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Doctoral Thesis

Experiences of trainee clinical psychologists and workplace supervisors when mental health difficulties are shared

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Word count

Thesis Section	Text	Tables, References and Appendices	Total
Thesis Abstract	256	-	
Literature Review	7991	11577	19568
Research Paper	7971	7633	15604
Critical Appraisal	3600	500	4100
Ethics Application	4167	3362	7541
Total	**23985**	**23072**	**46813**

Thesis Abstract

This thesis consists of three papers including a literature review, research paper and a critical appraisal. The systematic literature review focuses on the experiences of workplace supervisors and managers when managing employees with mental health difficulties. A thematic synthesis was undertaken on 19 papers. Four themes were developed which highlighted the influence of supervisors' perceptions of mental health difficulties and of their role in the provision of support, the need for supervisors to have access to support and advice to provide effective support to employees, the influence of understanding of mental health difficulties and the barriers to understanding, and the emotional challenges and rewards of supporting employees with mental health difficulties. Recommendations are made for supervisors and organisations regarding the support needs of supervisors when managing employees with mental health difficulties.

The research paper explores the experiences of trainee clinical psychologists when sharing their mental health difficulties with tutors and supervisors during training. Thematic analysis was utilised to explore the experiences of 12 participants. Four themes were developed; namely, weighing up whether to share; creating safety to share and feeling supported; dilemmas, feeling vulnerable and powerless to challenge perceptions; and experience shaping their practice and identity. Recommendations are made for supervisors, tutors and training programmes regarding creating safe supportive environments to support trainees to share their mental health difficulties.

The critical appraisal chapter reviews the findings of these two papers alongside a discussion of epistemological influences and methodological decisions taken during these projects and some of the challenges of undertaking research in this area.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from June 2018 to February 2023. The work presented here is my own, except where references are made accordingly. The work has not been submitted for the award of a higher degree elsewhere.

Name: Serena Hannah

Date 28th February 2023

Acknowledgements

Firstly, I would like to thank my participants for sharing their stories with me. I am incredibly appreciative that people gave up their own time to discuss their experiences with me. I hope that this research can do justice to the contributions they made. I have learned a lot from my participants about the kind of supervisor I aspire to be. I hope that their contributions can help supervisors and trainees in the future to recognise the benefits and challenges of sharing conversations and work towards providing supportive environments which facilitate sharing.

I would also like to thank my supervisors for their support during the different stages of this thesis. Dr Anna Daiches and Dr Pete Greasley were instrumental in the development of the research focus and providing guidance and feedback during the early stages of the research project. Dr Greasley retired part way through the project as such I had a change in supervisor to Dr Ian Smith whom I want to thank for his encouragement and seemingly unending patience while supporting me through the remainder of the thesis.

Finally, I want to thank my parents for their love, support and encouragement throughout training. And to all of my friends who have constantly supported me and encouraged me, in particular Anne-Marie, Kelly, Alex, Molly, Sarah, Catherine, Luisa, Kerri and Lauren. I am very thankful to have such amazing friends.

Contents

Chapter 1 Literature Review

Employer experiences of managing employees with mental health difficulties: a thematic synthesis

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Abstract

People with mental health difficulties face significant challenges obtaining and retaining employment. Supervisors and managers without experience of working with people with mental health difficulties often report stigmatised beliefs resulting in reluctance to offer employment. Evidence suggests that having contact with people with mental health difficulties can reduce stigma resulting in employers being more likely to offer and support employment. It is important to understand the experiences of these employers to support wider employment opportunities for people with mental health difficulties. Therefore, this review aims to explore the experiences of supervisors and managers who have employed people with mental health difficulties.

A systematic literature review was conducted across seven electronic databases identifying 19 articles for inclusion. Thematic synthesis was undertaken, and four themes were developed. These themes focused how perceptions of mental health difficulties and their role influence manager and supervisor responses, needing support to provide support, understanding and the barriers to understanding, and the emotional challenges and rewards of supporting employees.

The findings illustrate the need for organisations to provide clear guidance and systems of support for supervisors and managers to facilitate their knowledge and confidence when supporting employees with mental health difficulties.

Keywords: Employer, Employee, Mental Health, Qualitative

Employment and mental health stigma

Employment rates of people with diagnosed mental health difficulties are lower than employment rates of people without diagnosed mental health difficulties. The employment rates of people with diagnoses of severe mental health difficulties are substantially lower (Luciano & Meara, 2014; OECD, 2012a). Research indicates that having mental health difficulties can lead to challenges obtaining and retaining employment due to various factors such as stigma, discrimination and access to workplace support (Brouwers, 2020). For the purpose of this paper, stigma is defined as the process of discrediting an individual based on perceived undesirable attributes and discrimination is defined as the action taken by others to limit opportunities of the stigmatised person due to these attitudes (Goffman, 2016).

Research into attitudes and beliefs have found that employers can hold stigmatising beliefs that applicants and employees with mental health difficulties will not be able to meet the demands of the job, will require more resources, will disrupt team dynamics, are potentially dangerous or unpredictable, and that it would be unsafe for them to work with certain groups of people, such as children and older people (Brohan et al., 2012; Brouwers, 2020).

Many of these beliefs represent untrue or stereotypical views of a complex issue. For example, beliefs that people with mental health difficulties are dangerous or potentially violent is inaccurate; people with mental health difficulties do not pose a higher risk of violence in the absence of substance abuse (Stuart, 2003). However, sensational media portrayals have instilled a stronger link between mental health difficulties and violence in the mind of the public than is the case (Mancuso & Bruyère, 2000; Stuart, 2003).

Beliefs that employees will require more resources and are not able to meet the demands of job roles reflect a simplistic view of a complex issue. There can be economic costs for businesses associated with reduced work productivity and increased sickness absence due to mental health difficulties (OECD, 2012a). This can also lead to increased workloads and

stress within teams to compensate for reduced productivity. However, this view often neglects the causal role workplaces play in employee mental health difficulties. For example, job insecurity, poor working conditions and manager attitudes and behaviour contribute causally to mental health difficulties and general workplace productivity (OECD, 2012b).

Challenging stigma

Stigmatising attitudes have been found to be prevalent within wider society and in workplaces. This has led to societal-level and workplace anti-stigma campaigns to challenge attitudes through education campaigns (Corrigan et al., 2012; Evans-Lacko et al., 2014; Hanisch et al., 2016; Henderson et al., 2020; Morgan et al., 2018). Anti-stigma campaigns have also incorporated contact with people with mental health difficulties as an effective strategy for reducing stigma (Corrigan et al., 2012; Morgan et al., 2018). This is based on contact theory which has identified that those with personal experience of someone with a mental health difficulty tend to hold less stigmatising attitudes (Couture & Penn, 2003; Crisp et al., 2005; Pettigrew et al., 2011; Pettigrew & Tropp, 2006).

Reviews and meta-analyses have found mild to moderate improvements in societal knowledge, attitudes and behaviour towards people with mental health difficulties due to anti-stigma campaigns (Corrigan et al., 2012; Morgan et al., 2018). However, concerns have been raised about how to further improve attitudes, how to ensure long-term improvements, and that there has been unintentional ‘othering’ through biomedical explanations (Evans-Lacko et al., 2014; Morgan et al., 2018; Walsh & Foster, 2021).

In addition to challenging societal stigma through anti-stigma campaigns, increasing mental health knowledge and improving workplace practices have led to beneficial effects for employees. For example, mental health training for managers, implementing supportive and encouraging supervision and having clear work policies have been associated with lower levels of employee sick leave and higher productivity (Evans-Lacko & Knapp, 2018;

Gilbreath & Benson, 2004; Milligan-Saville et al., 2017; OECD, 2012b). Furthermore, attaining and retaining employment can lead to greater financial independence, improved self-esteem, increased sense of purpose and increased social connections for people with mental health difficulties (Axiotidou & Papakonstantinou, 2021; Modini et al., 2016). Research has identified that good quality supervision (Brohan et al., 2012; Evans-Lacko & Knapp, 2018; Gilbreath & Benson, 2004; Modini et al., 2016), and the implementation of workplace reasonable adjustments/accommodations (Brohan et al., 2012; Ebuenyi et al., 2018; Zafar et al., 2019) are crucial for creating supportive environments for people with mental health difficulties to thrive.

There are clear benefits to challenging stigma within society and workplaces and improving workplace practices to create supportive environments which mitigate workplace causal factors of mental health difficulties. This is particularly important as mental health difficulties can affect anyone in an organisation and are estimated to affect over 12% of the population in any given year (World Health Organisation, 2022).

Contact influences stigmatising attitudes

Studies exploring stigmatising attitudes among employers have found previous contact with people with mental health difficulties to be influential on attitudes. Studies exploring hypothetical attitudes have found that employers who have had little or no previous contact tend to hold greater concerns about hiring (Dolce & Bates, 2019; Ebuenyi et al., 2020; Pettersen & Fugletveit, 2015). Conversely, those with experience tend to report fewer stigmatising beliefs, fewer concerns and greater willingness to employ people with mental health difficulties (Diksa & Rogers, 1996; Hand & Tryssenaar, 2006).

Researchers have theorised that in the absence of direct experience, employers will often rely on societal attitudes and beliefs about mental health difficulties (Hand & Tryssenaar, 2006). This has been found to be the case regarding hiring decisions on the basis of ethnicity,

whereby in the absence of direct experience, employers discriminated between candidates on the basis of strongly held societal stereotypes (Birkelund et al., 2020).

Reviews of employer attitudes have often focused on employer hiring decisions and incorporate proportions of employers with little or no experience of employees with mental health difficulties (Brohan et al., 2012; Papakonstantinou, 2018). This has provided insight into the influence of stigma on hiring decisions. However, no reviews to date have focused the experiences of employers who have employed people with mental health difficulties.

Current review

Given the influence of contact with people with mental health difficulties on attitudes, the current review will focus on the experiences of employers, managers and supervisors who had staff responsibility including direct experience of one or more employees with mental health difficulties. While employers, managers and supervisors may carry out different roles and functions within companies there is often overlap in their responsibilities, roles are often not defined in research and studies often use these terms interchangeably (Hales, 2005).

This review will aim to provide an in-depth understanding of the factors which influence experiences of those supporting employees with mental health difficulties alongside the benefits and challenges they experienced. This may highlight training and support needs and help to inform policies and practices in this area.

Method

Qualitative research articles exploring the experiences, attitudes and perspectives of employers, supervisors and managers when recruiting or employing people with mental health difficulties were systematically identified for inclusion in this review.

Search strategy and eligibility criteria

A systematic search was undertaken on 27th July 2021 using seven electronic databases: PsycInfo, PsycArticles, Medline, Web of Science, CINAHL, Academic Search Ultimate and

Business Source Complete. Update searches were undertaken on 5th January and 19th December 2022. A comprehensive search strategy using the PICO tool (population, intervention, comparison, outcome) was developed in consultation with a faculty librarian. The PICO tool offers greater sensitivity to identify relevant articles than the SPIDER tool (sample, phenomenon of interest, design, evaluation, research type) (Methley et al., 2014). Within each database, free-text and thesaurus search terms related to employer/manager/supervisor (population), were combined with proximity searches for terms related to experience/perspective (outcome) and mental health difficulties (intervention). A comparison term was not applicable. Table 1 outlines key search terms used, and Appendix 1-B provides the detailed search strategies used within each database. No date of publication limits were applied.

[Insert Table 1 here]

The following eligibility criteria were applied during screening:

Inclusion criteria:

- Studies must focus on actual experiences and attitudes of participants when recruiting or managing employees with mental health difficulties.
- Studies must clearly state that participants had experience of staff responsibility for at least one employee with mental health difficulties.
- Studies were required to undertake primary research utilising qualitative methodology or analyse qualitative elements such as free-text survey responses.
- Studies must be published in English in a peer reviewed journal.

Exclusion criteria

- Studies assessing attitudes indirectly using only vignette or hypothetical scenarios were excluded.

- Studies focused on the implementation of reasonable adjustments were excluded due to a recent systematic review (Zafar et al., 2019).

Figure 1 illustrates the search stages on a PRISMA flow diagram. The initial search identified 13294 articles. Following deduplication outlined by Bramer et al (2016), 7968 articles remained. Articles were imported into Rayyan.ai and screened for eligibility. Title and abstract screening identified 46 articles, of which 13 articles were retained following full-text review. Forward citation and reference list searches of these 13 articles and of systematic reviews in this area identified two articles for inclusion. An updated search in January 2022 identified no additional articles. A subsequent search in December 2022 yielded four articles for inclusion. Forward citation and reference list searches of these articles yielded no further articles. In total 19 articles were identified for inclusion. Article screening was undertaken by the lead author.

[Insert Figure 1 here]

Quality assessment

Studies were quality assessed using the qualitative CASP checklist (Critical Appraisal Skills Programme; CASP, 2018). This assesses quality across 10 domains: study aims, methodology, research design, recruitment strategy, data collection, researcher-participant relationship, ethical issues, data analysis rigor, clarity of findings and the research value. Following Butler et al's (2015) scoring system, each paper was rated for each domain as providing evidence of thorough (1), partial/unlcear (0.5) or absent (0) discussion. Total scores for each study were calculated: 9 or above was considered high quality, 7.5-9 was considered moderate quality and below 7.5 was considered low quality (Butler et al., 2015). In accordance with Sandelowski et al (1997), no studies were excluded based on quality as numerous factors can affect subjective ratings of qualitative research quality. Quality appraisal was undertaken by the lead researcher and a sample of eight papers were appraised

by another trainee clinical psychologist. Ratings were similar between researchers and any differing scores were discussed until final ratings were agreed.

[Insert Table 2 here]

Two studies were appraised as high quality, 12 as moderate quality and five as low quality. Several studies received low scores due to insufficient detail in reporting. Discussion of the potential for bias and examination of the researcher-participant relationship were insufficient across all 19 studies.

Data extraction and synthesis

This review represents data collected from 361 employers across eight countries; Canada, Sweden, United Kingdom, Australia, Denmark, Norway, Ireland, and New Zealand (see Table 3 for further study details).

Data relating to employer experiences of employees with mental health difficulties were extracted by the lead author. Findings were drawn from across the entirety of the abstract, results, and discussions sections in all but the following five studies. Findings extracted from Gignac et al (2021) selectively extracted employers' experiences of employees with episodic mental health difficulties and did not extract findings relating to episodic physical health difficulties. Lexén et al (2019), Tighe & Murphy (2021) and Van Eerd et al (2021) incorporated various stakeholder participants, however only employer experiences were extracted. Østerud (2022) undertook an experimental and qualitative design to explore hiring decisions for candidates with or without mental health difficulties. Qualitative data examining previous experiences and influences on employers' decision-making were extracted. Articles by Martin et al (2015, 2018) utilised the same participant dataset, however, reported different results and themes therefore both were included.

[Insert Table 3 here]

Studies utilised various qualitative analyses ranging from descriptive to interpretative approaches. Consequently, extracted findings incorporated both first-order participant quotes and second-order analytical themes drawn from the abstract, results and discussion sections (Sandelowski & Barroso, 2002; Thomas & Harden, 2008). Thematic synthesis was undertaken as this approach can be used to synthesise first and second-order themes, and is suitable for addressing questions about individual experiences and perspectives (Booth et al., 2012; Thomas & Harden, 2008). Synthesis involved line-by-line coding of the extracted findings, producing 42 codes (see Appendix 1-C for an excerpt of coding). Codes were reread alongside their contextual quotes, mind-mapped and arranged to develop descriptive themes. These themes were further developed and interpreted into analytical themes addressing the focus of the synthesis (Thomas & Harden, 2008). Analysis and theme development were discussed and reviewed alongside the research supervisor (Appendix 1-D illustrates synthesis theme development).

Results

Four themes were developed during synthesis; namely, how perceptions of mental health difficulties and their role influence manager and supervisor responses, needing support to provide support, understanding and the barriers to understanding, and the emotional challenges and rewards of supporting employees.

Theme one: How perceptions of mental health difficulties and their role influence manager and supervisor responses

Supervisors' and managers' perceptions of their supervisory role and perceptions of employee mental health difficulties influenced the support they offered. Many supervisors felt that supporting the wellbeing of all employees and problem-solving issues was an integral part of their role. Therefore, when employees faced challenges "they simply 'understand and work around [them],' '[would] find ways around it' and find 'simple ways to

help out'". (Mizzoni & Kirsh, 2006, p.199). They tended to view supporting employee mental health and identifying and implementing workplace reasonable adjustments as an extension of this problem-solving role.

While most supervisors felt that supporting employee mental health was part of their role, there was some variation on this. For a minority of supervisors, the type and cause of employee mental health difficulties influenced whether they viewed it as a workplace issue within their remit to support. When they perceived employee mental health difficulties to be caused or exacerbated by work then "employers feel more responsible … because of the direct link between the disorder and the work environment" (Thisted et al., 2020, p. 860). Supervisors also reflected on the causal link between the work environment and stress which could result from high workloads, difficulties managing work-life balance, and workplace reorganisation. This understanding supported supervisors to implement work-based interventions such as adjusting employee workloads. However, the success of such interventions was not often discussed.

Conversely, some supervisors conceptualised mental health difficulties as a private issue or caused by factors outside of work, therefore, it was regarded as the employee's responsibility to manage themselves. For example, depression was "understood as a private matter that is caused by personal factors, and therefore…not the employers' responsibility" (Thisted et al., 2020, p.860). This conceptualisation led to avoidance of discussions with employees about their difficulties thus preventing identification or provision of workplace adjustments. Østerud (2022) argues that this avoidance of discussion and engagement also appears to be linked to supervisors reporting negative experiences with employees with mental health difficulties. These employers tended to retain stigmatised beliefs which guided their future decision making, such as rejecting job applicants with mental health difficulties

because “we’ve had bad experiences before with people who have struggled mentally and…haven’t been able to do the job they’re hired to do” (Østerud, 2022, p.10).

Willingness to support employees was also influenced by how employers viewed their responsibilities for company productivity. Some supervisors perceived a conflict between hiring and supporting employees with mental health difficulties and the pressure to maximise productivity, feeling they “lacked guidance on how to strike a balance between obligations to help versus having a healthy business” (Shankar et al., 2014, p.7). Those who viewed their role as focusing on maximising productivity held concerns about hiring and employing people with mental health difficulties (despite the illegality of this in their countries). These supervisors and managers were more likely to overlook the contextual role of workplace factors in employee performance and fail to consider workplace support or intervention. As one Human Resources (HR) manager reflected it can be difficult for supervisors and managers when they’re “looking at it from a business sense and it’s very difficult sometimes for them to get down to the personal side of it” (Shankar et al., 2014, p.6).

These concerns about employing people with mental health difficulties appears to assume that reduced productivity is inevitable. However, as some employers reflected, “when people’s health condition was stable they could perform the necessary tasks just as well as a person who had no mental health problem” (Tse, 2004, p.270). In addition, the assumption of reduced productivity often neglected other factors which affected productivity, such as, the degree of job matching between work tasks and employee skills, employee training, workplace support and the stability of the employees’ mental health difficulties.

Company culture could reinforce the conflict between maximising productivity and providing support. For example, within Gignac et al (2021), several HR personnel and disability managers reflected that “efforts to build awareness, increase training, and provide accommodations for workers with episodic disabilities were seen by their senior management

as expensive and time consuming and as not contributing to the bottom-line of the organization" (p.159). Company cultures which emphasised productivity and profitability could restrict the supervisor's ability to manage the effect of employee sick leave or reduced performance. Whereas supportive company cultures could increase the availability of additional staff or resources to temporarily increase the work capacity of the team and could adjust performance expectations or timescales to reduce the stress of heightened workloads on the team. As one supervisor reflected there needs to be a system wide approach to supporting staff which acknowledges through management that if an individual's expected work activity changes, then "your expectations around what that project – or how fast that project will be delivered needs to be tempered. Or additional resources need to be put on, because otherwise then you create…stress" (Kirsh et al., 2018, p.551).

It is notable that a few employers did not experience this conflict within their organisation. For these organisations, investing in support for employees had increased company profitability, encouraged employee loyalty and improved team relationships. As one employer identified, investment in employee support had improved their "bottom line. We've increased our profitability 50%" (Mizzoni & Kirsh, 2006, p.201).

In addition to the influence of company culture, the size and resources of the company could also influence supervisors' concerns about hiring people with mental health difficulties. Within smaller sized companies the lack of resources to support employees and supervisors, such as HR and Occupational Health teams, resulted in reluctance to hire and concerns about supporting existing employees due to a lack of expertise "available to provide guidance and share the burden of support" (Suter et al., 2023, p.25). Company size varied across articles and was often not detailed beyond categorial small, medium and large sized companies. While it was often smaller sized companies that encountered this resource issue, it is not possible to further specify the size of company most affected.

The conflict between productivity and employee support appeared to be mitigated for some companies by financial incentive schemes, such as, wage subsidy schemes. This could reduce the potential financial risks of lower employee productivity making "it more appealing…to hire someone" (Porter et al., 2019, p.332). However, utilising financial incentive schemes was impeded by lack of knowledge and their availability.

Theme two: Needing support to provide support

The majority of articles discussed supervisors' and managers' needs for support in order to provide effective support to employees. Direct support needs of supervisors and managers were identified alongside the benefit of additional support for employees. Additional employee support served as an indirect support for supervisors and managers as it enabled them to focus on providing support within their own role.

Several articles discussed the need for sufficient training and understanding of mental health difficulties, sufficient knowledge of the employee and knowledge of workplace to identify reasonable adjustments/accommodations. However, supervisors and managers felt that they rarely possessed sufficient knowledge in all of these areas. Supervisors often felt they had insufficient mental health knowledge and occasionally insufficient knowledge of the employee, leaving them feeling that they were "groping in the dark when I'm trying to support co-workers with mental health issues in a situation (that) I can't really grasp and that I lack strategies to handle adequately" (Lexén et al., 2019, p.501).

Several supervisors and employers reported difficulties understanding and assessing whether employees were able and fit to work. Therefore, they often sought this information from others, such as health care professionals or HR staff. This could lead to frustration when professionals were not able to give definitive answers about fitness to work, as employee ability to work could fluctuate depending on their mental health and the work assigned. When reasonable adjustments were recommended by HR staff, external employment services or

healthcare providers, supervisors felt they were not always appropriate to the work and workplace. Supervisors reflected that “we need to stop asking them [physicians] if the person can do their job…They are very intelligent people… but they do not have the time to understand the workplace.” (Gignac et al., 2021, p.160).

Supervisors and managers navigated this tension by accessing support to discuss employee situations and employee distress, workplace problems and reasonable adjustments and access their own emotional support. Supervisors and managers experienced the most benefit from accessing support from individuals with knowledge of mental health difficulties, knowledge of the employee, and who were reliable to return to for support over time. This support came from within-company personnel such as disability managers and HR staff, external agency staff involved in employment support, and healthcare professionals. Issues were identified with accessing some of these supports due insufficient mental health knowledge and high staff turnover resulting in inconsistent and unreliable support.

