. which I find incredibly frustrating."*
- Resentful at the use of reflective spaces as trivial matters are brought, and their difficulties feel bigger. p2, line62-68
  "And I I kind of I get a little bit resentful"

Worries about speaking out

- Ideals about how to use reflective space but fear in being the first person to talk about LE. p14, 432-440 *"But I'm also too nervous to be the one that does its first"*

Further support from training courses

Ideas of further support

- There is a need for more support on courses for LE. pg 2, line 37-40
  "I think they could do with a lot more [short pause] thinking about the kind of support that people need on clinical training and kind of reflective spaces and things"
- The need for more support at uni, more specific then the wellbeing service or having someone to talk to outside of tutors. p17, line522-535
  "perhaps some sort of built in.I don't want to say like a a different. Well, because I think you know, the university has a well being service,"
- Need for coproduction on courses p17, line536-548
  "think erm… using a lot more co-production. So I think it would be great if clinical training"

Cohorts are diversifying without provisions

- University are trying to diversify course and it being seen as a positive, however there are no provision or thoughts about how to support a diverse cohort. P1, Line 26-33
  "But then I think you get here and erm, you know, it's… it's okay. Go on, go with all the rest."

Limitations/ challenges

Challenges on the course

- Teaching being triggering, especially when its 'close to home'. p4, line 117-123
  "But yeah, certainly some of the teaching content that you know very close to home is more difficult."

Challenges within therapeutic work

- Some clients resonating with you and the transference within the room being seen as a possible limitation. p11,line354-366
  "Some clients experiences really resonate or quite, quite upsetting"

Self-barriers

- Feeling of not belonging there or others thinking that, and feeling different seen as limitation of LE. p11, line350-354 *"Maybe, like, you're not quite supposed to be there, or the other people will think that you're not supposed to be there"*
- Despite being very resilient, there are times when feeling not so resilient and finding things more difficult then others may find it. p11, line344-351
  "And then there's other times where? I'm not so resilient."
- The course has challenges, but biggest challenge is self doubt pg 4, line 125-126
  "I think, I think the hardest thing for me is we're probably just around self doubt."

Need for more Lived Experience within the profession

- Needing more LE within the profession and the need of mentorship. p14, line445-450
  "And I guess it's more. It's more train, you know. It's more of us get qualified, and move on into into full time work."
- Psychologists voicing diversity on the course as a positive p9, line265-273
  "I overheard either my supervisor or clinical tutor saying, You know what's so good we've got, you know, people with diverse experiences coming on to training"

Assumptions of what a psychologist/ trainee is

- Trying to fit in with cohort and be what they think a trainee should be. p2, line 49-56
  "So for me. I I really tried to to fit in and to be, I guess, to be somebody else, to be somebody who would get on to clinical training, you know"
- Misconception that people who have LE and people who do training are separate and cannot be the one. However this is more blurry then acknowledged. p6, line 179-181
  "I guess there's kind of like a false dichotomy drawn, isn't there between people who have lived experience and people who do clinical training"

Miscellaneous

Place was due to being a tick box

- Worries that getting on the course was not due to won merit and about fitting a box. P1, Line 21-25
  "when I got on to training, I kind of assumed I was a contextual admission. I was like, Oh, you know, if they've let me in because I fit a box or something."

Needing prove LE to access support

- Support from uni Couse needed medical proof. P8, line 241-247
  "That's kind of like the university Wellbeing, which says, you know, I had to prove with kind of medical notes, and then that that says I can have an extension if I need to"

Appendix R- Grouping of GET's
each colour represents a different participant

Appendix S- GET table

Group Experiential Themes

Overarching theme	Subordinate themes	PET's
Identity	*LE is a big part of them/identity*	LE is intrinsic part of identity (P8)
		Identity us deep-rooted Acceptance of Identity (P3)
		LE makes up a nig part of identity (P1)
		LE as apart of identity (P2)
		Identity (p4)
		Being authentic (p5)
	Identity is multi-faceted	Showing identity to others (P2)
		Trainee vs patient (P5)
		More to identity (P6)
		Identity is made up of multiple aspects (P1)
		Shame of concealing identity (P8)
	Identity not always visible	Identity not always visible (P1)
	Shame around identity	Identity shame (P3)
		Shame of concealing identity (P8)
	Uncertainty of LE identity	Uncertainty of LE label (P6)
		LE creates disconnect to psychologist identity (P7)
Worries	*Being different/ not fitting in*	Difference is noticeable by others (P1)
		Worries how others will see her (P3)
		Being seen as different (P2) Being different
		Worries about peers (P5)
	Worries around the Dclin	Self-doubt (P3)
		Worrying about completing the course (P7)
		Others seeing as not deserving of place (P2)
		Worries around competencies Worries about the course (P5)
Disclosure	*Vulnerability of disclosure*	Vulnerabilities of disclosure (P7)
		Factors limiting disclosure (P1) Worries about speaking out
		Concealing vs disclosure (P3) Difficult experience of disclosure
		Concealing/not disclosing (P6) Considerations of disclosure
		Apprehension and worries around disclosure(P4) Negative experiences
		Selective disclosure (P5) Barriers of disclosure
	Psychological safeness needed for disclosure	Factors limiting disclosure (P1) Experiences of disclosure Factors needed to disclose Importance of disclosure
		Experiences of disclosure (P2):

		Need for compassion for disclosure (P7)
		Rules of disclosure Others disclosure Concealing vs disclosure (P3)
		Positive experiences (P4) Apprehension and worries around disclosure
		Facilitators to disclosure (P5) Barriers to disclosure
		Things that help disclosure (P6)
training		Difficult experiences of teaching/course (P8) - retraumatising
		Difficulties as a training (P1) -it's a lot of work, hardest thing
		Course feeling difficulty at start (P3)
		Course increasing mental health symptoms (p7) Lack of compassion from training program
		Course is hard (P4)
		Teaching (P2) - not emotive and positive
		Purpose (p3) -Course giving purpose during difficulties
Strengths	*Increased Empath and Compassion*	Understanding of clients thoughts and feelings (P1) Allows for positive responses Allowing for authenticity
		Increased understanding (P2)
		Positives (P3)
		Increased empathy and understanding (P4) Advocate for clients
		Trainee vs patient (P5)
		LE Increased empathy and understanding (P6)
		LE increases understanding and empathy (P7) LE enhances emotions
		LE gives unique strengths (P8)
	Unique insights shape practice	Benefits of LE (P1)
		Value of LE (P2)
		Positives (P3)
		Advocate for clients (P4)
		Trainee vs patient (P5)
		LE enhances practice (P6)
		LE challenges prejudice (P7)

Psycho-emotional experience of being a trainee with lived experience		Challenges within therapeutic work (p1) Challenges on the course
		Emotional impact (P2) Time constraints
		Difficulties of training (P4)
		Limitations (P5)
		LE impacting work and stress (P6)
		LE can be consuming (P7) LE barriers to training
Support	*Safe spaces*	Experiences of helpful support (P1)
		Experiences that helped (P2)
		Support (P3)
		Experiences of support and reflective spaces (P4)
		Expereince3s of support (P5) Connecting with others
		Support that's helped (P6)
		Experiences of support (P7)
		Experiences of support (P8)