Accessing support about employee mental health and collaboratively identifying reasonable adjustments gave supervisors and managers reassurance and a “feeling of safety” (Lexén et al., 2016, p.11) as they had “a person to speak to in case something happened, and we didn’t know how to deal with it” (Tighe & Murphy, 2021, p.21). This led to increased “confidence in meeting and supporting my employees with mental health issues” (Lexén et al., 2019, p.499). This support could also challenge inaccurate and stigmatising beliefs and support the development of managerial and interpersonal skills for managing employees in distress.

Supervisors and managers who lacked sufficient understanding about mental health difficulties and lacked adequate and reliable support reported feeling out of their depth when managing employees with mental health difficulties. This led to employers who “may not hire workers who disclose mental illness because of a lack of needed resources such as HR

department, staff trained to deal with mental health issues of workers, and time to dedicate to supporting workers" (Shankar et al., 2014, p.6).

Supervisors also identified that workplace policies and procedures could guide their response and management of workplace situations. Established policies and procedures guided their response and supported clear and transparent communication with employees by referring to relevant policies. Managers who did not have guidelines discussed feeling out of their depth and unsure what actions they should take. One manager wondered if they "were interfering too far and also from an operational point of view I wasn't aware of what grounds I had to say to the staff member 'oh well you're not fit to come to work so don't come'" (Martin et al., 2018, p.452).

The provision of mental health training for supervisors and managers was seen as a positive indication of the company's culture and commitment to supporting employees. However, the specific training received by supervisors was not often discussed and articles gave more focus to the training needs of supervisors.

In addition to direct support for supervisors, there was an indirect benefit to supervisors when employees accessed their own support systems. A small number of supervisors found it helpful for employees to have additional support from within their company or from employment specialists or union representatives. This support worked with the employee, "knew her really well…who came to act as a sort of liaison…and to guide her as well…It was helpful because there were several of us watching the case" (Lemieux & Durand, 2011, p.299). This support afforded the employee a space outside of the power dynamic of the supervisor-manager-employee relationship to discuss their mental health and workplace difficulties without fear of repercussions: "because the union representation cannot fire and hire" (Thisted et al., 2020, p.862).

Healthcare support for employees was also helpful to manage crises and support employee mental health in the longer-term while occasionally identifying reasonable adjustments to support employees at work. However, these reasonable adjustments needed to be translated to the specific workplace environment and job role. The awareness that employees were receiving healthcare and/or employment-based support appeared to be reassuring for supervisors and alleviated some stress and distress of feeling solely responsible for managing the situation. This allowed them to maintain the employer-employee relationship and focus on their role of providing reasonable adjustments. When additional employee support was not available some managers reflected that they could feel under "pressure to provide emotional support for the employee outside of working hours" (Martin et al., 2015, p.58) which in turn increased their own stress, anxiety and distress for the employee and created challenging managerial situations.

Issues were discussed regarding the timeliness of healthcare support for employees as delays could result in ongoing problems for employees at work, deterioration in workplace relationships and frustration for supervisors. As one manager reflected "no-one would walk around with a broken arm for a few weeks, yet that happens with mental health" (Van Eerd et al., 2021, p.16).

Theme three: Understanding and barriers to understanding

Supervisors' and managers' understanding of mental health difficulties influenced their confidence and willingness to provide relevant workplace support and accommodations. Depression and anxiety were reported to be easier to understand when supervisors and managers had knowledge of the 'triggering event' of these difficulties. For example, "One of my employees became depressed after her son died. It is understandable that she got sick" (Lexén et al., 2019, p.500). Recognising the context and causes of the mental health difficulties and empathising with the employee's circumstances enabled supervisors to

identify more relevant reasonable adjustments which accounted for employee difficulties. As one employer reflected, when they understood the employee's difficulties, they were able to identify that "I have to give him various tasks during the day, otherwise it gets too boring."(Jansson & Gunnarsson, 2018, p.590).

Several supervisors empathised with employee difficulties due to their own or loved ones' experiences of mental health difficulties: "I have a lot of empathy for what she's been through, and I've spoken to her about some of that from my own experiences at different times, I think that has definitely helped" (Nielsen & Yarker, 2022, p.7). In the absence of relating through previous experience, one supervisor had used curiosity to gain understanding, learn about the employee's difficulties and explore their support needs. This employer had asked "'Can you explain to me what happens, how do you feel, what do you experience?' and so she sort of gave me a bit of a background as to how it affected her which was helpful from my perspective" (Martin et al., 2018, p.452).

In contrast, when supervisors couldn't relate to employees' experiences or there was not a known triggering event, they found it more difficult understand and identify appropriate reasonable adjustments. Some supervisors experienced feelings of insecurity "about whether the advice I was providing was appropriate" (Martin et al., 2018, p.452). Some managers and supervisors discussed feeling fearful and insecure supporting employees with "more serious psychiatric diagnoses (such as schizophrenia)" (Lexén et al., 2019, p.500). They found these conditions difficult to understand and could be "afraid they will snap at any moment" (Lexén et al., 2019, p.500). Participants did not often reflect on the origins of these stigmatised beliefs, however, a small number of participants felt that societal stigma and media portrayals of violent incidents had perpetuated their views. They had felt that it was "society that drills it…in my head that you gotta keep an eye on this person" (Shankar et al., 2014, p.7). Stigma

led these employers to make assumptions about applicant and employee abilities and behaviour resulting in them feeling fearful and less able to provide support.

Organisational processes could also impede supervisor understanding and thus impede empathy for employee difficulties. For example, when HR departments directed reasonable adjustments, frontline supervisors felt frustrated due to their lack of involvement and reduced empathy for the employee's circumstances due to their lack of knowledge. This situation evokes an ethical dilemma between supporting understanding and empathy for the employee and maintaining the employee's right to privacy. This dilemma was prominent when supervisors were aware of employee difficulties, but they maintained the employee's right to privacy from the employee's co-workers. Supervisors discussed that this could often lead to team conflicts as co-workers did not understand the reason for the employee's reduced performance, decreased workload or reasonable adjustments. Co-workers' lack of understanding resulted in reduced empathy for the employee, increased tensions within the team, a lower likelihood of co-workers offering support and additional team conflict management for the supervisor. As one manager reflected, co-workers "who weren't sort of privy to this person's personal situation weren't sort of making any allowances for that person's behavior so was sort of writing it off as just not pulling their weight, there was no empathy there for their situation so I think that sort of translates into a bit of animosity on their part and not being as supportive…as they could have been" (Martin et al., 2018, p.453).

Theme four: Emotional challenges and rewards of supporting employees

Several supervisors discussed feeling distressed, stressed or upset while supporting employees with mental health difficulties. This appears to be an empathic response to the distress of their employee combined with feeling out of their depth managing the employee and the consequences on productivity and team dynamics. Many supervisors reported feeling they lacked sufficient skills and knowledge to improve the situation. This appears to draw

upon supervisors' feelings of responsibility to problem solve workplace difficulties alongside their empathic desire to alleviate employee distress. As one manager discussed "I felt a bit helpless because I couldn't do anything personally to fix it…I'm in a managerial position, you're supposed to be able to fix things and it wasn't anything that I could control" (Martin et al., 2018, p.455).

While supporting employees could be stressful and distressing, several supervisors reported that seeing their employee recover and return to work had made this distress worthwhile because "seeing her come out the other end of it was really rewarding" (Martin et al., 2018, p.455). Supervisors felt they gained skills and confidence to manage future situations and the company benefited by "retaining the employee, and having other staff members perceive the organization as a supportive employer" (Martin et al., 2015, p.59).

For some supervisors, managers and teams, working with employees with mental health difficulties had served to destigmatise mental health difficulties. These supervisors and managers reflected that employees had exceeded their expectations and as a result undermined previously held stigma and stereotypes. As one employer discussed "I think that's [stereotypes], pardon the expression, been all blown to hell. Those theories here, the stigma, has been washed right out the window" (Mizzoni & Kirsh, 2006, p.201). This employer felt that recruiting people with mental health difficulties had created a "stigma-free environment because people are exposed to it [mental illness] all the time and…they realize, hey, they're really not that different" (Mizzoni & Kirsh, 2006, p.201).

Discussion

This review aimed to explore the experiences of employers, managers and supervisors who have supported employees with mental health difficulties in the workplace. The results highlighted several factors which influenced supervisors' ability and willingness to provide support alongside their support needs.

Supervisors' conceptualisations of their role and mental health difficulties influenced their ability and willingness to support employees. While many participants felt that employee support was an important part of their role, a minority of supervisors conceptualised employee mental health as a private issue and felt their role was to maximise productivity and were therefore reluctant to become involved. Other studies have identified similar challenges when promoting employee physical health initiatives (McCoy et al., 2014; Pescud et al., 2015). Many employers felt that the promotion of employee physical health was an important part of their role and beneficial to the workforce, whereas others resisted involvement as they did not want to take a paternalistic role in employee health emphasising that "workplaces only exist to make money"(Pescud et al., 2015, pp.7). The perceived conflict between productivity and maximising profits versus employee health and mental health appears to be central to employer reluctance to provide support. However, as found in this review and Pescud et al (2015) providing external funding to alleviate the financial costs of workplace initiatives reduces employers' concerns about involvement in employee health. This suggests that employers may be more likely to proactively support employee physical and mental health if the financial burden of doing so was reduced. Other factors influencing employer involvement in physical health promotion includes company culture, support from the management structures, and resources within smaller businesses (McCoy et al., 2014). These factors were also identified in the current review. These issues have also been highlighted by the UK Government 'Thriving at Work' review (Stevenson & Farmer, 2017) as important targets for workplace mental health improvement. This review emphasises the importance of company leadership in encouraging a culture which prioritises employee mental health, and recognises the benefits of providing support to cultivate an open and supportive approach to all employees.

The current review also highlighted the need for supervisors and managers to be able to access support and advice on the management of employees with mental health difficulties. Access to support created a sense of safety for supervisors and managers and increased their confidence and knowledge to manage employees with mental health difficulties. This is noteworthy in the context of research which identified that increasing managers' confidence to initiate discussions with employees about mental health reduced employee sick leave and associated financial costs (Milligan-Saville et al., 2017). Mental health training had facilitated increased confidence (Bryan et al., 2018; Milligan-Saville et al., 2017), the current review suggests that providing supervisor access to support systems also facilitates increased understanding and confidence.

This review identified that supervisors' interactions with employees with mental health difficulties can lead to reductions in stigmatising attitudes. However, this was not solely a consequence of contact with the employee but appeared to be mediated by mental health understanding, access to support, perceiving employee behaviour which challenged negative assumptions, and engaging in open and empathic discussions with employees. For example, Østerud (2022) reported that engagement in open discussions with employees was associated with more positive experiences and fewer prejudices, and across several studies engagement and understanding had facilitated support. Contact theory outlines that intergroup contact can reduce prejudice through increasing knowledge, reducing anxiety and increasing empathy for the outgroup (Pettigrew et al., 2011; Pettigrew & Tropp, 2006). The findings from this review are consistent with contact theory as they identify that openly engaging with employees with mental health difficulties increased managers' and supervisors' knowledge and confidence to manage situations thereby reducing stigma. Gaining understanding of employees' difficulties had led to increased empathy and receiving advice had reduced their anxiety, leading to more supportive behaviour. The subsequent influence on stigma was not always discussed in

studies, however contact theory predicts that the presence of increased empathy and reduced anxiety would reduce prejudice (Pettigrew et al., 2011). It is possible that the responsibility to provide support without the necessary skills, while under pressure to prioritise productivity, creates a sense of threat in supervisors, leading to negative experiences and continued stigma. Feeling threatened and obliged (non-voluntary contact) is linked to reduced empathy, negative experiences, and reinforced prejudice (Pettigrew et al., 2011).

However, empathically engaging with employee distress could also be distressing for supervisors. This experience of supervisor distress and, at times, frustration when situations did not improve, highlights the need for supervisors to access emotional support to reduce risks of empathic distress and compassion fatigue. Empathic distress and compassion fatigue occurs when people experience distress in response to the distress of others, often leading to withdrawal from those in distress (Maillet & Read, 2021; Singer & Klimecki, 2014). Instances of compassion were identified in this review wherein supervisors experienced concern for their employee's suffering alongside the motivation and ability to help (Singer & Klimecki, 2014). In the current review, the distress experienced by supervisors was moderated by having their own support systems, feeling able to provide support to employees, and the ability to navigate the competing demands of productivity and supporting employees. Supervisors without these measures in place experienced anxiety and insecurity with managing situations, increased potential for becoming unwell themselves due to stress, or resisted engaging with employees with mental health difficulties. This may increase the risk of developing compassion fatigue in supervisors due to feeling overburdened by competing work demands, reduced autonomy to make decisions, and a lack of supportive supervision (Maillet & Read, 2021).

Limitations

Limitations of this review include aspects of the search strategy and synthesis. While there

was an extensive search of multiple databases there may be articles within grey literature, such as personal accounts, which could be pertinent to understanding supervisor experiences. In addition, articles using hypothetical scenarios were excluded from this review at the stage of title and abstract screening if the role of experience was not discussed. It is possible that the role of employer experiences was discussed within their results, but the article was excluded at an earlier stage of screening.

This review did not exclude articles on the basis of quality due to the numerous factors which influence subjective quality assessments. Theoretically the inclusion of lower quality papers could have influenced the review findings. However, the findings of this review are highly consistent with the findings of the moderate and higher quality papers only suggesting very little skewing influence of lower quality papers.

This review included employer experiences of a range of employee mental health difficulties. This was beneficial to give insight across a variety of experiences; however, this approach may have grouped experiences and as a result lost some of the nuance between experiences regarding managing employees experiencing varying levels of distress.

The reviewed articles cover almost twenty years across several countries. During this time some of these countries have undertaken nationwide anti-stigma campaigns, for example UK Time to Change campaign which may have influenced employer and supervisor attitudes. However, anti-stigma campaigns offer moderate effects in improving stigmatising attitudes (Evans-Lacko et al., 2014; Henderson et al., 2020) meaning some stigma is likely to be retained. In more recently published papers, there remained indications of stigmatising attitudes influencing employer behaviour, for example, Gignac et al (2021) referred to the need for greater awareness of influencing stereotypes and biases. This could suggest the ongoing presence of stigma. Therefore, the findings of this review may be more broadly relevant across countries in different positions of anti-stigma campaign activity. However, the

nuanced understanding of improvements in changes employer attitudes over time have not been explored.

The influence of study location on employer experiences was not a main focus of the current review as it was not explicitly discussed in many of the included studies. However, it must be acknowledged that this review has not explored the influence that the political climate, legislation, and cultural norms of different countries could have had on employer's experiences. This review only included studies published in English and from a limited range of countries, namely within northern Europe, Canada, Australia and New Zealand. Therefore, conclusions may be culturally bound to these countries. Culture has been found to influence understanding of mental health and mental health stigma (Abdullah & Brown, 2011; Ahad et al., 2023; Angermeyer & Schomerus, 2017; Ran et al., 2021). The countries included in this review are often regarded as western countries (World Population Review, n.d.) which may indicate somewhat similar attitudes to mental health (Ahad et al., 2023). However, it must be recognized that individuals' cultural background can also be influential in addition to the culture of the country of residence (Abdullah & Brown, 2011). This is not possible to explore in the included studies due to a lack of information regarding the cultural background of the participants and recommendation is that future research includes information about participant's cultural background.

Practical and clinical implications

Reducing mental health stigma and opening up discussions about mental health difficulties requires workplace cultures which support supervisors to empathise with employees and decreases anxiety about managing these situations (Pettigrew et al., 2011). Therefore, the organisational recommendations of this review are focused on the need to create clarity and support within organisations in relation to employee mental health. Based on the factors which contributed to supervisor supportive behaviour, this review recommends that

companies take the following actions: clearly communicate expectations of supervisors in supporting employee mental health and ensure supervisor and leadership understanding of the benefits that supporting employee mental health has on employee recovery and workplace productivity (Evans-Lacko & Knapp, 2018; Gilbreath & Benson, 2004; Milligan-Saville et al., 2017; OECD, 2012b). Encourage open discussion between employees and supervisors about mental health and workplace accommodations while ensuring access to supervision, training and advice for supervisors. Provide clear organisational policies and procedures to direct their work and ensure all staff are aware of wellbeing and mental health support within and outside of the organisation. Many of these recommendations are consistent with Stevenson & Farmer's (2017) review on supporting employees to thrive at work.

Clinical psychologists may be particularly interested in the finding that supervisors of individuals with mental health difficulties also experience distress in navigating this experience. Clinical psychologists may have a role in developing tools to support employers and employees which promote empathy for those with mental health difficulties. Compassion focused therapy has been increasingly utilised within mental health care to support coping (Millard et al., 2023). Adopting an organisation-wide compassionate leadership approach has the potential to support both employees and supervisors (Wasylyshyn & Masterpasqua, 2018; West & Chowla, 2017). Such approaches are encouraged within the NHS as they promote compassionate care for staff and are linked to higher patient satisfaction (West et al., 2022; West et al., 2017). Clinical psychologists have a role in delivering training in compassion-focused leadership to supervisors to enhance self-compassion and compassion towards others, promote resilience and improve supportive responses to others in distress (Irons & Beaumont, 2017; Singer & Klimecki, 2014). It may be beneficial to incorporate follow-up sessions which allow supervisors to discuss workplace scenarios to further build confidence in applying the approach and to supplement supervisor support systems. Compassionate

leadership training also promotes stigma reduction through encouraging empathic engagement as supervisors would feel more skilled to notice, understand, empathise and respond in ways which reduce employee distress (Irons & Beaumont, 2017; Pettigrew et al., 2011).

Clinical psychologists may also need to consider how they support clients who are working or returning to work. It may be beneficial for clinical psychologists and mental health professions to recognise the client's decisional conflict about disclosing to employers and utilise disclosure decision tools such as CORAL to support clients in their decision (Henderson et al., 2013). Furthermore, clinical psychologists may have a role in recommending reasonable adjustments based on formulations of client difficulties. Based on this review it is recommended that this is done within a framework of interprofessional collaboration with the employer (Leathard, 2003). Collaboration between the client, clinical psychologist, and employer could support employer understanding and empathy and devise more appropriate workplace reasonable adjustments. This support may be particularly beneficial when clients are working in smaller organisations and where supervisor access to organisational support systems, such as HR, may be limited. However, clinical psychologists will need to carefully consider the ethics and power dynamics of working with their client while supporting supervisor understanding.

Research implications

The findings of this review alongside previous research suggests that reduced stigma may be a function of increased understanding of employee mental health difficulties, engagement in discussions with employees and empathy for employees, rather than simply arising from contact with employees with mental health difficulties. This area would benefit from further study to explore the link between emotional engagement (or lack thereof), barriers to empathic engagement such as workplace threats, and the effect of these on stigmatised

attitudes. While qualitative longitudinal designs such as interviews across multiple time points could be insightful, a more practical approach would be retrospective qualitative designs. This would allow the exploration of supervisors' engagement in conversations about employee difficulties, influences on supervisors' engagement, supervisors' emotional responses such as empathy, behavioural responses such as reasonable adjustments, and the influence on supervisor attitudes or future behaviour.

Increasing supportive emotional and behavioural responses to employees to undermine stigma was indicated as a key target from this review and previous research. To support this target implementing compassion training across organisations to support employee and supervisor own mental health and effective supervisor support is recommended. Compassion-focused organisations have been increasingly discussed in the literature, however there is currently limited research evidence for such approaches. A research recommendation from this review is to explore the impact of compassion training on supervisors' emotional engagement with employees, and the impact on supervisor attitudes and employee outcomes before and after compassion training. The design should include a longer-term follow-up of at least six months to compare whether stigmatised attitudes and responses to employee distress changed over time and the effect on employee outcomes and retention.

The current review identified the importance of organisational culture, policies and access to support and advice for supervisors to facilitate effective support for employees. Further research could explore whether the implementation of support systems for supervisors improved their ability to provide effective support to employees and improved employee outcomes, such as improved employee retention, reduced sick leave or improved perceived support at work. This could involve undertaking a research trial utilising a mixed-methods design comparing employee retention data prior to and following the introduction of supervisor support systems, alongside qualitative exploration of experiences of supervisors

and employees after the introduction of supervisor support. Support systems could include individuals knowledgeable in HR and/or mental health. This could be a trial aimed at smaller companies who have had little access to HR and other advice services previously.

Conclusion

This review has highlighted the need for supervisors and managers to have access to support and advice when managing employees with mental health difficulties. It has also highlighted the need for organisations to be clear about the expectations and importance of supervisor involvement in supporting employees with mental health difficulties to thrive at work.

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Tables and Figures

Table 1

Keyword terms used in title and abstract searches in each database

Title and abstract searches	employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*"	Within 5 words of	attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*
	mental OR psych* OR emotion*	With 5 words of	difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health

Table 2

Quality analysis using CASP

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Score
Gignac et al (2021)	1	1	0.5	1	1	0	0.5	1	1	1	8
Jansson & Gunnarsson (2018)	1	1	1	1	1	0.5	1	1	1	0.5	9
Kirsh et al (2018)	1	1	0.5	1	0.5	0	0.5	0.5	1	1	7
Lemieux & Durand (2011)	1	1	0.5	1	0.5	0	0.5	1	1	1	7.5
Lexén et al (2016)	1	1	0.5	1	1	0	0.5	0.5	1	1	7.5
Lexén et al (2019)	1	1	0.5	1	1	0.5	0.5	0.5	1	1	8
Martin et al (2015)	1	1	0.5	1	1	0.5	0.5	1	1	1	8.5
Martin et al (2018)	1	1	1	1	1	0	1	1	1	1	9
Mizzoni & Kirsh (2006)	1	1	1	1	0.5	0.5	0.5	0.5	0.5	1	7.5
Nielsen & Yarker (2022)	1	1	0.5	1	1	0.5	1	0.5	1	1	8.5
Østerud (2022)	1	1	1	1	1	0	1	0.5	1	1	8.5
Porter et al (2019)	1	1	0.5	1	1	0	1	0.5	1	0.5	7.5
Shankar et al (2014)	1	1	0.5	1	0.5	0	0	0.5	1	1	6.5
Suter et al (2023)	1	1	0.5	0.5	1	0	0	0.5	0.5	1	6
Tengelin et al (2022)	1	1	1	1	1	0	1	0.5	1	1	8.5
Thisted et al (2020)	1	1	0.5	0.5	1	0	1	0.5	0.5	1	7
Tighe & Murphy (2021)	1	1	0.5	1	0.5	0	0.5	0.5	0.5	1	6.5
Tse (2004)	1	1	0	1	1	0.5	0	0.5	1	0.5	6.5
Van Eerd et al (2021)	1	1	0.5	1	1	0	1	0.5	1	1	8

Table 3

Study and participant characteristics

Study	Aims of the study	Country of recruitment	Sampling and Participants (N, type and size of employing organisation)	Methodology and analysis	Findings
Gignac et al (2021)	Gain insight into the perspectives of individuals with support responsibility for employees with episodic disabilities.	Canada	Sampling – purposive. 27 participants (supervisors, HR professionals, disability managers, worker advocates, health and safety representatives and labour lawyers. Organisations represented – various sectors and size of organisations.	Qualitative semi-structured interviews analysed using content analysis.	Seven themes underpinned communication-support processes: (1) similarities and differences among physical and mental health episodic disabilities; (2) cultures of workplace support, including contrasting medical and biopsychosocial perspectives; (3) misgivings about others and their role in communication-support processes; (4) that subjective perceptions matter; (5) the inherent complexity of the response process; (6) challenges arising when a worker denies a disability; and (7) casting disability as a performance problem.
Jansson & Gunnarsson (2018)	Identify and characterise employers' perceptions of the impact of mental health problems on work ability.	Sweden . .	Sampling – purposive 12 employers Organisations represented – various sectors and sizes of organisations.	Qualitative semi-structured and open-ended dialogue interviews analysed using phenomenographic method	Two main categories were identified: "Experiences of employees with MHP", included experiences of diffuse and unexpressed signs of the onset of difficulties and frustration among employers and work-mates which was difficult to verbalise. MHP could also be turned off, thus having no impact on work ability. "Strategies to handle effects of MHP in the workplace", included the importance of continual responsiveness and communication, and of fluctuating

					adaptations. The informants expressed diversity in the workplace as an important strategy to pursue.
Kirsh et al (2018)	Examine how supervisors experience and perceive mental health difficulties and stigma in their workplace.	Canada	Sampling – purposive. 11 supervisors Organisations represented – Participants from one organisation which participated in an anti-stigma program.	Qualitative interviews analysed using content analysis.	Several themes were identified: perceptions of the supervisory role relative to managing mental health problems at the workplace; supervisors' perceptions of mental health issues at the workplace; and supervisors' experiences of managing mental health issues at work. The research reveals the tensions supervisors experience as they carry out responsibilities to benefit both the individual and workplace, and protect their own well-being as well.
Lemieux & Durand (2011)	Investigate the perceptions held by supervisors of the factors facilitating or hindering the return to work of workers with common mental disorders.	Canada	Sampling – purposive 11 supervisors Organisations represented – various industries from medium to large sized organisations.	Qualitative semi-structured interviews analysed using content analysis.	The study identified 24 factors which could hinder or facilitate the return-to-work process. These were classified into three main categories: factors related to the worker, work context, and return-to-work process.
Lexén et al (2016)	Explore the experiences and views of	Sweden	Sampling – theoretical. 9 employers	Qualitative semi-structured interviews analysed	A core category was identified of being socially committed was identified. Six stages/categories illustrated the employer

	employers who have participated in the IPS (individual placement and support) network.		Organisations represented – various industries from small to medium sized organisations.	using grounded theory and situational analysis.	process, from taking on IPS service users to supporting them at work: 1) IPS is the keyhole, 2) being ready to open the door, 3) making a job offer, 4) removing barriers, 5) achieving the goal, and 6) pride mixed with negative feelings.
Lexén et al (2019)	Develop a model that explains how employer and rehabilitation professional experiences, attitudes, and knowledge influence the strategies used during return to work of employees with mental health difficulties.	Sweden	Sampling – theoretical 45 participants (23 employers and 22 rehabilitation professionals) Organisations represented – various sectors and sizes of organisation.	Qualitative semi-structured interviews alongside vignettes were analysed using grounded theory.	Four themes were identified: seeing mental health problems through past experiences, separating understandable and incomprehensible MH problems, balancing safeguarding one's personal interest with providing adequate support and facing conflicts and uncertainty in employee/service user return to work.
Martin et al (2015) (Paper linked to Martin et al (2018)	Determine managers' experiences of supervising an employee with	Australia	Sampling – convenience 24 managers.	Qualitative semi-structured interviews analysed to develop themes.	Findings indicate that managers reference specific forms of conceptual and procedural knowledge when (1) becoming aware of the employee's mental health issue; (2) exploring the workplace implications and

	a mental health difficulty.		Organisations represented – variety of industries, size of company could not be reported.	Type of analysis not specified.	developing an action response; (3) implementing the response and managing it as an ongoing situation, and (4) engaging in reflective learning.
Martin et al., (2018) (Paper based on research from Martin et al (2015)	Explore the experiences, challenges and rewards of managers when managing employees with mental health difficulties.	Australia	Sampling – convenience (Same as above)	Qualitative semi-structured interviews analysed using thematic analysis.	Managing an employee with a mental health issue involves becoming aware of the issue, taking action to understand the situation and develop an action response, implementing the response and managing the ongoing situation. Each of these tasks had a range of positive and negative aspects, e.g., managing the situation can be experienced as both a source of stress for the manager but also as an opportunity to develop greater management skills.
Mizzoni & Kirsh (2006)	Examine the experiences, challenges, rewards and support needs of employers participating in a mental health agency employment program.	Canada	Sampling – purposive. 5 employers Organisations represented – various sectors from predominantly large organisations.	Qualitative semi-structured interviews analysed using grounded theory.	Four themes were identified: the importance of employer/co-worker awareness and the challenges of navigating co-worker dynamics, employers views of accommodations and finding solutions to workplace problems, stigma and its dissolution and the benefits of employing people with mental health problems.
Nielsen & Yarker (2022)	Examine how line managers support	United Kingdom	Sampling – purposive. 20 Line managers	Methodology – qualitative. Semi-structured	Line managers engage in several strategies to support employees returning to work, namely: workload management, flexible

	employees returning to work after long term sick leave due to common mental disorders		Organisations represented – variety of industries, size of company was not reported.	interviews analysed using reflexive thematic analysis	hours and location of work, check-in contact and ongoing support. These strategies were influenced by individuals own experiences and by organisational support and policies.
Østerud (2022)	Explore the effect of stigma and previous experience on hiring decisions	Norway	Sampling – purposive. 20 Line managers Organisations represented – various sectors and sizes of organisation	Qualitative and candidate application selection exercise. Semi-structured interviews exploring reasoning and past experiences analysed using reflexive thematic analysis	Common stigmatised stereotypes influenced whether employers invited candidate for interview. Those with negative previous experiences held more negative attitudes and were less likely to invite candidates with mental health difficulties to interview. Negative previous experiences tended to be characterised by avoidance while those with more positive previous experiences tended to discuss having had empathic dialogue with employees.
Porter et al (2019)	Explore employer beliefs and knowledge of mental health difficulties and their use of strategies to support employees	Sweden	Sampling – theoretical 24 employers Organisations represented – various sectors and sizes of organisation.	Qualitative semi-structured interviews alongside vignettes were analysed using grounded theory.	Employers discussed finding comprehending mental health difficulties to be complex and that they lacked strategies, support systems and knowledge. Employers' previous experiences could affect their perception of mental health difficulties and employees work ability.

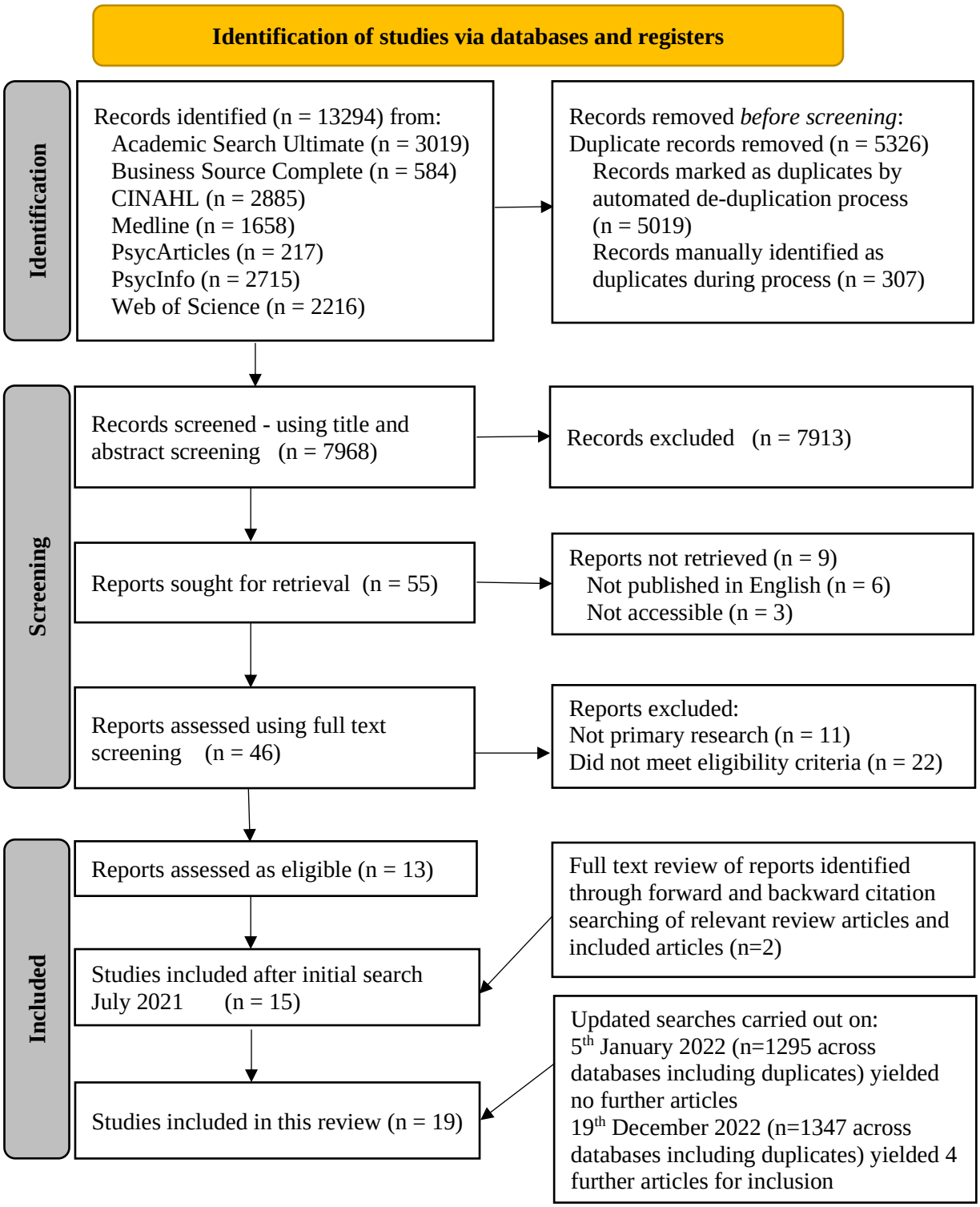
	with mental health difficulties.				
Shankar et al (2014)	Examine the challenges and support needs to hire and accommodate workers with mental health difficulties.	Canada	Sampling – Purposive 28 participants (employers, HR personnel and disability consultants). 2 participant reported limited experience of working with employees with mental health difficulties Organisations represented – various sectors and sizes of organisation.	Qualitative semi-structured interviews were analysed using grounded theory.	The study highlighted positive and negative experiences of employing people with mental health difficulties. Those who had positive experiences reported less prejudicial attitudes compared with those who had negative experiences. Challenges and barriers to hiring and accommodating staff were discussed and the influence of support availability on decisions making.
Suter et al (2023)	Explore the experiences of managers of small and micro businesses when responding to employee mental health difficulties.	United Kingdom	Sampling – Self-selecting 21 Business managers from small (up to 50 employees) and micro businesses (one to nine employees) from a variety of sectors.	Qualitative, narrative and semi-structured interviews were analysed using thematic and matrix analysis.	Findings identified three main managerial tensions which arose within small business contexts. These were evident when managing performance or conduct issues and identified tensions between individual support and the impact on the collective workforce, confidence versus caution and informal versus formal approaches to managing employees.
Tengelin et al (2022)	Explore managers experiences of understanding	Sweden	Sampling – self-selecting.	Qualitative focus groups were analysed using	Managers perspectives on capacity to work of employees with common mental disorders. Managers identified five areas which can be affected: ability to focus on

	the capacity to work of employees with common mental disorders.		31 Managers. Organisations represented – various sectors and sizes of organisation.	inductive manifest content analysis.	work tasks, focus on continuous tasks without fragmentation of tasks, ability to work independently, maintaining professional appearances, and ability to maintain social interactions in the workplace.
Thisted et al (2020)	Investigate employers' attitudes to manage employees' depression, and the opportunities and challenges supporting employees with depression.	Denmark	Sampling – purposive 5 employers Organisations represented – predominantly education and healthcare sectors across small to medium sized organisations.	Qualitative semi-structured interviews were analysed using inductive content analysis.	Four themes were outlined: Attitude to and understanding of depression affects the supportive practices of employers; employers experience dilemmas between supporting employees with depression and accommodating workplace needs; The employer employee relationship influences supportive practices; and the opportunity to provide work accommodations is limited by employer knowledge and attitudes and maintains an individual focus.
Tighe & Murphy (2021)	Investigate support needs when facilitating return to work for people with mental health difficulties within a publicly	Ireland	Sampling – convenience sample 22 participants (8 employers, 8 healthcare professionals and 6 IPS users (Individual Placement and Support)) Organisations represented - Predominantly retail or charity work. All organisations were small to medium sized.	Qualitative structured and semi-structured interviews were analysed using thematic analysis.	Four themes were identified: Suitability of the IPS model of supported employment, the challenges of cognitive and social functioning at work, employment/ vocational related issues and stigma surrounding mental health. These themes emphasise the supports available, and resources needed to enable employment participation.

	funded programme.				
Tse (2004)	Investigate employers' experiences of employing people with mental health issues and providing accommodations for employees or applicants	New Zealand	Sampling – random sampling of the local business directory 72 business owners or personnel managers (47 had experience of employing people with mental health difficulties Organisations represented – various sectors and sizes of organisation approximating that of the local area	Qualitative semi-structured interviews were analysed via theme generation. Type of analysis was not specified.	Employers reported that it could be a rewarding and positive experience employing people with mental health difficulties. Employers identified the importance of developing trustworthy relationships, working through issues and seeking external support to support employees.
Van Eerd et al (2021)	Identify workplace expertise and practices which support and accommodate employees with depression	Canada	Sampling – convenience sample 453 survey respondents (employees and employing staff) 21 participants (11 employees, and 10 employers, managers, supervisors, occupational health and safety personnel). Organisations represented – various sectors and predominantly large organisations	Mixed (survey and focus groups). Semi-structured interviews/focus groups and open-ended survey questions were analysed using thematic analysis.	Findings emphasised the importance of awareness, knowledge and training about depression, identifying aspects of work which contribute to or reduce the development of depression, the need for adaptations and flexibility, the importance of communication and coordinating with external support resources.

Figure 1

PRISMA flow diagram (Preferred Reporting Items for Systematic reviews and Meta-Analyses) (Page et al., 2021)



Appendices

Appendix 1-A

Journal of Mental Health – Author guidelines

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Appendix 1-B

Detailed search term strategy used in each database

Database	Search Line number	Search terms
Academic Search Ultimate	S1	((DE "EMPLOYER attitude surveys" OR DE "EMPLOYER attitudes" OR DE "ATTITUDES toward disabilities" OR DE "ATTITUDES toward mental illness" OR DE "EMPLOYER attitudes" OR DE "EXECUTIVES' attitudes" OR DE "SUPERVISORS" OR DE "SUPERVISION of employees")) OR TI ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((DE "PSYCHOSES" OR DE "PARANOID schizophrenia" OR DE "SCHIZOAFFECTIVE disorders" OR DE "SCHIZOTYPAL personality disorder" OR DE "PARAPHILIAS" OR DE "SCHIZOPHRENIA" OR DE "MENTAL health" OR DE "DEPRESSED persons" OR DE "PEOPLE with bipolar disorder" OR DE "MENTAL illness" OR DE "AFFECTIVE disorders" OR DE "DEPRESSION in college students" OR DE "DEPRESSION in men" OR DE "DEPRESSION in women" OR DE "DYSTHYMIC disorder" OR DE "PSYCHOTIC depression" OR DE "ANXIETY" OR DE "PANIC disorders" OR DE "PERFORMANCE anxiety" OR DE "SEPARATION anxiety" OR DE "SOCIAL anxiety" OR DE "SPEECH anxiety" OR DE "TEST anxiety" OR DE "PERSONALITY disorder diagnosis" OR DE "ANOREXIA nervosa" OR DE "BINGE-eating disorder" OR DE "BULIMIA" OR DE "COMPULSIVE eating" OR DE "EATING disorders" OR DE "EATING disorders in women")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 and S2
Business Source Complete	S1	(DE "EMPLOYER attitude surveys" OR DE "EMPLOYER attitudes" OR DE "SUPERVISION of employees" OR DE "SUPERVISORS" OR DE "EMPLOYER attitude surveys" OR DE "EXECUTIVES' attitudes" OR DE "EMPLOYER attitudes") OR TI

		((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((DE "EMPLOYMENT of the mentally ill")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 and S2
CINAHL	S1	((MH "Supervisors and Supervision") OR (MH "Employer-Employee Relations") OR (MH "Discrimination, Employment") OR (MH "Employment of Persons with Disabilities")) OR TI ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((MH "Mental Health") OR (MH "Adjustment Disorders") OR (MH "Attitude to Mental Illness") OR (MH "Mental Disorders, Chronic") OR (MH "Mental Disorders Diagnosed in Childhood") OR (MH "Neurotic Disorders") OR (MH "Organic Mental Disorders") OR (MH "Personality Disorders") OR (MH "Psychophysiologic Disorders") OR (MH "Psychotic Disorders") OR (MH "Sexual and Gender Disorders") OR (MH "Psychological Trauma") OR (MH "Organic Mental Disorders, Psychotic") OR (MH "Anxiety Disorders") OR (MH "Dissociative Disorders") OR (MH "Somatoform Disorders") OR (MH "Depression") OR (MH "Affective Disorders") OR (MH "Affective Disorders, Psychotic") OR (MH "Bipolar Disorder") OR (MH "Seasonal Affective Disorder") OR (MH "Cyclothymic Disorder") OR (MH "Antisocial Personality Disorder") OR (MH "Histrionic Personality Disorder") OR (MH "Passive-Aggressive Personality Disorder") OR (MH "Dependent Personality Disorder") OR (MH "Multiple-Personality Disorder") OR (MH "Avoidant Personality Disorder") OR (MH

		"Narcissistic Personality Disorder") OR (MH "Schizotypal Personality Disorder") OR (MH "Compulsive Personality Disorder") OR (MH "Eating Disorders") OR (MH "Binge Eating Disorder") OR (MH "Avoidant Restrictive Food Intake Disorder") OR (MH "Bulimia Nervosa") OR (MH "Social Anxiety Disorders") OR (MH "Generalized Anxiety Disorder") OR (MH "Catastrophization") OR (MH "Separation Anxiety") OR (MH "Anxiety") OR (MH "Psychological Distress") OR (MH "Gender Dysphoria") OR (MH "Mental Disorders") OR (MH "Depression, Reactive") OR (MH "Phobic Disorders")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 and S2
Medline	S1	TI ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((MH "Mental Health") OR (MH "Mentally Ill Persons") OR (MH "Trauma and Stressor Related Disorders") OR (MH "Stress Disorders, Traumatic") OR (MH "Adjustment Disorders") OR (MH "Mental Disorders") OR (MH "Hypochondriasis") OR (MH "Conversion Disorder") OR (MH "Somatoform Disorders") OR (MH "Schizophrenia Spectrum and Other Psychotic Disorders") OR (MH "Schizophrenia") OR (MH "Psychotic Disorders") OR (MH "Schizophrenia, Paranoid") OR (MH "Schizophrenia, Disorganized") OR (MH "Shared Paranoid Disorder") OR (MH "Schizophrenia, Catatonic") OR (MH "Affective Disorders, Psychotic") OR (MH "Personality Disorders") OR (MH "Schizotypal Personality Disorder") OR (MH "Schizoid Personality Disorder") OR (MH "Passive-Aggressive Personality Disorder") OR (MH "Paranoid Personality Disorder") OR (MH "Histrionic Personality Disorder") OR (MH "Compulsive Personality Disorder") OR (MH "Dependent Personality Disorder") OR (MH "Borderline Personality Disorder") OR (MH "Antisocial Personality Disorder") OR (MH "Paraphilic Disorders") OR (MH "Neurotic Disorders") OR (MH "Feeding and Eating Disorders") OR (MH "Binge-Eating Disorder") OR (MH "Rumination Syndrome") OR (MH "Food Addiction") OR (MH "Bulimia Nervosa") OR (MH "Anorexia Nervosa") OR (MH "Diabulimia") OR (MH "Mood Disorders") OR (MH "Depressive Disorder") OR (MH "Cyclothymic Disorder") OR

		(MH "Bipolar and Related Disorders") OR (MH "Bipolar Disorder") OR (MH "Disruptive, Impulse Control, and Conduct Disorders") OR (MH "Trichotillomania") OR (MH "Dissociative Disorders") OR (MH "Dissociative Identity Disorder") OR (MH "Anxiety Disorders") OR (MH "Phobic Disorders") OR (MH "Panic Disorder") OR (MH "Obsessive-Compulsive Disorder") OR (MH "Agoraphobia") OR (MH "Depression")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 and S2
PsycArticles	S1	((DE "Employer Attitudes" OR DE "Employment Discrimination") OR (DE "Supervisor Employee Interaction")) OR TI ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((DE "Mental Health" OR DE "Mental Health Stigma" OR DE "Serious Mental Illness" OR DE "Mental Disorders" OR DE "Disorders" OR DE "Affective Disorders" OR DE "Anxiety Disorders" OR DE "Bipolar Disorder" OR DE "Borderline States" OR DE "Chronic Mental Illness" OR DE "Dissociative Disorders" OR DE "Eating Disorders" OR DE "Gender Dysphoria" OR DE "Mental Disorders due to General Medical Conditions" OR DE "Neurosis" OR DE "Paraphilias" OR DE "Personality Disorders" OR DE "Psychosis" OR DE "Serious Mental Illness" OR DE "Somatoform Disorders" OR DE "Stress and Trauma Related Disorders" OR DE "Thought Disturbances" OR DE "Depression (Emotion)" OR DE "Anxiety Disorders" OR DE "Generalized Anxiety Disorder" OR DE "Obsessive Compulsive Disorder" OR DE "Panic Attack" OR DE "Panic Disorder" OR DE "Phobias" OR DE "Trichotillomania" OR DE "Anxiety" OR DE "Antisocial Personality Disorder" OR DE "Avoidant Personality Disorder" OR DE "Borderline Personality Disorder" OR DE "Dependent Personality Disorder" OR DE "Histrionic Personality Disorder" OR DE "Narcissistic Personality Disorder" OR DE "Obsessive Compulsive Personality Disorder" OR DE "Paranoid Personality Disorder" OR DE "Passive Aggressive Personality Disorder" OR DE "Sadomasochistic Personality" OR DE "Schizoid Personality Disorder" OR DE "Schizotypal Personality Disorder" OR DE "Acute Psychosis" OR DE "Affective Psychosis" OR DE "Chronic

		Psychosis" OR DE "Paranoia (Psychosis)" OR DE "Reactive Psychosis" OR DE "Schizophrenia" OR DE "Paranoid Schizophrenia")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 and S2
PsycInfo	S1	((DE "Employer Attitudes" OR DE "Employment Discrimination" OR DE "Supervisor Employee Interaction")) OR TI ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)) OR AB ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") N5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	S2	((DE "Mental Health" OR DE "Disorders" OR DE "Affective Disorders" OR DE "Bipolar Disorder" OR DE "Borderline States" OR DE "Chronic Mental Illness" OR DE "Dissociative Disorders" OR DE "Eating Disorders" OR DE "Gender Dysphoria" OR DE "Mental Disorders due to General Medical Conditions" OR DE "Neurocognitive Disorders" OR DE "Paraphilias" OR DE "Personality Disorders" OR DE "Psychosis" OR DE "Serious Mental Illness" OR DE "Somatoform Disorders" OR DE "Stress and Trauma Related Disorders" OR DE "Thought Disturbances" OR DE "Major Depression" OR DE "Health Anxiety" OR DE "Neurosis" OR DE "Catastrophizing" OR DE "Anxiety Sensitivity" OR DE "Anxiety Disorders" OR DE "Mental Disorders" OR DE "Generalized Anxiety Disorder" OR DE "Obsessive Compulsive Disorder" OR DE "Panic Attack" OR DE "Panic Disorder" OR DE "Phobias" OR DE "Trichotillomania" OR DE "Anxiety" OR DE "Anxiety Management" OR DE "Death Anxiety" OR DE "Hypochondriasis" OR DE "Antisocial Personality Disorder" OR DE "Avoidant Personality Disorder" OR DE "Borderline Personality Disorder" OR DE "Dependent Personality Disorder" OR DE "Histrionic Personality Disorder" OR DE "Narcissistic Personality Disorder" OR DE "Obsessive Compulsive Personality Disorder" OR DE "Paranoid Personality Disorder" OR DE "Passive Aggressive Personality Disorder" OR DE "Sadomasochistic Personality" OR DE "Schizoid Personality Disorder" OR DE "Schizotypal Personality Disorder" OR DE "Explosive Disorder" OR DE "Psychosis" OR DE "Acute Schizophrenia" OR DE "Catatonic Schizophrenia" OR DE "Paranoid Schizophrenia" OR DE "Process Schizophrenia" OR DE "Schizoaffective Disorder" OR DE "Schizophrenia (Disorganized Type)" OR DE "Schizophreniform

		Disorder" OR DE "Undifferentiated Schizophrenia" OR DE "Affective Psychosis" OR DE "Reactive Psychosis")) OR TI ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health)) OR AB ((mental OR psych* OR emotion*) N5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	S3	S1 AND S2
Web of Science	1	(TI=((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") near/5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))) OR AB=((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") near/5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*))
	2	(TI=((mental OR psych* OR emotion*) near/5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))) OR AB=((mental OR psych* OR emotion*) near/5 (difficult* OR struggle* OR problem* OR issue* OR disorder* OR illness* OR condition* OR health))
	3	KP = ("Mental Health" OR "Disorders" OR "Affective Disorders" OR "Bipolar Disorder" OR "Borderline States" OR "Chronic Mental Illness" OR "Dissociative Disorders" OR "Eating Disorders" OR "Gender Dysphoria" OR "Mental Disorders due to General Medical Conditions" OR "Neurocognitive Disorders" OR "Paraphilias" OR "Personality Disorders" OR "Psychosis" OR "Serious Mental Illness" OR "Somatoform Disorders" OR "Stress and Trauma Related Disorders" OR "Thought Disturbances" OR "Major Depression" OR "Health Anxiety" OR "Neurosis" OR "Catastrophizing" OR "Anxiety Sensitivity" OR "Anxiety Disorders" OR "Mental Disorders" OR "Generalized Anxiety Disorder" OR "Obsessive Compulsive Disorder" OR "Panic Attack" OR "Panic Disorder" OR "Phobias" OR "Trichotillomania" OR "Anxiety" OR "Anxiety Management" OR "Death Anxiety" OR "Hypochondriasis" OR "Antisocial Personality Disorder" OR "Avoidant Personality Disorder" OR "Borderline Personality Disorder" OR "Dependent Personality Disorder" OR "Histrionic Personality Disorder" OR "Narcissistic Personality Disorder" OR "Obsessive Compulsive Personality Disorder" OR "Paranoid Personality Disorder" OR "Passive Aggressive Personality Disorder" OR "Sadomasochistic Personality" OR "Schizoid Personality Disorder" OR "Schizotypal Personality Disorder" OR "Explosive Disorder" OR "Psychosis" OR "Acute Schizophrenia" OR "Catatonic Schizophrenia" OR "Paranoid Schizophrenia" OR

	"Process Schizophrenia" OR "Schizoaffective Disorder" OR "Schizophrenia (Disorganized Type)" OR "Schizophreniform Disorder" OR "Undifferentiated Schizophrenia" OR "Affective Psychosis" OR "Reactive Psychosis")
4	(#3) OR #2
5	KP=(("Employer Attitudes" OR "Employment Discrimination" OR "Supervisor Employee Interaction") OR ((employer* OR employment OR workplace* OR work-place* OR "work place*" OR supervisor* OR manager* OR director OR executive* OR "senior leader*" OR "HR" OR "human resource*") near/5 (attitude* OR experience* OR opinion* OR view* OR perspective* OR perception*)))
6	(#5) OR #1
7	(#6) AND #4

Appendix 1-C

Excerpt of coding

Article findings	Coding
Eight managers reported that becoming aware of and investigating their employee's EMH issue generated positive outcomes in helping them gain a better understanding of mental health issues, such as that identified by Manager 125: I said to [my employee who told me she had depression] "well I've never had it before. Can you explain to me what happens, how do you feel, what do you experience?" and so she sort of gave me a bit of a background as to how it affected her which was helpful from my perspective.	Need understanding to empathise/provide support Benefit of supporting employees Benefit of supporting employees
Manager 109 explained that this initial learning positively influenced her subsequent handling of the situation because: The symptoms [the employee] demonstrated in feeling very stressed at that time were quite pronounced but I was able to sort of keep those in mind later on and if she started to demonstrate those types of symptoms I knew there was something not quite right so it gave me an opening to discuss them with her.	Previous experience guiding understanding/ intention/ action Need understanding to empathise/provide support
Challenging aspects of becoming aware of the employee's EMH issue	
For some managers, holding conversations with their employee about the employee's mental health was challenging due to the manager feeling uncomfortable or under-confident when discussing such topics. Five managers acknowledged that when managing an employee with an EMH issue they felt "out of their depth" because	Feeling out of depth Lack of knowledge /understanding

they had a limited knowledge and understanding of mental health issues. Manager 107 provided the most detailed explanation of this challenge: The biggest [challenge] was kind of not understanding what she was going through […][which made me] not sure about whether the advice I was providing was appropriate […]. I felt really ignorant to the whole issue and so that kind of made it a bit difficult.

Four managers said they found it difficult because they felt uncomfortable discussing personal issues, such as mental health, with their employee and/or were concerned about the employee's emotional reaction if they did approach the subject. For some managers, these challenges were exacerbated by a lack of organizational support and insufficient guidance about the appropriate actions to take. As Manager 127 stated:

You had no guidelines as to what to follow so you didn't know if you were interfering too far and also from an operational point of view I wasn't aware of what grounds I had to say to the staff member "oh well you're not fit to come to work so don't come" […]. [I] didn't know whether to say to come into work and deal with their mistakes or stand them down.

Feeling out of depth

MH relatable/difficult to understand

Private issue

Empathy distress/ Compassion fatigue

Policies and procedures

Needing support to provide support

Systemic/organisational culture

Ability to work

Appendix 1-D

Synthesis theme development

Theme	Sub-theme	Initial codes	Example quotes
How perceptions of mental health difficulties and their role influenced manager and supervisor responses	Part of their role (Supporting employee wellbeing and problem solving issues)	Part of role	"the importance of being responsive and being attentive to the emotional atmosphere among all employees" (Jansson & Gunnarsson, 2018)
	Mental health difficulties and role remit – private issue or related to work	Private issue	"Many employers described mental illness as something private, taboo and shameful" Østerud, 2022)
		Part of role	"Some employers believed that it was the employees' responsibility to deal with their stress, just like the employers had to do themselves" (Porter et al., 2019)
	Dilemma of productivity and company needs verses employee needs	Disability as productivity/ performance issue	"economic dilemmas with fears of high sick leave costs as well as doubts concerning the employee's productivity" (Jansson & Gunnarsson, 2018)
		Business priorities	"torn between offering support to the returned worker and meeting the demands from the organization" (Nielsen & Yarker, 2022)
	Influences on response - Company culture - Size of company	Systemic/organisational culture	"None of our line managers felt the organizational context facilitated the enactment of proactive behaviors. Line managers lacked training; HR policies were inflexible and senior management devolved responsibility without devolving the autonomy to make work adjustments" (Nielsen & Yarker, 2022)
		Size of company – large/small	"different managers or an HR function, is usually unavailable to managers in microbusinesses and some small firms. Managers lack the option of creating independent distance between support and more formalised performance management procedures" (Suter et al., 2023)

Need for support to provide support	Responsibilities for reasonable adjustments and support but lacking knowledge and understanding	Need knowledge of workplace and employee to support	"As an employer, one has to consider the question, "Is this a disability that can be accommodated in the workplace, given again, the nature of the work? And what's a bona fide requirement and what isn't?" (Mizzoni & Kirsh, 2006)
		Feeling out of depth	"They did not know how best to support their employee, or the extent to which the mental health problem impacted on work ability, social context, and productivity" (Porter et al., 2019)
	Support and advice for supervisors		
	- Advice from internal and external company resources	Needing support to provide support	"support provided by an employment specialist as important in this regard: 'Just a person to contact … a person to speak to in case something happened, and we didn't know how to deal with it" (Tighe and Murphy, 2021)
	- Policies and procedures	Policies and procedure	"Being able to refer to a return to work policy that is inclusive of any medical condition (as opposed to focus on physical only vs mental illness only) demonstrates the employer's willingness to treat everyone the same" (Van Eerd et al., 2021)
	- Training	Training	"mental health anti-stigma training was considered evidence of the organization's investment in the issue of workplace mental health" (Kirsh et al., 2018)
	Support for employees	Needing support to provide support	"To overcome challenges caused by the balance of power, the employer relies on others such as general practitioners, co-workers or union representatives" (Thisted et al., 2020)
	- Reassurance for supervisors		
	- Employee support outside of the power dynamics of the supervising role	Accessing health care	"Some supervisors emphasized that the attending physicians did not always provide enough medical follow-up or did not prepare the worker adequately for the return to work" (Lemieux et al., 2011)
	- Timeliness of support		

Understanding and the barriers to understanding	Understanding supported empathy and action	Previous experience guiding understanding/ intention/ action	"Their previous experience with mental illness and/or experiences of meeting persons in vulnerable situations functioned as the rationale, and the employer's life experience gave self-awareness and confidence when using different support strategies" Lexén et al., 2016)
		Need understanding to empathise/provide support	"Work accommodations were often needed but employers might be hesitant to make these because of lack of relevant knowledge and experiences" (Porter et al., 2019)
		Lack of knowledge/understanding	"Knowledge of depression provides opportunities to take depressive symptoms into account in the communication with employees" (Thisted et al., 2020)
	Understandable versus incomprehensible mental health difficulties	Stigma	"People say, well, there's nothing wrong with them. "Why do they need accommodation? Look at them. They look fine…The person is milking the system" (Gignac et al., 2021)
		MH relatable/difficult to understand	"schizophrenia and other enduring MH problems were difficult to explain and understand, and were described as incomprehensible MH problems" Lexén et al., 2019)
	Understanding versus employee privacy	Privacy vs understanding	"often find themselves at an impasse in terms of how to act if, within their organization, they are not given any information about the nature of the employee's disability" (Lemieux & Durand, 2011)
Emotional challenges and rewards of supporting employees with mental health difficulties	Effect of employee distress on the supervisor	Empathy distress/ Compassion fatigue	"Several of the managers in this study noted the experience impacted their own mental health and well-being, with managers feeling 'out of their depth' and stressed, at work and in their personal lives" (Martin et al., 2018)
	Reward and benefits of providing support	Benefit of supporting employees	"Some employers found it as a very rewarding experience to see somebody able to regain a full life" (Tse, 2004)

Chapter 2 Research Paper

Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

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Prepared for Clinical Psychology and Psychotherapy (see Appendix 2-A for journal author guidelines)

Abstract

Research indicates that a substantial proportion of trainee clinical psychologists have experienced mental health difficulties and considered sharing this information with their tutors and supervisors during training. This study explored experiences of trainee clinical psychologists who shared their mental health difficulties with tutors and supervisors to identify influencing factors and the effect of sharing over time.

Twelve qualified clinical psychologists were interviewed regarding their experiences of sharing during training. Thematic analysis was utilised, and four themes were developed. These comprised weighing up whether to share; creating safety to share and feeling supported; dilemmas, feeling vulnerable and powerless to challenge perceptions; and experience shaping their practice and identity. The findings contribute further detail to models of trainee disclosure and sharing, consider ways of creating a safe environment to facilitate trainee sharing, and highlight longer-term impacts of sharing conversations.

Key Practitioner Message

- Trainee clinical psychologists adopt a position of non-sharing unless there are compelling reasons to share, such as needing reasonable adjustments.
- Supervisors and tutors can encourage a sense of safety in supervision which can facilitate trainee sharing.
- Supervisors and tutors should be mindful of the power dynamics in the supervisor/trainee relationship and where possible work collaboratively to facilitate supportive experiences.

Keywords: lived experience, mental health, self-disclosure, trainee clinical psychologist, supervisor, qualitative

It is estimated that a substantial proportion of clinical psychologists have experienced mental health difficulties. Recent surveys have found that approximately 62% of qualified clinical psychologists (Tay et al., 2018) and 67% of trainees (Grice et al., 2018) reported having had a mental health difficulty. Earlier studies have reported similar levels, suggesting that between 25% and 59% of clinical psychology trainees have experienced difficulties with self-esteem, anxiety, depression and work adjustment (Brooks et al., 2002; Cushway, 1992; Kuyken et al., 1998). A number of factors may contribute to this prevalence. For example, previous experience of mental health difficultuies or marginalisation may motivate an individual to train as a mental health professional (Barnett, 2007; Farber et al., 2005). Factors associated with mental health professional roles can increase the likelihood of developing mental health difficulties, such as secondary traumatic stress (Makadia et al., 2017) and stress and burnout (Pakenham & Stafford-Brown, 2012). Self-selection bias may mean that reported incidence of mental health difficulties is over-estimated (British Psychological Society [BPS], 2020), however there is likely to be a significant level of lived experience of mental health difficulties within the clinical psychology profession.

Experience of mental health difficulties can be beneficial to the work of mental health professionals, while also presenting several considerations for practise. For example, lived experience can foster increased empathy and insight into client difficulties, support the therapeutic alliance and offer hope to clients for their own recovery (de Vos et al., 2016; Lovell et al., 2020; Marino et al., 2016). However, when considering sharing[1] lived experience with clients it is strongly advised that practitioners carefully consider their intentions with their supervisors prior to sharing with clients to ensure it is done appropriately (Dunlop et al., 2022).

[1] The term sharing is preferred to disclosure in this study as the latter has negative connotations of making known secret information (BBC, 2014; BPS, 2020).

It may also be beneficial for practitioners to share information about their mental health with their supervisors to access reasonable adjustments in line with the Equality Act (2010), access employment-based wellbeing support, and ensure their safe working practise in line with regulatory expectations of monitoring fitness to practice and taking action if performance is negatively affected (HCPC, 2016a, 2016b). In addition, sharing with supervisors may allow employees to explain their reactions and alleviate the stress of concealing mental health difficulties (Brohan et al., 2012). However, mental health practitioners and trainees are often reluctant to share due to concerns about stigma, the risk of discrimination, and fear that their professional competence will be questioned (Brohan et al., 2012; King et al., 2020; Stanley et al., 2007).

This reluctance to share with supervisors is reflected in recent research asking clinical psychology trainees who they would approach if they were experiencing their own mental health difficulties. Trainees were less likely to consider sharing with supervisors than with friends or family, unless they anticipated needing practical support for training which could override their concerns about mental health stigma (Grice et al., 2018). This is consistent with research exploring instances of employees sharing their mental health difficulties in the workplace where they tended to adopt a stance of non-sharing due to fear of stigmatisation (Toth & Dewa, 2014). Employees assessed the characteristics of the recipient and shared if there was sufficient potential benefit to outweigh the risks (Toth & Dewa, 2014).

However, despite the prevalence of mental health difficulties among clinical psychologists and the potential benefits of sharing with supervisors, there are few studies which have explored the experiences of clinical psychologists and trainee clinical psychologists when sharing their mental health difficulties or the impact of sharing. Studies which have been conducted have usually focused on factors supporting or deterring sharing. Factors which supported sharing included a supportive managerial relationship (Charlemagne-Odle et al.,

2014; Turner et al., 2021; Waugh et al., 2017), the need for emotional and practical support (Charlemagne-Odle et al., 2014; Turner et al., 2021; Waugh et al., 2017), and feeling a professional duty to share with supervisors (Turner et al., 2021; Waugh et al., 2017). Deterrents included fears about negative judgements and past experiences of discrimination (Charlemagne-Odle et al., 2014), fears of supervisors and colleagues raising fitness to practice concerns (Charlemagne-Odle et al., 2014; Huet & Holttum, 2016; Turner et al., 2021), whether their difficulties were affecting their capacity to do their job (Waugh et al., 2017), and the perception that discussing mental health difficulties was unacceptable within the profession (Charlemagne-Odle et al., 2014; Turner et al., 2021).

However, it is difficult to draw conclusions about lived experiences of sharing within supervisory relationships from these studies due to their methodology. Waugh et al (2017) explored participant attitudes to hypothetical sharing and attitudes to sharing by colleagues, limiting the generalisability of results to real-life sharing. Turner et al (2021) and Charlemagne-Odle et al (2014) explored the experiences of trainee and qualified clinical psychologists respectively when sharing with different groups of people, namely, peers, colleagues and supervisors. The variety of sharing recipients makes it challenging to discern the specific experience of sharing within the supervisory relationship specifically.

Some studies have identified helpful and unhelpful aspects of responses received by participants. Helpful experiences included receiving empathic, supportive responses (Huet & Holttum, 2016; Turner et al., 2021; Waugh et al., 2017), recipient curiosity without trying to fix (Turner et al., 2021) and feeling cared for (Charlemagne-Odle et al., 2014). Unhelpful experiences included feeling ignored (Huet & Holttum, 2016; Waugh et al., 2017), a lack of practical support (Charlemagne-Odle et al., 2014) and a sense that it was unacceptable to talk about their mental health difficulties or the personal impact of work (Charlemagne-Odle et al., 2014). The impact of sharing was briefly discussed within studies and findings ranged

from subsequently feeling it was easier to be open about difficulties, developing deeper relationships with the recipient, feeling able to integrate parts of themselves (Turner et al., 2021), finding the right support (Turner et al., 2021), improved work-life balance (Charlemagne-Odle et al., 2014). Negative experiences often led to future reluctance to share (Elliott & Ragsdale, 2020). However, most studies tended to focus on the immediate impact of sharing, such as receiving support. Participants in Turner and colleagues' (2021) study were interviewed while they were trainees so it was not possible to discern the longer-term impacts of sharing. Therefore, this area would benefit from further exploration.

Trainee clinical psychologists may experience additional barriers to sharing mental health difficulties due to the involvement of supervisors in their evaluation and assessment (Wilson et al., 2016). Frequent placement and supervisor changes during training can disrupt the establishment of ongoing supportive supervisory relationships which promote sharing. While these issues were not discussed by Turner et al (2021) this may be due to the inclusion of peer and colleague sharing experiences alongside sharing with supervisors. Therefore, it would be beneficial to further explore the experiences of trainee clinical psychologists specifically sharing their mental health difficulties with supervisors and tutors.

This study will seek to explore the experiences of trainee clinical psychologists sharing their mental health difficulties with supervisors and tutors. Qualified clinical psychologists will be interviewed to explore the long-term impact of sharing their experiences and to enable reflection on sharing experiences throughout clinical training. This study will contribute further detail to the facilitative and deterrent factors of sharing in supervisory conversations, explore helpful or unhelpful aspects of these sharing experiences, and provide insight into the experience of sharing over time. This could support services and training programmes to develop processes and working relationships which reduce barriers to trainee sharing which could promote access to support at earlier opportunities.

Method

Design

A qualitative design was utilised, undertaking individual interviews to facilitate the in-depth exploration of participant experiences of sharing. Thematic analysis was used to explore common themes across participants.

Eligibility criteria

Eligible participants were required to have qualified as a Clinical Psychologist in the United Kingdom (UK) in the five years prior to being interviewed and to have shared their mental health difficulties with their placement supervisor and/or programme tutor during training. For the purposes of this study, mental health difficulties could be self-identified, or clinician diagnosed. The five-year timeframe was chosen to increase the likelihood the likelihood of clear recall. This also increased the likelihood that participants began training following the introduction of the Equality Act (2010) as changes in legislation could impact on experiences, for example influencing support provision. The Equality Act 2010) requires employers and universities to make reasonable adjustments for individuals with disabilities, such as mental health difficulties, and not discriminate against individuals based on protected characteristics. Recruitment was restricted to participants who had trained in the UK to limit the influence of differences in disability legislation and training programme arrangements between countries.

Participants

Nineteen individuals expressed an interest in participating. Three individuals were ineligible due to being current trainees or qualified for over five years. It was not possible to arrange a time for a further four individuals to participate resulting in a self-selecting sample of 12 participants. Interviews took place between January and March 2019 and participants

chose their preferred method of participation which included participation in-person (N=3), by telephone (N=6) and video call (N=3).

Three males and nine females took part in this study. Participants were aged 29-46 years (mean=36.4 years), and had qualified between 5 months and 5.5 years prior to participation (mean=2.2 years). Participants discussed having experienced a range of mental health difficulties prior to or during training, as outlined in table 1. Participants first shared their difficulties with tutors and/or supervisors in their first year of training (N=7), second year of training (N=3) and third year of training (N=2) and continued to do so at times during the remainder of their training. Participants qualified from nine course centres (out of 30 UK-based course centres): four course centres were based in southern England, one in the Midlands, and four in northern England.

[Insert Table 1]

Ethics

Ethical approval was granted by Lancaster University Faculty of Health and Medicine Research Ethics Committee in December 2018 (see chapter four for the ethics application and approval information). Subsequent amendments were granted to provide additional procedures for participant consent (January 2019) and to amend the data analysis approach (May 2020).

Procedure

The study advert (appendix 4-B) was circulated in January and February 2019 via Twitter, 'UK based clinical psychology Facebook group' and 'word of mouth'. Those interested in participating were invited to express interest via email whereupon the Participant Information Sheet (appendix 4-C) and Consent Form (appendix 4-D) were provided. Participants were given the opportunity to ask questions and discuss any concerns prior to arranging participation. On the day of the interview participants were given further opportunity to ask

questions and were reassured that they could stop the interview at any time should they need to. Participants completed the consent form or verbal consent process prior to participation.

Interviews employed a narrative approach to support participants to develop their own story and timeline whilst exploring the context of their experiences (Muylaert et al., 2014; Riessman, 2012). Participant interviews began with an initial question to facilitate participants to tell their story: "When did you first realise that you wanted to or needed to talk to your tutors or supervisors about your own mental health difficulties?". The remainder of the interview was unstructured. Contextual prompts were used to encourage further exploration, such as "what happened next?". A list of possible contextual prompt topics (appendix 4-A) was developed based on issues highlighted in the literature and through discussion with a small number of current trainee clinical psychologists who self-identified as having a mental health difficulty.

Interviews were audio recorded and transcribed. Recordings were assigned a participant number and stored securely. Identifying information was redacted during transcription and a pseudonym was assigned. Interviews lasted between 42-79 minutes (mean=58 minutes). Following the interview, participants were provided with debrief information (appendix 4-E) which outlined their right to withdraw and support available. Participants were also invited to provide feedback on the initial analysis once developed; one participant declined.

Data analysis

Reflexive thematic analysis was undertaken to identify themes across participant experiences. Reflexive thematic analysis recognises the context in which participants' experiences arose and utilises my subjectivity as a researcher when interpreting these experiences (Braun et al., 2019). Data analysis was amended from narrative analysis to thematic analysis to allow for the comparison of a variety of participant experiences to identify commonalities and maintain focus on participant experiences rather than exploring

underlying structures of participant narratives to examine how participants made sense of their experiences (McAllum et al., 2019). The change of analysis aligned more closely to my epistemology and to the research question which focused on understanding participant experiences.

Braun and Clarke's (2006; Braun et al., 2019) method of reflexive thematic analysis was followed alongside inductive coding. This approach recognises that I bring my own values and pre-existing knowledge to the research process whilst strongly grounding the initial coding in the data without imposing theoretical thematic frameworks based on previous research (Braun et al., 2019; Braun & Clarke, 2006, 2019a).

Transcription served as the initial stages of data familiarisation. Following transcription, an overall summary of individual participant experiences was developed to support deeper engagement with each transcript. Possible initial codes, overall experiences, and my understanding of these experiences were noted. Subsequently, each transcript was coded by identifying interesting elements of individual experiences and an initial coding list was developed (see appendix 2-B for an excerpt of coded transcript). Codes were re-examined, refined, compared to the original data and grouped to generate initial themes (appendix 2-C illustrates the development themes and sub-themes from the initial coding alongside exemplar quotes). Written descriptions of each theme were produced and reviewed alongside the research supervisor to support theme refinement and development. Exemplar quotes which highlighted the issues discussed were selected during the final stage of theme development. The quantity of participants supporting each theme was not reported as this would imply that the theme is only characteristic of those participants. As an unstructured interviewing approach was used, it is not possible to determine that an absence of discussion of a topic implies an absence of that experience. This reflects the value of qualitative research

in exploring participant experiences rather than identifying frequencies of experiences (Braun & Clarke, 2019b).

Reflexivity and epistemology

Prior to beginning clinical psychology training I worked in disability support assisting university students with mental health difficulties. We often discussed the challenges of deciding to share their mental health difficulties with course staff and I witnessed the importance of these conversations in supporting students to thrive. This has shaped my views around the importance and influence of sharing conversations and underlies my motivation for this topic.

I employed a critical realist stance in the current study. This position recognises the meaning and experiences of participants whilst acknowledging the context in which these experiences arose (Braun & Clarke, 2006; Harper, 2012). I employed several methods to ensure coding remained grounded in the data during analysis. I utilised a reflexive journal prior to and during data collection and analysis to explore my reasons for undertaking the research, record decision-making and reflect on my thoughts and emotional reactions to the data. This supported me to set aside my preconceptions and maintain focus on the data itself (Tufford & Newman, 2012). Theme development was discussed during supervision and participants were given the opportunity to provide feedback on the resonance of the developing themes (Birt et al., 2016; Spencer & Ritchie, 2012). Two participants responded and did not have any specific feedback regarding the developing themes.

Results

Four themes were developed during the analysis. “Weighing up whether to share” outlines factors participants considered when determining whether and with whom to share information about their mental health difficulty. “Creating safety to share and feeling supported” outlines the elements of the supervisory relationship which had facilitated

participants to share and feel supported. “Dilemmas, feeling vulnerable and powerless to challenge perceptions” discusses some of the difficulties which participants encountered when they shared with tutors and supervisors and “experience shaping their practice and identity” illustrates the impact that these conversations had on participants in the short and longer term.

Due to organisational and role differences between clinical psychology programmes the term supervisor refers to placement supervisors and tutor refers to a non-administrative member of the programme team such as clinical, research or personal tutor.

Theme one: Weighing up whether to share

Participants experienced a dilemma weighing up potential benefits and disadvantages of sharing alongside considering who to share with. Participants often discussed needing to share to access support or reasonable adjustments for their course, coursework, or placement. This was weighed against fears that supervisors and tutors may regard them as unfit to practise and ask them to leave the course or suspend training. Participants tried to strike a balance between sharing enough to show that they needed support: “they need to know how much I’m struggling because I need the adaptations” (Susan) without eliciting tutor and supervisor concerns about their abilities: “…I don’t want them to think that I’m struggling so much that I can’t do it and therefore… write me off” (Susan).

Participants tended to be selective about who they shared with based on the working relationship context. For example, some participants felt more comfortable sharing with their allocated tutor due an established working relationship with them over an extended period and it was perceived to be within the tutor’s remit to discuss trainee personal issues. When trainees felt that placement attendance or clinical work may be affected this often determined the need to share with their supervisor. The information shared tended to be limited to the

minimum that they deemed necessary as Mary discussed “I was a bit vague to begin with like I’ve got some health stuff going on…but that was all they needed to know” (Mary).

For participants the potential benefits often outweighed their fears about sharing. Participants discussed numerous fears prior to sharing and whilst participants did not always reflect on the origin of their fears, a number of factors appeared to contribute to the development and exacerbation of their fears. These included societal and professional stigma of mental health difficulties; past experiences which shaped perceptions of tutors and supervisor receptiveness to employee mental health; a lack of visible role models, pathways and narratives about non-traditional training routes; lack of knowledge about reasonable adjustments and fitness to practise processes; and the competitiveness of applying for training.

Some participants reflected that their fears were influenced by the general stigma of mental health difficulties within society and an additional stigma of experiencing mental health difficulties as a psychologist. Participants reflected on feeling a pressure to be seen as ‘perfect’ and be able to manage any difficulties themselves. This message was perceived as coming from people outside of training, because “people see you as a psychologist and see you as someone who can use that skill therefore why can’t you apply that to yourself” (Becky). A similar narrative was experienced within training through the emphasis placed on being strong and resilient and mental health difficulties being framed as historical difficulties which motivated people to become clinical psychologists. These narratives conflicted with struggling or having current mental health difficulties. Discussions about trainees’ own mental health within teaching tended to focus on instances where they had continued to function well with feelings of “stress and things like that but it was all very within this narrow normal spectrum” (Lily). The discussion of only a narrow spectrum of distress tended

to perpetuate the stigma of participants' own mental health difficulties and the perception that certain difficulties were more acceptable.

In addition to stigma, participants discussed that previous job experienced could influence their fears of how tutors and supervisors may react. Participants with previously supportive experiences reported feeling less concerned or fearful: "the fact that I had been able to make these disclosures elsewhere that would have helped me" (Mark). Participants often expected that tutors and supervisors would, and should, be supportive given their role as clinical psychologists. However, participants with past negative experiences of sharing or who had heard about negative experiences from other trainees felt increased stigma and fear.

A lack of information or visible information about navigating disruptions to training also exacerbated participant's fears. This included a lack of information about negotiating reasonable adjustments with programme staff and supervisors and uncertainty about fitness to practise procedures also increased their fears because these processes felt unknown and threatening.

Several participants were concerned that suspending or extending training beyond their contract would have financial implications and could impact on their professional registration. The lack of well-known pathways and normalising examples of trainees taking longer than three years to complete training meant that this option felt unknown and scary. "It was never quite clear what happens…if you're not finished. I mean we kind of knew that a lot of people don't finish on time, but those conversations were never really had explicitly, that became a huge source of anxiety" (Lily).

Finally, participants reflected that the length of time it had taken to develop their career and the competitiveness of gaining a place on training increased their fears. Participants feared that their training place could be taken away, and they would be powerless to prevent

it which would mean changing career having “invested years into this, I can’t start from the beginning again” (Susan).

Theme two: Creating safety to share and feeling supported

Several participants felt the support they received from tutors and supervisors had been instrumental in their completion of training. While this was not the case for all participants, or all supervisory relationships, there were several features of these relationships which helped to create a sense of safety to share and sense of support.

One factor was the reliability of supervision meetings and the continuity of an ongoing working relationship with a specified tutor, such as clinical or personal tutor. This presence of a reliable, safe relationship accessed across multiple meetings had helped to create safety so that they could be “…quite open and honest with her. I think again based on the fact that I already had a relationship with her” (Susan). There were challenges to creating safe ongoing working relationships due to frequent changes in tutors and supervisors, such as when starting new placements. This tended to reignite previous concerns: “[it was] a new relationship and so all of the old worries come back again” (Eve).

Regularly planned supervisor and tutor meetings which protected time to discuss trainee wellbeing and pro-active tutors contacting trainees they hadn’t seen regularly created a space for participants to share and alleviated the pressure on trainees to raise it as an issue. For example, David discussed that he would not have shared if his tutor not asked about his wellbeing during a regularly scheduled meeting. David was “almost waiting for a window to open…to be able to say…I’m struggling a bit”. Lily also appreciated the pro-active approach of her thesis supervisor who would contact her if she “hadn’t been in touch with her for a while…I would get an email just to see how it was, and if everything was alright, like not pressuring me but in quite a nice way”.

In addition to the reliability of contact, another features of the working relationship which helped to create safety was when supervisors and tutors shared their own past mental health difficulties. This normalised having difficulties and offered reassurance that this wasn't a barrier to becoming a psychologist. Eve reflected that hearing her supervisor share about her own difficulties during training had "made it feel a bit more acceptable to actually say that [I am]…struggling".

Some tutors clarified information about fitness to practise processes which reassured participants that they did not meet the criteria for a concern allaying their initial fears. James recalled being told "yes, you have to make sure that you're fit to practise but this [diagnosis] doesn't mean…that you're not". These conversations had clarified fitness to practise concerns, provided reassurance that the presence of a mental health difficulty did not automatically raise concerns about their practice, and in turn supported participants to feel safe to continue to discuss their difficulties with tutors and supervisors.

Participants also reflected on other responses from tutors and supervisors which had helped to create a sense of safety and support. These included responding with compassion, curiosity, respecting privacy, seeking consent to share information, and providing practical problem-solving support. These responses helped participants to feel 'cared for' and supported. Participants appreciated a focus on supporting their wellbeing, identifying reasonable adjustments and reassuring them about the availability of other placement staff to support clients if necessary. For example, Charlotte's supervisor had reassured her that they work within "a wider service, and there are other people around and we will manage this…that was great because you know that you really matter, and we want to get you through this, and we will find a way through this".

Tutors and supervisors noticing changes in the participant's mood and initiating conversation about their wellbeing was seen as helpful. However, this needed to be done with

curiosity and reassurance so as not to frame it as an 'issue'. Eve noted that if her supervisor "had noticed a slight shift [she] would reflect on that in like a gentle way that was not too like confronting and so I think she paved the way for me…rather than me feeling like I'm raising it like totally out of the blue".

While curiosity could be helpful to open up a conversation, it was also important to respect the extent to which participants wanted to discuss their mental health within the supervisory relationship. There was a clear delineation between the helpfulness of compassion and curiosity and the unhelpfulness and intrusiveness of in-depth exploration/assessment and formulation which felt more akin to therapy. When tutors and supervisors made assumptions about the participant's mental health, especially in the absence of a compassionate response, this was experienced as unhelpful or uncaring. This was particularly true for participants whose supervisors or tutors focused on risk of harm to themselves or others in the absence of indications that there was a risk. For example, Sarah had felt that her tutor had focused on following a safety protocol despite there being no evidence of risk. Her tutor had insisted that "you need to go and speak to your GP. And I said, well, I don't think I do. I had sought my own therapy, I don't want medication, erm I'm no, I'm not risky…She said 'I insist'." (Sarah).

Similarly, when supervisors and tutors adopted an assessment and formulation approach it was experienced as intrusive and uncollaborative. James recalled feeling "vulnerable, and it felt like I didn't want to do this, it didn't feel collaborative…It's kind of like therapy, but not therapy you've opted in to". In these instances, participants felt that this approach stepped outside the boundaries of the supervisory relationship. However, they felt unable to refuse to answer questions due to the power imbalance of tutors and supervisors also being their assessors.

Instead, participants found it helpful when tutors and supervisors used practical problem-solving skills to collaboratively identify reasonable adjustments to support trainee progression. Reasonable adjustments included increased frequency of meetings, delaying or extending academic deadlines, transferring to part-time working, and signposting to other sources of support such as therapy. Practical problem-solving support was particularly helpful as several participants reflected that when distressed they did not always know what might support their progress, nor what reasonable adjustments might be possible given their circumstances. Participants had found it helpful for tutor and supervisors to provide guidance because "I didn't know what was possible, I didn't know how flexible the course could be, I didn't know that I could go back part-time…so I needed them to guide me and give me the options" (Susan).

The safety of the working relationship could be challenged when information was shared with others. Whilst there was often a necessity to share information with additional tutors and supervisors verbally or through administrative processes it was experienced as more helpful when the reasons for further sharing were clearly discussed, and it was agreed what information would be communicated and to whom. When this was not the case, participants were left wondering; "did they all know? I assume they did…It's a small world clinical psychology and it was like, well, who knows?" (James). When information was shared without the participants involvement, they felt concerned about the accuracy of communicated information and who had been told.

Theme three: Dilemmas, feeling vulnerable and powerless to challenge perceptions

The responsibilities of tutors and supervisors and the power inherent to these roles influenced participants' experiences of sharing their mental health difficulties. Several participants experienced an increased power imbalance following sharing with their tutor or supervisor. They felt more vulnerable to judgements as they perceived their tutors and

supervisors to have the power to make decisions about their progress on training and about their fitness to practise. This was particularly the case for placement supervisors: “it did shift the power balance and then you worry more about ‘am I being judged? Is she going to fail me?’.” (James).

Whilst participants acknowledged that evaluation of their practice was part of the supervisor’s role, there were concerns that their perception had been skewed, and consequently they were being viewed through the lens of their mental health difficulties. These participants felt that they were viewed more negatively, their work assessed more critically, feedback focused on areas of improvement and neglected areas of success, inaccurate assumptions were made about their mental health and work capabilities, and they were not as trusted as they had been prior to sharing. Participants worried that challenging these perceptions could have consequences for passing the placement: “I said that the feedback wasn’t fair, but…how much do I complain about this because you know she’s going to mark if I pass or fail” (James). Participants also felt that challenging these judgements or declining to answer intrusive questions could be seen as being defensive and consequently confirm the tutor or supervisor’s concerns about their mental health difficulties: “Any problem I had then was just attributed to my perception of what was going on, which is annoying because I felt there was no real way to defend myself from that because if I had been more upset or defensive…the more unreliable I would seem” (Lily).

How tutors and supervisors used the power inherent in their roles was identified as influential on participant experiences in several contrasting narratives. These examples highlighted that the decision-making power inherent in the tutor and supervisor’s role can be shared collaboratively with trainees resulting in more supportive experiences and participants feeling more involved and empowered. However, there can be difficulties collaboratively

agreeing actions if tutors, supervisors and trainees fundamentally disagree about the need for those actions.

Participants discussed having more helpful experiences when they were involved in discussions about reasonable adjustments and programme changes. For example, Susan had felt involved in the decision to change her placement, tutors engaged her in discussions about the work she felt able to do and had discussed the options and benefits of changing placement given her circumstances. This contrasted with Sarah's experience, where she had felt excluded from discussions and as such, changes to the placement to monitor her practice had felt punitive: "My supervisor and my tutor at uni were talking together and they decided I needed to work jointly".

However, collaborative agreement was not always possible especially when participants and their tutors and supervisors fundamentally disagreed. For example, one participant, Hayley, discussed having her placement activity restricted and her fitness to practise questioned upon sharing her past mental health difficulties. Hayley felt these actions were not necessary as she had accessed therapy, had been reviewed by Occupational Health prior to training and had worked successfully in similar environments previously.

Hayley's experience contrasted to that of James who had been given reassurance that the presence of a diagnosis doesn't automatically raise concerns about practise. Tutors reassured James that "you know your warning signs and stuff really well, so you're kind of [a] safe bet in terms of…your suitability for fitness to practise" (James). In this respect tutors and supervisors responded to the presence of a mental health diagnosis very differently indicating differences in interpretations of when to raise fitness to practise concerns.

Theme four: Experience shaping practice and identity

Several participants discussed that their experiences had a lasting effect on their comfort with sharing in future, their own practice as a supervisor, and for some participants also

impacted on their identity.

Participants who felt they had experienced generally supportive responses discussed feeling more comfortable about sharing their difficulties subsequently: “people were very understanding and…[it] paved the way for me to be a bit more open about how I was feeling and what was going on, I didn’t feel that I had to hold back” (Charlotte).

However, participants who felt distrusted and scrutinised became more concerned about subsequent sharing. Hayley discussed that when subsequent sharing was needed she felt “very defensive it’s as if it’s been negatively reinforced”.

Some participants reflected that their experiences of sharing had long-term effects on how they approached their supervision of others. Participants discussed modelling their supervisor practice on supportive experiences they had received or wished they had received. For some participants their experiences guided them to discuss mental health and wellbeing with their supervisees and highlight the messages they wished they had received: “I wish someone had said that to me right at the start, it is okay to make mistakes you’re here to learn…it’s okay to have mental health problems, it’s okay to struggle” (James).

For a small number of participants, the influence of these experiences had also extended to their sense of self and identity. Some participants discussed that it had been “like a fantastic psychological intervention” (Mark) as they had felt accepted and came to accept themselves more. However, one participant who had felt distrusted, unsupported, and felt she was viewed as disabled from the early stages of training subsequently came to view herself as disabled: “it changes how you view yourself and what you can do and…it’s been damaging if I’m honest” (Hayley).

Discussion

This research sought to explore the experiences of UK clinical psychologists when sharing their mental health difficulties with tutors and supervisors during training. The study

highlighted factors which trainees considered prior to sharing, aspects of the supervisory relationship which created safety to share and aspects of their experiences which had been helpful or unhelpful alongside the impact of these experiences.

Participants reported adopting a default position of non-sharing unless the potential benefits outweighed the risks of stigma and discrimination. This is consistent with other studies and review exploring experiences of sharing mental health difficulties and other stigmatised identities at work (Charlemagne-Odle et al., 2014; Chaudoir & Fisher, 2010; Follmer et al., 2020; Hudson et al., 2021; Huet & Holttum, 2016; Stanley et al., 2007; Toth & Dewa, 2014; Turner et al., 2021; Waugh et al., 2017). Participants' fears were consistent with other health care students and professionals when sharing stigmatised identities as they often centred around their professional competence being questioned and being asked to leave the course (Brohan et al., 2012; Charlemagne-Odle et al., 2014; Huet & Holttum, 2016; King et al., 2020; Stanley et al., 2007).

Several factors exacerbated participant fears such as the lack of discussion about trainee mental health and the lack of knowledge and discussion about reasonable adjustments processes, fitness to practise processes and non-traditional routes through training such as extending training beyond three years. This contributed to participants feeling that they did not fit prominent narratives about being a trainee. This is consistent with Turner et al (2021) who also identified that the lack of open conversation about lived experience contributed to a sense that mental health difficulties are unacceptable to discuss.

A number of features of the tutor and supervisor relationship were identified as helping to create safety to share. Reliability of supervision, frequent opportunities to discuss trainee wellbeing and responding calmly with compassion, curiosity are in line with Turner et al's (2021) model of trainee self-disclosure and BPS recommendations for valuing lived experience in clinical psychology training (BPS, 2020).

Participant fears were often reignited when starting new placements as the previously established supervisory relationship was lost. Furthermore, the involvement of tutors and supervisors in their assessment often increased fears of sharing. This finding is novel compared to Turner et al's (2021) model, however it is consistent with barriers to sharing identified by Wilson et al (2016) and BPS (2020).

Tutor and supervisor self-disclosure can normalise supervisee experiences and support supervisees to share (BPS, 2020; Wilson et al., 2016), and was also identified by participants in the current study.

The influence of power in trainee experiences of supportiveness in their working relationship with supervisors and tutors was emphasised by participants. This was highlighted in participant experiences of collaboration and involvement in decision making, difficulties challenging evaluations about their work and difficulties challenging assumptions about their mental health. Tutors and supervisors are encouraged to have an awareness of power dynamics and where possible work collaboratively with supervisees (BPS, 2020; Spence et al., 2014; Wilson et al., 2016), and this study has contributed further examples of how these power dynamics can be experienced within supervisory relationships.

The current study highlights the importance of tutor and supervisor support in challenging stigma and highlights the longer-term impact that supervisor and tutor support can have on identity and qualified practice. Positive influences of sharing in the current study reflect those found by Turner et al (2021). The negative impact of unsupportive experiences is a novel finding although it is consistent with the feedback loop within the Chaudoir and Fisher (2010) model of disclosure of stigmatised identities in which instances of sharing can influence subsequent experiences.

Recommendations for practice

Based on the findings of the current study and previous research in this area, in particular

Turner et al (2021) and BPS (2020), there are a number of practice recommendations for tutors, supervisors and training course centres.

It is recommended that trainees receive reliable and regular opportunities for supervisor and tutor meetings which incorporate time to discuss wellbeing (BPS, 2020; Turner et al., 2021). Reliability and sufficient time for supervision are outlined within supervision guidelines (BPS, 2010, 2014), however, participants' interviews indicated that this was not always the case. The importance of an ongoing trusted relationship was emphasised in the current study. It is acknowledged that it will be necessary for trainees to change supervisors with each new placement, as such, training course centres could consider assigning a university-based tutor which is consistent across placements and year groups. A novel recommendation based on findings from the current research is that supervisor and tutor meetings protect time within meetings to discuss trainee wellbeing alongside caseload/workload management.

Further recommendations based on current and previous research focus on creating an emotionally safe and supportive atmosphere for trainees to share should they choose to. This includes using therapeutic skills such as active listening and empathic and compassionate responding when supporting trainees. In addition, taking time to discuss trainee support needs and collaboratively working with trainees to consider reasonable adjustments.

While considering power dynamics inherent to the supervisor/tutor and trainee working relationship was highlighted by BPS (2020) this research has explored how this power dynamic can be experienced by trainees. As such, further advice is offered to tutors and supervisors to avoid engaging in assessment, formulation and therapy interventions with supervisees and remain focused on providing compassionate responses alongside collaboratively agreed reasonable adjustments to support trainee progress. However, should trainees feel that therapy would be a helpful option then it may be appropriate for supervisors

or tutors to advise trainees on how to access therapy and explore funding options for therapy as a practical problem-solving support.

In line with BPS (2020) recommendations and highlighted by participants in the current study it is important to be transparent about confidentiality of information and where possible collaboratively agree what information will communicated and with whom.

In addition, the current study, BPS (2020) and Wilson et al (2016) recommend that tutors and supervisors may want to consider modelling and sharing their own experience of mental health difficulties if they feel comfortable to do so. This could lead to more open discussions and reassure trainees of the acceptability of their own lived experience and potentially challenge experiences of trainee self-stigma.

Further to the BPS (2020) guidance which suggests reassuring trainees that utilising time out processes can indicate competence in action, the current study recommends that training programmes also provide more visible examples of alternative routes of training such as time-out and part-time options, support available for trainees and examples of reasonable adjustments processes. Several sources of support internal and external to university systems are provided in the BPS (2020) guidance, such as University-based counselling services and the in2gr8mentalhealth forum. This document would be a helpful resource for tutors and supervisors when having discussions with trainees. Visible examples of reasonable adjustments and support available may reduce the fear of the unknown associated with these choices and reduce the stigma of accessing these pathways should they become necessary.

Finally, trainees may be concerned about issues surrounding fitness to practice and as such it may be beneficial to offer trainees reassurance about these fears and where necessary collaboratively discuss options to ensure they are working safely. The fear of being judged as unfit to practise and the lack of clarity participants had about fitness to practise processes

suggests that more may need to be done to improve transparency about fitness standards and the communication of this to trainees.

Training culture considerations and recommendations

This research has highlighted the variation in responses by supervisors and tutors to trainees sharing mental health difficulties. This may reflect a training need for supervisors and tutors on how to support trainees in distress and how to fulfil their obligations under the Equality Act (2010). Heckert's (2022) study supports this as they found that some supervisors feel unprepared and insufficiently supported themselves when managing trainees with mental health difficulties.

This highlights another influential issue that of training course culture and leadership. While it is recommended that there is broader discussion of trainee mental health within training and that tutors and supervisors share their own lived experience of mental health difficulties to reduce the stigma of mental health difficulties, it must be acknowledged that this needs to be done within a culture and leadership approach which values lived experience and supports and encourages tutors and supervisors to share. Recent research suggests that course culture is very influential on tutor and supervisor concerns about negative repercussions of sharing their own lived experience with trainees (Davies et al., 2023). Davies et al (2023) emphasised that supervisors and tutors need explicitly open and supportive course cultures with explicit values-guided leadership to alleviate concerns about the professional consequences of sharing.

Strengths and limitations

The sample for the current study was self-selecting, and as such, findings may not be fully representative of all trainee experiences of sharing with tutors and supervisors. However, findings from the current study are similar to findings from other research in this area which increases confidence in the transferability of the findings. The participant sample includes

perspectives from males and females and across the age range. The average age of participants is slightly higher than the average age of those accepted onto clinical psychology training (Clinical Psychology Clearing House, 2014, 2015, 2016) and those in the Turner et al (2021) sample. However, due to the consistency in findings this lends confidence in the transferability of the findings. Furthermore, the mental health difficulties discussed by participants are similar in ratio to those identified in Grice et al (2018) implying some representativeness of the sample. Information regarding participant ethnicity was not collected at the time of participation and as such this study is unable to reflect on the influence of ethnicity or the transferability of these findings in relation to ethnicity.

This research did not set a definition of mental health difficulties and included both self- and clinician- diagnosed difficulties. This may have resulted in the inclusion of diverse experiences as mental health difficulties was subjectively determined. Similarly, this study did not control for the level of distress participants experienced at the time of sharing which could influence tutor and supervisor's responses. It is interesting to note that participants did not describe different types of helpful responses between those who were distressed at the time of sharing compared to those who were not. This broad inclusion criteria aimed to sample a variety of participant experiences and could also be seen as a strength of the current study as it highlighted helpful responses experienced by participants under different circumstances.

Research implications/future studies

This research explored the experiences of those who had shared their mental health difficulties and who had subsequently qualified as clinical psychologists. While this has illuminated factors which supported and caused difficulties for trainees when sharing, it has only captured the experiences of those who subsequently qualified. The current research did not capture the experiences of those who did not qualify or did not complete training.

Exploring the experiences of these two groups further may highlight additional barriers to sharing and additional impacts of sharing and non-sharing which have not been possible to capture here.

This research highlighted differences in tutor and supervisor responses to trainee mental health difficulties and the impact this had on participants. Exploration of tutor and supervisor responses and the factors which influence how they respond when trainees share mental health difficulties would benefit from further study. Recent doctoral research has identified that tutors and supervisors feel unprepared and unsupported when managing trainee mental health difficulties (Heckert, 2022). However, course culture can influence how tutors and supervisors respond to trainees (Davies et al., 2023). Qualitative exploration of tutor and supervisor's own emotional reactions alongside other factors which influence response when trainees share mental health difficulties would complement the findings of the current study and offer further recommendations for supporting trainees, supervisors, and tutors.

Conclusion

This study has highlighted the motivations and dilemmas that trainees experience when sharing their mental health difficulties with tutors and supervisors. The research has made recommendations for supervisors, tutors and training programmes around how to facilitate safety within the supervisor/trainee relationship to support trainees to share and has emphasised the importance of trainee experiences of sharing conversations on their future practice and identity.

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Tables and Figures

Table 1

Participant difficulties prior to or during training

Difficulties experienced	n
Depression	6
Anxiety	7
Phobias	1
Eating Disorders	2
Bipolar Disorder	1
Post-Traumatic Stress Disorder	1
Multiple difficulties	6
Anxiety and Depression	4

Appendices

Appendix 2-A

Clinical Psychology and Psychotherapy – Author guidelines

Instructions for authors

Sections
1. Submission
2. Manuscript Categories and Requirements
3. Preparing The Submission
4. Editorial Policies and Ethical Considerations
5. Author Licensing
6. Publication Process After Acceptance
7. Post Publication
8. Editorial Office Contact Details

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6. Acknowledgments;
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10. References;
11. Tables (each table complete with title and footnotes);
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Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

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

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Appendix 2-B

Excerpt of coded transcript

TEXT	COMMENTARY
And the support I required, it wasn't particularly high, it wasn't high-intensity kind of support, it was just to have a safe base, basically to just use supervision as (chuckles) supervision should be used for, your not…, to kind of have a space to kind of reflect on one's own stuff, one's own er kind of er experiences that are kind of interacting with the work that we do with people and with interacting with the person and the stuff they are bringing. So yeah it didn't feel like it was, it didn't feel like what I was asking for was, having had the first experience where it just seemed very erm okay, it was just part of the agenda and yer so when it happened with the second supervisor in a way that it did, it just, that was the one kind of experience through training where it hadn't felt… Not necessarily that the disclosure wasn't helpful, just that it wasn't necessarily erm you know always kind of responded to or that the planning around that didn't really, wasn't really followed up and left and contained. Whereas then, in all my other placements, you know that wasn't the experience and whilst er I didn't get to the point that it was never discussed, but I did get to a point where it wasn't put on the table in the kind of psychological contracting of the supervisory relationship.	Not needing additional support but just to have supervision as a safe base, as supervision should be used Qualities of the supervision/supervisor – supervision to reflect on own stuff/ experiences that may be interacting with the work Qualities of the supervision/supervisor – first placement, support needs were fine and agreed and became part of the agenda. Qualities of the supervision/supervisor – one placement where support wasn't always followed up on/followed through. Change over time – did get to the point of not needing to specifically contract for this type of support,

Appendix 2-C

Emergent theme development

Theme	Sub-theme	Initial codes	Exemplar quotes
Weighing up whether to share	Reason for sharing	• Realisation/identification of problem	• "kind of lots of events conspired. I think one of the triggers was kind of failing a research project, erm which was a sore spot for me because I'm a proud geek" (James)
		• Reason – MH impacting on work	• "it was that realisation this is just getting worse and this is going to impact my training and it had been impacting, and it was going to continue to do so" (Mary)
		• Reason – deciding factor	• "I had loads of really weird side-effects for the first couple of weeks of it just really odd stuff, I felt really out of it, and I felt at that point I do need to mention it because I was just quite paranoid people were noticing that I was just being a bit odd" (Lily)
	Being selective	• Deciding what felt necessary to share	• "So before they accepted me onto placement, onto an elective placement, I disclosed at our first meeting, erm because I felt that they had a right to know and it was relevant to the placement" (Hayley)
		• Continuity in support	• "I was a bit scared to go (…) but obviously within the personal tutor remit about progress that I was doing through first year (…) that the conversation came about and I just said you know I feel really like this" (David)
	Fears of sharing	• Fears before discussion	• "I was also scared that they were going to say actually you need to stop training, or you need to take a break, I didn't think they were going to say that I had to leave, I didn't think it would be that bad but like you know it was kind of worrying to me as well" (Imogen)
	Factors influencing the development and exacerbation of fears	• Stigma	• "there's so many layers to it but there's obviously just fundamentally a lot a stigma still in society and then when you're in a professional role that's amplified because there's always then things like whether you're fit to practice and blah blah blah which are important to think about. The theory is always that if you're not perfect and have any problems that you fall into that sort of not fit to practice category or that people might overreact, that was definitely one of my worries" (Eve)

		• Challenges of being a CP when have own personal challenges	• "it's not like that dirty shameful secret which it shouldn't be at all, especially not for a clinical psychologist but it is" (James)
		• Expectations of personal tutors/supervisors because they are CPs	• "there are a few people on that training course who you couldn't sit and talk about your personal feelings with ironically given that they are all psychologists" (Mary)
		• Trainees discuss their experiences with each other	• "I know other people that had mental health difficulties on my course and also had their fitness to practice questioned" (Hayley)
		• Past experiences	• "I'd had a couple of negative experiences with things it had become, I became a lot more hesitant to have some of those conversations" (Lily)
		• Narratives of training	• "I think what would be really interesting would be kind of more visibility of people struggling with their own stuff during training (…)if it's mentioned at all within clinical psychology it's very much a past, resolved issue, it's not something that people are dealing with now" (Lily)
		• Long time to get on to training	• "it was also a fear of what else could I do?, I've invested, you know what it's like getting on to training, I've invested years in to this, I can't start from the beginning again" (Susan)
		• Fitness to practice	• "I remember saying to my wife I can't tell them on the course, they won't say I'm fit to practice" (James)
Creating safety to share and feeling supported	Reliability of supervision	• Value of the support	• "I did find the course really, really helpful and really supportive and I did just get a lot of support with it. I wouldn't have finished the course without the support that they gave me" (Susan)
		• Continuity in support	• "I'd had conversations with her earlier on when everything was happening so erm it still felt like the support, there were people that I was in contact with that knew what was going on that I could talk through things with" (Charlotte)
	Normalising difficulties, therapeutic skills but not therapy	• Qualities of the supervision/supervisor – therapeutic skills	• "I had conversations with, so my personal tutor, clinical tutor was (redacted), lovely woman who I just felt very comfortable and comfortable disclosing to her, she was extremely supportive" (Mark)

		• Qualities of the supervision/supervisor – respectful	• "that was a really positive response because she had the conversation with me in a very respectful way, erm and actually trusted what I said" (Hayley)
		• Reassuring	• "she spent a lot of time thinking with me about what makes a trainee, and you know, the fact that she would erm if she knows a trainee would come to her and talk to her when she was struggling not only is that reassurance to her that they are safe to practice on their own but erm the reflective skills that shows… so we spent a bit of time thinking about that, and that was really helpful" (Sarah)
	Practical problem solving	• Qualities of the supervision/supervisor – Workload management and problem solving	• "because I've made a disclosure to him and we had had a discussion around how we were going to work together to kind of help to mitigate that and have that kind of support" (Mark)
		• Adjustments to training	• "do it one-to-one with a member of staff that I didn't know so I still did the presentation I just didn't have to do in front of everybody" (Susan)
		• Support	• "I was very fortunate to have a great personal tutor at the time and she was very supportive, very empathic, and you would expect that there would be an impression I suppose that all personal tutors on a clinical psychology course would be like that but in hindsight but isn't actually always the case" (Charlotte)
	Sharing information	• Qualities of the supervision/supervisor – sharing information	• "she said I will email your research tutor and tell you can't and she was saying to me you know how much detail do you want me to give people, that was the other thing that was really helpful she was checking in that you know she wasn't saying okay going to talk to all the staff. I knew that it was very clear who she was going to be contacting, what she was going to be telling them" (Mary)
Dilemmas, feeling vulnerable and powerless to challenge perceptions	Power imbalance	• Power imbalance	• "when you're a trainee your supervisor is the one who passes or fails you, it has a… talking to your supervisor has a power dynamic that's really challenging (…) people feel hesitant to talk to their supervisor if they feel that it might have ramifications on passing a placement" (Sarah)
		• Difficulties while pressure of being assessed	• "then when we are being assessed on the course as well all the time that again makes it really difficult because you know that you need to pass the placement, you know that you're being judged on all of these different criteria and ultimately they could, if they felt that something was like serious enough they

			could say actually know this person is not, this person shouldn't be able to pass. So I think that makes it really hard to be honest" (Eve)
	Supervisor and tutor perceptions being skewed by knowledge of trainee mental health difficulties	• Lens of MH	• "you can't take it back later, and I felt it coloured a lot of people's views of me" (Lily)
	Contrasting experiences	• Fitness to practice	• "my supervisor I think panicked a little bit and raised concerns about me working with this population (…) She made assumptions about me not being able to distance myself or compartmentalise or I might…that it might be all about me rather than my clients or patients and that actually she was questioning whether I should be, and this was in my first meeting with her whether I should be even allowed to be on the course and she was concerned about my fitness to practice" (Hayley)
		• Collaboration	• "you have to make sure that you're fit to practice but this [diagnosis] doesn't mean you know that you're not" (James)
			• "I would be in discussion with (clinical tutor) about I hoped that by a certain point on the training, certainly hopefully by the end of training I wouldn't need to put on the table as it were" (Mark)
			• "told that I had to disclose my (mental health condition) to my new placement supervisor the following week" (Hayley)
Experience shaping their practice and identity	Template for the future	• Consequences of supervision	• "I think I felt more, even more open and trusting then in supervision after" (Becky)
		• Template for the future	• "I talk about looking after yourself and I say about my own mental health at the (redacted) training course. I wish someone had said that to me right at the start, it is okay to make mistakes you here to learn and make mistakes, it's okay to have mental health problem, it's okay to struggle" (James)

Chapter 3 Critical Appraisal

Critical Appraisal

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This critical appraisal is divided into two sections. The first section involves a discussion of the findings of the literature review and research study. The second section discusses some of the epistemological and methodological decisions taken during the research project alongside a discussion of some of the challenges encountered during this research.

Thesis summary

This thesis has explored the experiences of supervisors when managing employees with mental health difficulties and the experiences of clinical psychologists when sharing their mental health difficulties with tutors and supervisors during training.

The findings from both papers emphasised the importance of having supportive systems for advice and care for employee wellbeing. The impact of providing such systems of support were also identified. Trainee clinical psychologists in the research paper emphasised the need for caring, compassionate support and practical problem-solving advice from supervisors and tutors when sharing their mental health difficulties. This is similar to the needs of supervisors and employers within the literature review who discussed the need for their own support systems and access to advice when managing employees in distress. In the literature review supervisors in receipt of effective support felt more knowledgeable and confident enabling their support of employees with mental health difficulties. These supervisors also expressed fewer concerns about hiring people with mental health difficulties. In the research paper several trainee clinical psychologists with lived experience of mental health difficulties had discussed that receiving helpful support had been instrumental in their completion of training and had positively influenced their comfort with sharing with future supervisors and had influenced their own future supervisory practice.

Trainee clinical psychologists in the research paper and supervisors in the literature review identified challenges inherent in the supervisor's role which could interfere with the provision of support. For supervisors within the literature review there were organisational pressures on

productivity which were challenging to balance alongside support of employees. This pressure was especially present within organisations which viewed employee support in terms of financial cost. For trainee clinical psychologists within the research paper, it could be challenging to share their mental health difficulties with tutors and supervisors due to the power dynamics inherent in being assessed and their fear of being discriminated against.

Within the literature review supervisors had felt reassured when there were additional support systems in place for employees as this could allow them to focus on their supervisory responsibilities. Furthermore, supervisors felt this was also beneficial for employees as they also had access to support which was not complicated by the power dynamic of supervisors being in a performance management role.

Several trainee clinical psychologists within the research paper discussed that they had accessed their own therapy and benefitted from having this support outside of the supervisory relationship. It is important to note that trainees who had accessed therapy still discussed the benefits of receiving compassionate responses and problem-solving advice from their supervisors or tutors. On reflection, trainees viewed the supervisory relationship as very distinct to a therapy relationship.

Interestingly, several employers in the literature review discussed wanting to “fix” problems that their employees were experiencing while being aware that they were not therapists and weren’t equipped to help in this manner. This reflects the compassion and empathy employers had for their employees as they wanted to help and to improve the situation for their employees. However, they were aware of the limitations of what they were able to do and that employees had additional support needs which were outside the scope of their working relationship and the employers’ skills. This is an interesting view when compared to that of trainee clinical psychologists in the research study. Participants had reflected that they did not want therapy from their supervisors or tutors, even though most of

them were qualified therapists. While enacting therapy may be within the skillset of the supervisor or tutor it is not within the scope of the supervisory relationship as viewed by the trainee clinical psychologist. Those trainee clinical psychologists whose supervisors and tutors had enacted aspects of assessment and formulation akin to therapy had experienced it as unhelpful and not collaborative. The experience had emphasised the power dynamic involved in their relationship, and trainees discussed that it felt difficult to dissent to respond to tutor/supervisor questions. This may also explain why it was experienced as problematic as the supervisor/tutor's actions were experienced as a supervisory boundary violation. It may be helpful for future research to explore tutors and supervisor perspectives and motivations for undertaking assessment and formulation activities with trainees. It is possible that their actions reflect a want to "fix" the situation as expressed by employers in the literature review. However, given that undertaking therapy with supervisees is not advised within policy guidelines this may be difficult to explore directly with tutors or supervisors (British Psychological Society, 2014).

A small number of participants in the research paper reflected that their supervisors and tutors appeared to 'panic' in response to them sharing their mental health difficulties. One participant had wondered whether their supervisor's exposure to client mental health difficulties in their therapy role had heightened their awareness of what could go wrong prompting the supervisor to respond with high levels of caution to protect the public. Responding with caution to protect the public may be understandable within the responsibilities of practitioners to prioritise patient safety and wellbeing (British Psychological Society, 2014). However, supervisors and tutors also have responsibilities to assess trainees and ensure trainees are given equal opportunity to access training through the provision of a non-discriminatory environment and the provision of reasonable adjustments in accordance with the Equality Act (2010). This area would benefit from further exploration

to understand how supervisors and tutors manage these responsibilities. It would also be worthwhile to explore supervisor and tutor experiences of trainees sharing their mental health difficulties, explore tutor and supervisor responses to trainee distress and mental health difficulties, their understanding of their role in these situations, the principles they use to guide their decisions and how they formulate concerns about fitness to practice. Initial exploration into this area in a recent thesis research project has identified that supervisors felt unsure how to respond to trainee distress, unprepared to respond to trainee distress following supervisor training, felt they shouldn't ask some questions due to the power dynamic in the relationship owing to being the trainee's assessor and felt unsupported themselves when trying to manage trainees (Heckert, 2022). This is similar the experiences of employers in the literature review of this thesis insofar as they felt unsure and unprepared to respond to employee mental health difficulties and emphasised the need for their own support when managing such situations.

The findings from both studies emphasised the influence that previous experience had in guiding future behaviour and expectations of others. For example, in the literature review employers used their previous experience of supporting employees with mental health difficulties to guide how they responded to future employees and to applicants when considering hiring people with mental health difficulties. Similarly, in the research study, several trainee clinical psychologists discussed that their experiences of supervision had shaped by their own future practice and expectations of other supervisors. The longer-term impact of these experiences within both studies emphasises the importance of employers and companies recognising the support needs of their all of their staff in order to create an environment which promotes supportive experiences.

Further implications of the findings

The studies included in the literature review explored the experiences of employers from a

limited number of countries. The conclusions of the review may be culturally bound to the countries of the included studies, as such, it would be beneficial for future research to explore experiences across additional countries. Furthermore, the literature review did not explore the influence of the political climate, legislation or cultural norms of these countries on employer experiences as these factors were often not discussed explicitly within the papers in relation to employer experiences. It would be beneficial for future research to explore the influence that these factors have on employer experiences.

Based on the findings of the literature review there are a number of practical recommendations for organisations. This includes: providing support systems for supervisors to access advice about employee mental health difficulties and reasonable adjustments, ensuring employees have access to additional support outside of the supervisory relationship, providing supervisors with compassion training or support to manage empathy distress, providing clear guidelines and policies on support available for employees with mental health difficulties, providing supervisors with clear expectations of their role in supporting employees and explaining the organisational benefits of supporting employees.

Similarly, there are a number of practical recommendations for training programmes, supervisors and tutors based on the findings of the research paper. It would be beneficial for training programmes to provide supervisors and tutors with training on how to support trainees in distress and trainees with mental health difficulties. Training should also include a discussion of the recommendations made here regarding practices which trainees found supportive e.g. protecting time in meetings to discuss trainee wellbeing, compassionate responses combined with practical problems solving etc. Training programmes should also direct tutors and supervisors to additional sources of support if they need further advice. Recommendations made in this research could also be combined with those from previous

research to create written guidance for tutors and supervisors on supportive practices when supervising trainees in distress.

Epistemological and methodological decisions

Subjectivity in qualitative research

I am aware that the focus of the two papers within this thesis and the results which have been developed have been influenced by my own views and values in relation to disability and student support. My interest in pursuing the topic area of trainee experiences of sharing their mental health difficulties was motivated by witnessing the experiences of friends and of students I had worked with as a specialist learning mentor when they had shared information about their disability and support needs with their tutors at university. Students often discussed their fears of discrimination and stigma, and I witnessed the influence that these conversations had on students. This led me to choose to research in this area and to focus on trainee clinical psychologist's experiences given that their role as a mental health professional may add an additional layer of stigma to sharing mental health difficulties with tutors and supervisors.

At the beginning of my doctoral training, I was a relative novice at undertaking qualitative research as I had predominantly undertaken quantitative research during my undergraduate and postgraduate studies. This led to a lot of anxiety and discomfort around considering my subjectivity in the process of undertaking interviews and especially during analysis. I had previously undertaken quantitative research, often with an implied acceptance of positivism, as such, it was uncomfortable to accept that I had influence over the findings of my research.

However, within qualitative research, and within quantitative enquiry when it is examined critically, there are choices which influence the focus of the research and influence interpretations during the analysis. This influence is more explicitly discussed in qualitative research as it acknowledges the influence of the researcher at all stages of the research and

especially during the development of the analysis where participant data is interpreted through the values and views of the researcher (Peshkin, 2000; Ratner, 2002). For example, coding was grounded in the transcript data but also in what I personally found interesting about the data.

During my third year of training, I encountered several challenges in my own personal life which collided with difficulties on placement and with academic work which created a 'perfect storm' for difficulties with my own mental health. This further added to my anxiety about my subjectivity in relation to analysing interviews as I felt that some of the experiences of participants were reflected in my own experiences. I felt that it was prudent to take a step back from analysing my research at that time so that I could focus on my own mental health needs, and implementing a better work-life balance while I completed other aspects of training. My internal struggles with my subjectivity are similar to discussions about the subjectivity of lived experience researchers and their identification with experiences of participants (Roennfeldt & Byrne, 2020; Tufford & Newman, 2012). Researcher's lived experiences can support novel insights not previously identified in research, however it can be emotionally challenging (Tufford & Newman, 2012) and criticisms have been raised about researcher objectivity (Roennfeldt & Byrne, 2020). In the context of qualitative research however, it is acknowledged that research is always influenced by researcher subjectivity (Peshkin, 2000; Ratner, 2002). As a result, there are processes which can support researchers to manage and bring to conscious awareness their biases, assumptions and values such as field notes (Cruz, 2015), memos (Roennfeldt & Byrne, 2020; Tufford & Newman, 2012) and reflective journalling (Tufford & Newman, 2012).

When I did return to analysing my research, I was mindful that my own experiences might influence my analysis. As such, I utilised reflective journalling to consciously consider my own experiences alongside my thoughts and values in relation to participant experiences.

This reflective process supported me to maintain my focus on participant experiences during coding and theme development. While my own values and subjectivity will have guided my interest in certain aspects of participant experiences, the process of reflective journalling helped me to ensure that the development of codes and themes were firmly evidenced in participant data.

I am aware that some of the reflections that I recorded in my journal subsequently informed the analysis and written paper. For example, while analysing a participant transcript I reflected that it was interesting to note the times when the participant had chosen not to share their difficulties with tutors and supervisors due to the characteristics of safety in the relationship had been absent. This in turn led me to reflect on my project design as I had only sought to speak to individuals who had shared with tutors and supervisors and who had subsequently qualified. What about the people who did not qualify? Did not qualify and did not share with tutors and supervisors? Had they experienced other barriers or had less supportive experiences? This subsequently informed the limitations section of my research paper.

I also used supervision to discuss the process of coding, theme development, the evidence for the themes and at times discussing my self-doubts about the process to support my skill development as a researcher (Braun & Clarke, 2019).

Decisions about language

I am aware that my values have guided several choices I have made within the research project. For example, my beliefs that mental health difficulties should be destigmatised and discussed with more compassion and understanding in the general population has led me to utilise the language of sharing mental health difficulties throughout this thesis rather than using the terms such as disclosure. Language can influence our perceptions of events and the term disclosure tends to instil negative connotations implying that information was

previously being kept secret from the recipient (BBC, 2014; British Psychological Society, 2020).

In addition, I did not require participants to have received a diagnosis of their mental health difficulties. I instructed participants that they could self-identify or have received a clinical diagnosis. This decision reflected that individual's may not have sought a diagnosis or may have sought non-diagnostically driven support such as therapy and therefore had not received a diagnosis.

Decisions about participant contextual information

Within my research paper I have utilised grouped data rather than individual participant contextual information to protect the anonymity of participants. There were concerns at the outset of this project that the inclusion of multiple pieces of information about participants could render them identifiable to others when the demographic information provided does not often co-occur. For example, according to the UK Clinical Psychology Clearing House equality data in the years 2014-2016 just over 500 people entered clinical psychology training, of which, less than 3% of successful applicants were aged 40 years or over (Clinical Psychology Clearing House, 2014, 2015, 2016). This information alone when combined with knowledge of a person's mental health difficulty could render them recognisable to others.

The amount of information provided about participants was a concern at all stages of this research and guided the restrictions and redactions outlined in my ethics application, guided my presentation of aggregated participant information rather than individualised contextual information and was a consideration in the selection of participant quotes when evidencing themes. While there are other approaches to protecting anonymity in qualitative research, such as obtaining more nuanced informed consent based on the audience as discussed by Kaiser (2009) it must be acknowledged that it is the colleagues and peers of participants who are the audience of this research paper and therefore it is possible that even minimal

infrequently occurring personal information could render participants identifiable, as such, this has limited the availability of individualised contextual information.

Decisions about epistemology and analysis

As discussed in my research paper, I amended my data analysis method from narrative analysis to thematic analysis following data collection but prior to analysing my data. My initial research supervisor retired part-way through my project as such I changed supervisor. This prompted a discussion about the project generally and about my epistemological stance. As a result of this discussion, we agreed to change the analysis method to thematic analysis as this was more aligned to my interests of exploring experiences across a variety of participants and identifying commonalities across participant experiences. I had previously conceptualised using thematic narrative analysis which would have focused on exploring how participants had constructed their individual stories (McAllum et al., 2019). Changing approach was more aligned to a critical realist epistemology and was more aligned to my interest of understanding participant experiences, the context of these experiences and the causal influences on these experiences while acknowledging that resulting theories of causal mechanisms are approximations of reality which are continually refined (Fletcher, 2017; Harper, 2012). This stance also acknowledges the involvement of our interpretation in developing our understanding (Fletcher, 2017).

Data saturation debate

Saturation has been discussed as a gold standard within qualitative research as an indication that no further data collection is necessary because data collection and analysis have reached a point where no new codes and themes have become evident in the data. Saturation is often referenced when making decisions about sample size and evaluations of research quality, however it's use is problematic (Braun & Clarke, 2021; Low, 2019; Saunders et al., 2018). The number of novel codes and themes can be influenced by how

homogenous the sample is and decisions about sample size are often pragmatic and dependent on the resources available for a research project (Braun & Clarke, 2021). From a theoretical perspective there are a number of problematic applications and definitions of saturation not least that it is possible to reach a point of data saturation as if it is an event that can be completed (Saunders et al., 2018).

Within my research paper I have chosen to describe my process of data analysis without discussing saturation. I also recognise that, in accordance with Braun and Clarke (2021), I made a pragmatic decision to move away from further coding and further theme development as I had reached a sufficient understanding. From an epistemological view point, further analysis can always be undertaken and new insights into causal mechanisms can be made from existing datasets when the researcher considers other influencing factors on participant experiences and when researchers hold different interpretations and theories in mind during analysis (Braun & Clarke, 2021; Low, 2019; Saunders et al., 2018).

Similarly, insights into novel causal mechanisms can be made following the addition of participants whose experiences differ to those previously interviewed. For example, when comparing my analysis to that of Turner et al (2021) I was aware that there was overlap in several areas. However, several participants in my research study had discussed experiences and underlying processes which were dissimilar to those reported by Turner et al (2021). For example, several participants I interviewed appeared to have more challenging experiences than those discussed in Turner et al (2021). This highlights the richness of qualitative research in being able to explore participant experiences. It also highlights a challenge to the concept of data saturation since two similar research projects can develop divergent themes due to different participant experiences and different researcher perspectives about the underlying processes. It is always possible that there will be additional potential participants with experiences different to those previously interviewed, and researcher perspectives may

develop new insights by re-examining data; as such, saturation can never be achieved if it is conceptualised as a point to be reached (Saunders et al., 2018). Instead, researchers may consider the concept of sufficiency wherein the researcher feels they have developed sufficient depth of understanding to allow them to discontinue sampling (Saunders et al., 2018).

C**onclusion**

The findings of both papers in this thesis emphasise the importance of experience guiding behaviour and of the need for effective support to be in place for both supervisors of employees with mental health difficulties and for employees themselves. A number of factors which influenced supervisor provision of support were discussed in the literature review. In addition, several factors which influenced trainee clinical psychologists' experiences of sharing their mental health difficulties with supervisors and tutors during training were identified. The project findings were discussed alongside a discussion of some of the epistemological and methodological decisions taken during this project. In addition, there were reflections on some of the challenges I encountered and the opportunities this presented for my development as a qualitative researcher.

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Chapter 4 Ethics Application

Ethics Application for Research Paper: Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Highlighted blue = relate to amendments requested January 2019
Highlighted yellow = relate to amendments requested May 2021

Title of Project: Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

Name of applicant/researcher: Serena Hannah

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:
E-mail: s.hannah@lancaster.ac.uk **Telephone**: 07780580396 (please give a number on which you can be contacted at short notice)

Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Ian Smith – Research Director, Division of Clinical Psychology, Lancaster University
Dr Anna Daiches – Clinical Director, Division of Clinical Psychology, Lancaster University
~~Dr Pete Greasley – Teaching Fellow, Division of Clinical Psychology, Lancaster University~~

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Ian Smith, Dr Anna Daiches, ~~Dr Pete Greasley~~

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Ian Smith – Research Director, Division of Clinical Psychology, Lancaster University
Dr Anna Daiches – Clinical Director, Division of Clinical Psychology, Lancaster University
~~Dr Pete Greasley – Teaching Fellow, Division of Clinical Psychology, Lancaster University~~

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk
3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o
4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

6a. Is the secondary data you will be using in the public domain? n o
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

A recent UK study found that 29% of clinical psychology trainees were experiencing mental health difficulties at the time of survey. Trainees are expected to remain self-aware to issues which may affect their practice and take appropriate action if issues arise, such as discuss issues with supervisors. However, stigma and previous negative experiences can reduce the likelihood of sharing difficulties meaning staff are less likely to access support and can potentially lead to poor practice. Non-sharing reduces the ability of supervisors to monitor practice and provide reasonable adjustments as such it is important to support staff to share mental health difficulties. However, little is known about trainees' experiences of sharing their mental health difficulties with supervisors and the experience of sharing over time. Qualitative interviews will be undertaken using a narrative approach to support participants to discuss their experiences while recognising the social context in which these experiences developed.

2. **Anticipated project dates (month and year only**)

Start date: 12/2018 End date: ~~08/2019~~ 09/2021

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

This study will seek to recruit 8-12 participants. Participants will be individuals who have completed the Doctorate in Clinical Psychology in the United Kingdom within the last five years. The time frame of five years has been selected to increase the likelihood that participants will be able to recall their experiences in sufficient detail to allow them to discuss it during the interview. Recruiting individuals who have completed their Doctorate will enable participants to reflect across their whole training experience. Trainees with experience of mental health difficulties are considered to have a protected characteristic under the Equality Act (2010).

Participants need to self-identify as having had a mental health difficulty during training or have a diagnosed mental health difficulty prior to or during training. This can be a pre-existing mental health difficulty which trainees continued to experience during training or a mental health difficulty which re-emerged during the training period.

There are no specific requirements around age range or gender within this study.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited via word-of-mouth, Facebook and Twitter. Advertising information (appendix 4-B) will be circulated on twitter and via UK based clinical psychology relevant Facebook groups. Information will also be circulated to colleagues who will be asked to circulate the information to clinical psychologists who may be interested in participating. If insufficient clinical psychologists are recruited for this study I will re-circulate advertising posts to Facebook and Twitter using the same strategy. Advertising via word-of-mouth will involve discussing this research with others such as trainee clinical psychologists and friends and encouraging them to circulate the advertising information (Appendix 4-B) to others who may be interested in participating.

The advertising information (appendix 4-B) will request that potential participants contact the lead researcher via email if they are interested in taking part. The lead researcher's (Serena Hannah) university email address will be provided to participants on the advert. Upon initial contact from potential participants I will send them the participant information sheet (appendix 4-C) and consent form (appendix 4-D) and ask that they read these and give individuals the opportunity to ask questions. If individuals are interested in participating in the research, we will agree a mutually convenient day/time and method of participation (i.e. telephone, skype, face-to-face meeting).

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection will be via individual participant interviews. Interviews will either be conducted as face-to-face interviews or via telephone or skype. Telephone and skype are available to support individuals living at a distance to participate.

As little is known about the experiences of sharing mental health difficulties with tutors and/or supervisors during clinical psychology training it will be more appropriate to explore these experiences qualitatively to gain an in-depth understanding of these experiences. Individual interviews are preferred over focus groups in this instance to allow a fuller exploration of participant experiences. Furthermore, individuals may have had very different experiences across their course and as such may be difficult to establish a coherent narrative within a focus group setting.

Data collection will be via individual interviews which will be audio recorded using a dictaphone. A narrative approach will be used during the interviews to allow participants develop their own story and focus on what they feel is important to their narrative with minimal researcher prompting (Riessman, 2012). Occasional prompts will be used to encourage further exploration. This may incorporate general prompts such as "what happened then?" alongside more individual prompts developed in response to participants narratives and where these are of interest to the research (Muylaert et al., 2014).

The interviews will be transcribed (and anonymised) and analysed using a thematic analysis. Thematic analysis aims to identify themes across participant experiences while recognising the context in which their experiences arose (Braun & Clarke, 2006). Data analysis will follow the process outlined by (Braun & Clarke, 2006). Interviews will first be transcribed and coded systematically to explore features of the data. Following coding of each transcript, codes will be re-examined and brought together to identify potential themes. These themes will be defined and then re-examined alongside the original data to explore the suitability of these themes. Themes and their development will be discussed with the project supervisor in order to ensure that the themes remain grounded in the data. In addition, a brief written overview of each participant's experiences will be developed and offered to the participant to review, provided the participant has agreed to this. This will allow participants to check and provide feedback on their accuracy.

~~narrative analysis. Narrative analysis aims to maintain the integrity of the individual story during analysis in order to explore experiences over time while taking account of the social context in which the participants narrative has developed (Muylaert et al., 2014; Riessman, 2008). It will be important to maintain the integrity of individual's~~

~~experiences of sharing over time rather than break these down into separable instances since experiences of sharing may be influenced by previous experiences of sharing and in turn may influence subsequent experiences. A brief overview of the narrative of each interview will be constructed which will be offered to the participant to review, provided participants have agreed to this. This will allow participants to check and provide feedback on the accuracy of the initial narrative. Each interview will be analysed to identify themes within and between narratives, without deconstructing the overall individual narrative. These themes will be further developed and examined alongside an understanding of individual experiences within the whole narrative of each interview in order to draw explanatory understanding of these experiences in the context of their social context (Squire, 2008). The developing themes will also be explored and examined by the research supervisors of this project to check the evolving interpretations and ensure that the narrative remains grounded in the data (Squire, 2008).~~

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

I will transcribe the audio files of the participant interviews and these transcriptions will be stored on the Lancaster University server in a separate folder to the audio files. The interview audio files will be deleted by the lead researcher following successful examination of the thesis. The interview recordings will be retained alongside the transcripts throughout the project so that the recordings are available to support data analysis if needed. Access to the area where the transcripts are stored will be limited to myself. The audio and transcript files will be stored using anonymised file names, such as participant numbers. The transcripts may be shared with the project supervisors to discuss content and to support analysis.

Participant consent forms will be scanned and stored securely along with the audio consent files on the Lancaster University server for the duration of the study. Once scanned the paper copies of the consent forms will be disposed of using the confidential waste process within the Division of Clinical Psychology. On completion of the study the scanned consent forms will be encrypted and consent audio files will be encrypted in a password protected zip folder and transferred securely along with the encrypted interview transcripts to the Division of Clinical Psychology Research Coordinator and kept for 10 years. The Research Coordinator/Administrator in the Division of Clinical Psychology will be responsible for deleting the transcripts and consent audio recordings at the end of the storage period.

Participant email addresses will be stored on the lead researcher's Lancaster University email account for the duration of the study.

7. **Will audio or video recording take place?** ☐ **no** ☒ **audio** ☐ **video**

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

The dictaphone is not an encrypted device, as such the audio recordings will be transferred and stored on Lancaster University servers as soon as possible following recording. If it is not possible to connect to the university server immediately following the interview, then the audio file will initially be temporarily transferred to an encrypted memory stick and then transferred to the university server once it is possible to connect. Once saved to the server or memory stick the audio recording will be deleted from the dictaphone. Recordings will be stored on the server in a separate folder to transcripts and access will be restricted to myself. The audio interview files will be deleted by myself following examination of the thesis.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The audio files will be saved securely to the Lancaster University server and I will have sole access to the data. Audio recordings of the interviews will be deleted following successful examination of the thesis. Audio consent recordings will be retained and securely transferred to the Research Coordinator/Administrator in the Division of Clinical Psychology who will be responsible for their deletion at the end of the storage period.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?
Data will be held, managed and preserved on Lancaster University's PURE data repository for 10 years.

8b. Are there any restrictions on sharing your data?
Data access from PURE will only be granted on a case by case basis upon request by genuine researchers. Transcript data may be restricted due to the combination of the small sample size and the presence of sensitive information which may mean that participants are identifiable even following careful anonymisation.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?
Participants will be provided with full information about the study by email prior to confirming their intent to participate. Full information about the study will include the participant information sheet and consent form to allow participants to consider participation. This information will be provided to potential participants upon initial contact. Potential participants will also be given the opportunity to ask questions about the study when they initially make contact and following provision of the participant information sheet and consent form. If individuals are willing to participate then a convenient time and method of participation will be agreed.

For face-to-face interviews – on the day of the interview participants will be given further opportunity to ask questions about the study before being asked to sign the consent form. Only if the participant has signed the consent form will the research proceed.
Telephone and skype interviews – participants will be given the participant information sheet and consent form prior to arranging a time for interview. They will also be given the opportunity to ask questions by email or by phone prior to the study. Participants will be given the option to undertake a verbal consent process at the start of the interview or they can sign and return the consent form by email. For the verbal consent process ~~Consent will be discussed at the beginning of the phone call or skype call and~~ I will inform the participant that I will audio record the consent process. I will read the consent form to the participant and ask that they can give a verbal response to each item. Participants will again be given the opportunity to ask questions. The audio recording will be saved as a separate audio file to the main interview and the consent audio recording will be stored and transferred securely to the Research Coordinator/Administrator in the Division of Clinical Psychology at the end of the study for storage. Alternatively, participants can either insert their signature into the document or print, sign, scan and return their consent form by email. Where participants have completed the consent form and returned it in advance, I will check at the time of the interview that they are willing to participate and were happy to consent to the items on the consent form.

Where telephone contact is made with participants this will either be through the use of a university owned landline or using a university owned mobile phone specifically for the study. If participants would prefer to use skype to participate then I will use a skype account created specifically for this research (not my personal skype address). It is important to note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication. This is communicated to participants in the participant information sheet.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.
It is anticipated that the research will take approximately 1 hour of the participant's time. While the study is not aimed at specifically discussing the participant's mental health difficulties or their experiences which may have led to the development of these difficulties, there is a possibility that discussing their experience of sharing their mental health difficulties during training may be upsetting or distressing. Participants will be given information

regarding the focus of the interview when the study is advertised and prior to the interview to enable them to give informed consent regarding whether they want to participate.

If participants appear distressed during the interview I will check whether they want to pause or stop the interview. I will ensure participants are aware that they can pause or end the interview at any time; this will be communicated on the information sheet and reiterated at the beginning of the interview. Furthermore, participants will be given contact information for sources of support in the information sheet and debrief information should they need further support.

Participants may withdraw at any time prior to or during participation and may withdraw their data from the study up to two weeks following the research interview. Participants will be notified on this on the debrief information sheet.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There may be some potential risks involved depending on the method of participation. For participants who take part via telephone or skype it is not anticipated that there will be any particular risk of harm to the researcher. Where participants take part in face-to-face interviews considerations will be made regarding lone working and worker safety. For face-to-face interviews it is hoped that interviews will take place at Lancaster University. However, it may be necessary to offer participants alternative venues to enable participation, such as the participant's home. Where interviews are conducted face to face I will provide a designated colleague with information of where the research is being conducted and expected start/end times. This information will be given to the designated colleague in a sealed envelope and will be returned to me afterwards to be destroyed. This will be done via the confidential waste process within the Division of Clinical Psychology. I will notify this designated colleague of the anticipated end time of the research and I will notify them when leaving the venue. I will ensure that my mobile phone is charged to enable this to happen, and where there is no mobile signal I will call as soon as is possible. I will discuss with the designated colleague what to do if they do not hear from me at the expected time. If the colleague does not hear from me at the expected time they will be directed to contact me on my mobile. If they are not able to reach me on my mobile they will be asked to open the envelope and if possible contact the participant and contact the appropriate authorities (i.e. the police) providing the details of where the interview was due to take place and who I was meeting.

There is not anticipated to be a need or psychological support as a result of carrying out this research, however if this becomes necessary I am aware of a number of support routes; for example, Lancaster University counselling and mental health service, my GP and advice/support from my supervisors.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may not be a direct benefit to participants of this research. However, there are potentially indirect benefits to participating, such as giving participants the opportunity to feel heard and provide their own perspective on their experience of training. Findings from this research may be published and circulated to course centres which may in turn support course centres to understand the experiences and needs of trainees with mental health difficulties which may be of benefit to future trainees.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Not applicable

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

I will carry out the transcription of the audio files. Audio files and transcripts will be saved with a participant number and saved in a separate file to the consent forms/audio files. Identifying information about the

participant, such as their name, place of training and specific identifying information about their role or experience will not be included in reports of research. Pseudonyms or participant numbers will be used in reports of this research. An encrypted document saved on the Lancaster University Server will store participant full name and email address alongside their research pseudonym to support the provision of the individual narrative to the participants for checking. The narratives will be saved using pseudonym information; this document will allow the matching of information to provide the individual narrative to the participant. This document will be deleted once this process is complete. Participant contact details will remain on my Lancaster email account for the duration of the study.

Participant contact will be through my Lancaster email address, mobile phone provided by the course for the purposes of this research (not my personal mobile number) and skype account set up specifically for this research.

Participants are notified prior to participating that if I have concerns about harm to themselves or harm to others then I will need to seek advice from the research supervisor. Where possible, concerns will be fed back to the participant and a discussion regarding appropriate support will take place. Participants will be reassured that they can stop the interview at any time and if a participant does become distressed during the interview we will stop the interview and discuss how they would like to proceed.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

I have engaged with a small group of current trainees who self-identify as having a mental health difficulty in the development of key topics of interest, prompts and questions for this study.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The findings of this research will be incorporated in to an academic thesis submission as part of the lead researchers Doctorate in Clinical Psychology. The lead researcher will also present the findings to a group of stakeholders and trainee clinical psychologist as part of the Lancaster Clinical Psychology programme presentation event. Results of the research may also be submitted for publication in an academic/professional journal.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

I will need to be mindful that information is anonymised and redacted carefully such that participants or course centres are not identifiable from the information, or from discussion of the participant's experiences. The intention of this study is to explore the experiences of participant's more generally and not to generate specific feedback on course centres.

As discussed, it will also be important to ensure that participants remain anonymous and are not identifiable from any reports of this study.

SECTION FOUR: signature

Applicant electronic signature: Serena Hannah Date 10/5/2021 ~~16/10/18~~

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Ian Smith, ~~Dr Pete Greasley~~ Date application discussed 10/5/2021 ~~16/10/18~~

Submission Guidance

1. **Submit your FHMREC application by email to Diane Hopkins (**d.hopkins@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.
2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to **Diane Hopkins by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
        a. existing documents/data only;
        b. the evaluation of an existing project with no direct contact with human participants;
        c. service evaluations.
3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Research protocol

Research title:

Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

Name of applicant:

Serena Hannah, Trainee Clinical Psychologist, Division of Clinical Psychology, Lancaster University

Supervisors:

Dr Ian Smith, (Research Supervisor), Research Director, Division of Clinical Psychology, Lancaster University

Dr Anna Daiches (Field Supervisor), Clinical Director, Division of Clinical Psychology, Lancaster University

~~Dr Pete Greasley (Research Supervisor), Teaching Fellow, Division of Clinical Psychology, Lancaster University~~

Introduction

According to the Clinical Psychology Clearing house in 2016, 1% of applicants declared a mental health difficulty on application, and similarly 1% of those accepted on to clinical psychology training had declared a mental health difficulty (Clinical Psychology Clearing House, 2016). However, a recent study into the incidence of mental health difficulties amongst clinical psychology trainees in the UK found that 67% of trainees had experience of mental health difficulties and 29% of trainees were experiencing a mental health difficulty at the time of survey (Grice et al., 2018). While the sample obtained in the study represents just under 30% of the trainee population this is still a markedly higher percentage of trainees with mental health difficulties than had identified this on their application form.

In order to safeguard clients from instances where a clinician's mental or physical health difficulties impact on their ability to practice there is a professional expectation that clinical psychologists remain self-aware to identify if they are not fit to practice and take action to resolve this (HCPC, 2016a, 2016b). The requirement of supervision is a further safeguard to ensure that therapists are working appropriately with clients, working within their competence and ensuring that therapists are fit to practice (Spence et al., 2014; Wilson et al., 2016). However, in order to monitor this, supervisors are reliant on supervisees sharing information about their client work and their fitness to practice. Similarly course centres will be unable to provide reasonable adjustments in line with the (Equality Act, 2010) and provide support to trainees while on the course unless trainees share these difficulties at the time.

However, research exploring students considering sharing information about their mental health difficulties with course providers has identified stigma and previous negative experiences as being influential when considering sharing mental health difficulties on application or while on course (Williams et al., 2015). Research exploring anticipating sharing mental health difficulties identified stigma and recipient type (friend, family, supervisor) as being influential such that trainees anticipated that they were less likely to share mental health difficulties with supervisors unless there was a need for implementation of practical support and this could override concerns around stigma of mental health (Grice et al., 2018). However, this research focused on anticipated sharing based on vignette examples and did not explore lived experience directly. Very little research has explored the experience of sharing and discussing trainees' own mental health difficulties.

There has been some research exploring instances of non-sharing in supervision by trainee mental health professionals. However, this research tends to conflate sharing of personal difficulties, such as mental health difficulties, with other types of sharing such as sharing formulations and intervention plans with supervisors, discussing difficulties within

the supervisor-trainee relationship, concerns about being evaluated by their supervisor and positive or negative feelings towards their supervisor (Mehr et al., 2010; Yourman, 2003). This conflation of mental health difficulties with sharing of other types of information makes it difficult to draw conclusions regarding the experience of non-sharing of mental health difficulties in supervision. These instances of non-sharing are often discussed as being similar, however it must be acknowledged that seeking to share mental health difficulties may carry different levels of stigma and associated shame than other types of sharing, such as of formulation plans.

Relatively little focus has been given to the processes and experiences of sharing mental health difficulties. From the small number of studies which have explored the factors which influenced the sharing of mental health difficulties within qualified clinical psychologists several factors influenced who they shared this information with and how they chose to share it; factors included fear of negative judgements or consequences, self-stigma, past experience of negative consequences or discrimination following sharing, the quality of the supervisor relationship and personal characteristics of the recipient (Charlemagne-Odle et al., 2014; Spence et al., 2014).

Charlemagne-Odle et al (2014) explored the experiences of qualified clinical psychologists sharing significant distress in supervision and found that these experiences varied from being unhelpful and judgemental wherein supervisors and colleagues raised concerns regarding fitness to practice, to supportive responses whereby supervisors or colleagues offered emotional or practical support and adjustments to work (Charlemagne-Odle et al., 2014). These experiences are consistent with research exploring experiences of sharing a disability with employers (Schrader et al., 2014).

However, it must be acknowledged that additional challenges may be present for therapists during training as supervisors are also involved in their evaluation and assessment,

adding a further barrier to sharing difficult topics (Wilson et al., 2016) and as such may affect decision making when deciding to share mental health difficulties. Furthermore, during training there are often frequent changes in placement and, as such, changes in supervisors. This can present difficulties in building an ongoing supportive supervisory relationship and set an expectation of sharing difficulties such as mental health difficulties to multiple placement supervisors and university tutors, across the duration of the course. As such this study aims to explore the experiences of sharing and discussing their own mental health difficulties with supervisors during training.

Clinical Implications

Sharing mental health difficulties with supervisors is important to enable employers to implement reasonable adjustments as part of the (Equality Act, 2010) and to ensure safe practice of supervisees. There are several barriers to sharing mental health difficulties, however the experiences of sharing these difficulties has rarely been explored.

Exploring the experience of trainees sharing their mental health difficulties with supervisors will give further insight into what supports and hinders sharing in supervisory conversations and acknowledge the context in which these supports and hinderances occur. Furthermore, it will begin to give insight into the effect of previous sharing experiences on subsequent sharing experiences and insight into the potential self-stigma experienced by mental health professionals when discussing their own mental health difficulties.

Method

Design and data collection

As little is known about the experiences of sharing mental health difficulties with tutors and/or supervisors during clinical psychology training it will be more appropriate to explore these experiences qualitatively to gain an in depth understanding of these experiences. Individual interviews are preferred over focus groups in this instance to allow a fuller

exploration of participant experiences. Furthermore, individuals may have had very different experiences across their course and as such may be difficult to establish a coherent narrative within a focus group setting.

Data collection will be via individual interviews which will be audio recorded, transcribed (and anonymised) and analysed using thematic analysis. ~~a thematic narrative approach.~~ A narrative approach will be used during the interviews to allow participants develop their own story and focus on what they feel is important to their narrative with minimal researcher prompting (Riessman, 2012). Occasional prompts will be used to encourage further exploration. This may incorporate general prompts such as "what happened then?" alongside more individual prompts developed in response to participants narratives and where these are of interest to the research (Muylaert et al., 2014). ~~A narrative approach will also aim to maintain the integrity of the individual story during analysis rather than focusing on single instances of an experience in order to explore experiences over time while taking account of the social context in which the participants narrative has developed (Muylaert et al., 2014; Riessman, 2008). It will be important to maintain the integrity of individual's experiences of sharing over time rather than break these down into separable instances since experiences of sharing may be influenced by previous experiences of sharing and in turn may influence subsequent experiences.~~

Participants

This will be a self-selecting sample of clinical psychologists recruited via social media (see below for details). The study aims to recruit 8-12 participants. A minimum of 8 participants is sought to provide a breadth of participant experiences to analyse for themes across participant experiences. However, if there is sufficient participant interest up to 12 participants will be recruited in order to more fully investigate a range of experiences.

Inclusion criteria

- Participants need to have completed a UK Doctorate in Clinical Psychology course in the UK in the last five years. The time frame of five years has been selected to increase the likelihood that participants will be able to recall their experiences in sufficient detail to allow them to discuss it during the interview. Interviewing those who are currently on training or who finished their training early will not provide insights in to these experiences across full training journey. A UK trained sample is sought in order to limit the influence of training within countries with different disability legislation which may in turn influence individuals' experiences of discussing their mental health difficulties.
- Participants need to self-identify as having had a mental health difficulty during training or have a diagnosed mental health difficulty during training. This can be a pre-existing mental health difficulty which trainees continued to experience during training or a mental health difficulty which re-emerged during the training period. Participants do not need to have received a diagnosis, it is sufficient that they self-identify as having had a mental health difficulty of a type identified in DSM-5.
- Participants are required to have shared their mental health difficulty with the supervisors and/or tutors during their training. Initial and/or continuing sharing can be at any point during training.
- There are no specific requirements around age range or gender within this study.

Interview Schedule

The interview will use minimal interview questions and prompts to allow participants to direct their own exploration of their experiences and to develop their own narrative about these experiences. Open questions such as "and then what happened?" will be used to encourage the participant to continue with their narrative. A number of prompts related to experiences of sharing mental health difficulties will be considered for use during the interview to further explore participants experiences; these prompts will be utilised if they are

relevant to the narrative already discussed by the participant and do not divert the narrative away from the participants own narration of their experiences. These prompts are drawn from the literature and further developed in conjunction with a small group of current trainees who self-identify as having a mental health difficulty and have discussed their views on important areas for this research. As current trainees will not be eligible to participate in this study it will not interfere with the recruitment pool.

The interview schedule for this research is provided in appendix 4-A.

Procedure

This research is intending to advertise for participants on social media and via word-of-mouth by the lead researcher. Advertising via word-of-mouth will involve discussing this research with others such as trainee clinical psychologists and friends and encouraging them to circulate the advertising information (Appendix 4-B) to others who may be interested in participating.

Advertising via social media will involve circulating advertising information on Twitter and to clinical psychology-focused Facebook groups. Advertising via Twitter will be undertaken from the lead researcher's Twitter account, this is not a personal account. The advertising information will request that individuals contact the lead researcher (Serena Hannah) on my university email account if they are interested in participating. There are several Facebook groups which are focused on issues relating to clinical psychology in the UK which allow research recruitment advertising (e.g. UK based clinical psychology Facebook group, Clinical Psychologist PTSD/Trauma Special Interest Group) and I will seek to advertise within these forums. I will seek to advertise the research in these forums and via Twitter to support as many clinical psychologists as possible to become aware of the project. If insufficient clinical psychologists are recruited for this study, then I will re-circulate advertising posts on Facebook and Twitter using the same approach as outlined previously

and I will again ask other trainee clinical psychologists and friends to circulate the recruitment information to other clinical psychologists who may be interested in participating.

Upon initial email contact from potential participants I will ensure that they have access to the participant information sheet (appendix 4-C) and consent form (appendix 4-D) for their consideration and give them the opportunity to ask questions about the research. I will check that they have read the information about the study and if they are interested in participating we will agree a mutually convenient day/time and method of participation. Participation will either be:

- Face-to-face interviews – on the day of the interview the researcher will again check that the participant has read and understood the participant information sheet and consent form information and they will be given further opportunity to ask questions. The researcher will provide the participant with the study consent form, only if the participant has signed the consent form will the research proceed. Interviews will take place either at Lancaster University or a location convenient to the participant, such as their home.
- Telephone and skype interviews – participants will be emailed the participant information sheet and consent form prior to arranging a time for interview. They will also be given the opportunity to ask questions by email or by phone prior to the study. Participants will be given the option to undertake a verbal consent process at the start of the interview or they can sign and return the consent form by email. For the verbal consent process ~~Consent will be discussed at the beginning of the phone call or skype call and~~ I will inform the participant that I will audio record the consent process. I will read the consent form to the participant and ask that they can give a verbal response to each item. Participants will again be given the opportunity to ask questions. The audio recording will be saved as a separate audio file to the main interview and the consent

audio recording will be stored and transferred securely to the Research Coordinator/Administrator in the Division of Clinical Psychology at the end of the study for storage. Alternatively, participants can either insert their signature into the document or print, sign, scan and return their consent form by email. Where participants have completed the consent form and returned it in advance, I will check at the time of the interview that they are willing to participate and were happy to consent to the items on the consent form. Where telephone contact is made with participants this will either be through the use of a university owned landline or using a university owned mobile phone specifically for the study. If participants would prefer to use skype to participate then I will use a skype account created specifically for this research (not my personal skype address). It is important to note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication. This is communicated to participants in the participant information sheet.

It is anticipated that the interviews will take approximately 1 hour of the participant's time. While the study is not aimed at specifically discussing the participant's mental health difficulties or their experiences which may have led to the development of these difficulties, there is a possibility that discussing their experience of sharing their mental health difficulties during training may be upsetting or distressing. If participants appear distressed during the interview, I will check whether they want to pause or stop the interview. I will ensure participants are aware that they can pause or end the interview at any time; this will be communicated on the information sheet and reiterated at the beginning of the interview. Furthermore, participants will be given contact information for sources of support in the information sheet and debrief information should they need further support.

The lead researcher will debrief participants at the end of the research interview and participants will be reminded that they have two weeks from the date of participation to withdraw their data from the study should they wish to. In addition, the debrief information sheet (appendix 4-E) will be given to, or emailed to, participants for their information.

Data Storage

Dictaphone audio recordings will be transferred and stored on Lancaster University servers as soon as possible following recording of the interview. The dictaphone is not an encrypted device, as such the audio recordings will be transferred to the university servers immediately following the interview. If it is not possible to connect to the university server following recording, then the audio file will initially be transferred to an encrypted memory stick and then transferred to the university server once it is possible to connect. Once saved to the server or memory stick the audio recording will be deleted from the dictaphone. Recordings will be stored on the server in a separate folder to transcripts and access will be restricted to myself. The audio files will be deleted by myself following thesis examination.

I will transcribe the audio recordings of the participant interviews and these will be stored to the Lancaster University server in a separate folder to the audio files. Access to the area where the transcripts are stored will be limited to myself. The audio and transcript files will be stored using anonymised file names, such as participant numbers. The transcripts may be shared with the project supervisors to discuss content and to support analysis. Participants will be given the opportunity to request that their data is not reviewed by one or both of the project supervisors. Participants will be asked to request this prior to or on the day of the interview.

Participant consent forms will be scanned and stored securely alongside participant audio consent files on the Lancaster University server for the duration of the study. Once scanned the paper copies of the consent forms will be disposed of using the confidential

waste process within the Division of Clinical Psychology. On completion of the study the encrypted scanned consent forms and zip folder encrypted consent audio recordings will be transferred securely to the Division of Clinical Psychology Research Coordinator for long term storage.

The encrypted transcripts and encrypted scanned consent forms and zip folder encrypted consent audio files will be transferred securely to the Research Coordinator and kept for 10 years. The Research Coordinator/Administrator in the Division of Clinical Psychology will be responsible for deleting the transcripts and consent forms/audio consent files at the end of the storage period.

Proposed analysis

Transcribed interviews will be analysed using thematic analysis ~~narrative analysis.~~ Thematic analysis aims to identify themes across participant experiences while recognising the context in which their experiences arose (Braun & Clarke, 2006). Data analysis will follow the process outlined by (Braun & Clarke, 2006). Interviews will first be transcribed and coded systematically to explore features of the data. Following coding of each transcript, codes will be re-examined and brought together to identify potential themes. These themes will be defined and then re-examined alongside the original data to explore the suitability of these themes. Themes and their development will be discussed with the project supervisor in order to ensure that the themes remain grounded in the data.

In addition, a brief written overview of each participant's experiences will be developed and offered to the participant to review, provided the participant has agreed to this. This will allow participants to check and provide feedback on their accuracy.

No amendments have been made to the recruitment materials in the appendices as data collection is complete.

~~Thematic narrative analysis as discussed by Riessman (2008) aims to maintain the integrity of the individual story while drawing understanding and themes from the content of the narratives. The transcribed data will initially be read and reread to form an understanding of each participants narrative. A brief overview of this narrative will be constructed which will be offered to the participant to review, provided participants have agreed to this. This will allow participants to check and provide feedback on the accuracy of the initial narrative. The narrative and data will be further analysed to identify themes within and between narratives, without deconstructing the overall narrative. These themes will be further developed and examined alongside an understanding of individual experiences within the whole narrative of each interview in order to draw explanatory understanding of these experiences in the context of their social context (Squire, 2008). The developing themes will also be explored and examined by the research supervisors of this project to check the evolving interpretations and ensure that the narrative remains grounded in the data (Squire, 2008).~~

Practical issues

This research will potentially be recruiting participants from across the country and, as such, I will need to be flexible to support people to participate. This may involve undertaking interviews via telephone or skype or travelling to participants to enable them to participate. It is anticipated that I will only travel to participants where they live locally to Lancashire. It will be necessary to explore the use of telephone or skype for participants living outside of this area or if participants prefer not to meet in person.

It is hoped that face-to-face interviews take place at Lancaster University. However, it may be necessary to offer participants alternative venues to enable participation, such as the participant's home and outside of working hours. Where interviews are conducted face to face, I will provide a designated peer or colleague with information of who I am meeting,

where the interview is being conducted, contact details of the participant if available and expected start/end times. This information will be provided in a sealed envelope and will be returned to me afterwards to be destroyed. This will be done via the confidential waste process within the Division of Clinical Psychology. I will notify this person of the anticipated end time of the research and I will notify them when leaving the venue. I will ensure that my mobile phone is charged to enable this to happen, and where there is no mobile signal I will call as soon as is possible. I will discuss with the designated colleague what to do if they do not hear from me at the expected time. If the colleague does not hear from me at the expected time they will be directed to contact me on my mobile phone. If they are not able to reach me on my mobile phone they will be asked to open the envelope and if possible contact the participant and contact the appropriate authorities (i.e. the police) providing the details of where the interview was due to take place and who I was meeting.

For skype or telephone contact with participants I will use a skype account set up specifically for this research and use a mobile phone specifically for the research (not my personal mobile phone). Similarly, email contact with participants will be via my university email account.

Initial contact with participants is anticipated to be via email. Participants who make contact through colleagues it is anticipated that follow-up communication to provide the participant information sheet, consent form and to arrange a time to participate will be by email. Participant email addresses will be stored on the lead researcher's Lancaster University email account for the duration of the study to support meeting arrangements and the provision of feedback on the initial narrative.

Ethical concerns

I will need to be mindful that information is anonymised and redacted carefully such that participants or course centres are not identifiable from the information, or from discussion of

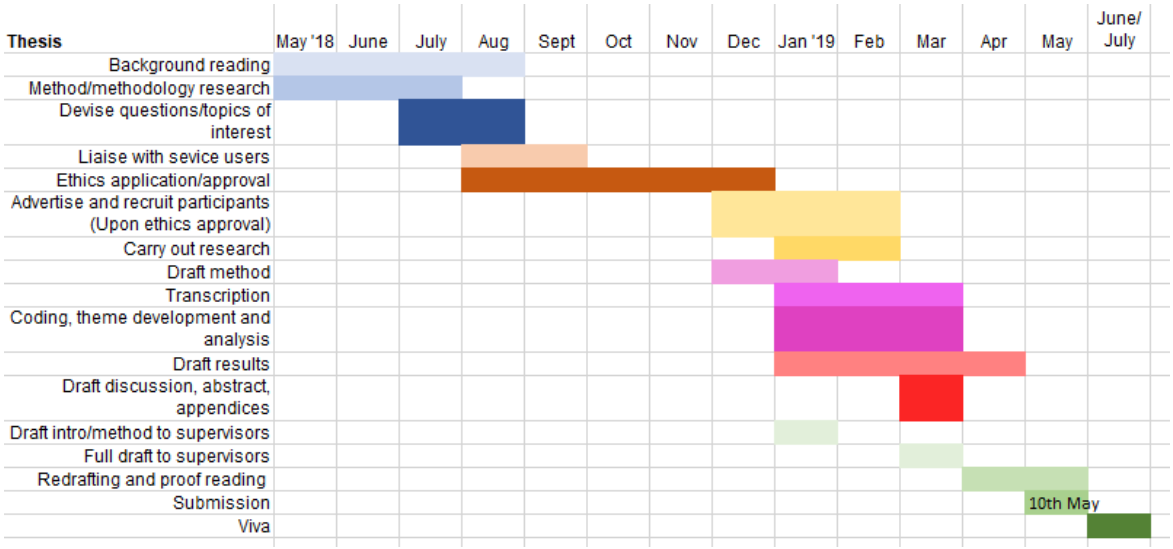
the participants' experiences.

It is possible that participants may become distressed when discussing their experiences of sharing their mental health difficulties during training especially where people have had negative experiences. It will be important to ensure that participants are aware of the potential for distress prior to participating, that participants or the interviewer feels able to stop or pause the interview should it become necessary and for the interviewer to be able to discuss and provide information on where participants can access support if needed. Available support information will also be discussed with participants following the interview and information will be provided in the participant debrief sheet for participants to consider after the interview. There is the possibility that participants may be currently experiencing difficulties with their mental health and may be distressed or may seek advice, as such it may be important to provide options for appropriate sources of support and advice for participants.

This project will not offer any monetary remuneration or participant expenses for participation.

Research time plan

Please see below for a Gantt chart for the proposed project. This is the ideal project timeline; however, it is acknowledged that ethics application approval, participant recruitment and interviewing could be delayed or take longer and as such the timeline may need to be revised during the project.


Thesis
May '18
June
July
Aug
Sept
Oct
Nov
Dec
Jan '19
Feb
Mar
Apr
May
June/ July
Background reading
Method/methodology research
Devise questions/topics of interest
Liaise with sevice users
Ethics application/approval
Advertise and recruit participants (Upon ethics approval)
Carry out research
Draft method
Transcription
Coding, theme development and analysis
Draft results
Draft discussion, abstract, appendices
Draft intro/method to supervisors
Full draft to supervisors
Redrafting and proof reading
Submission
10th May
Viva

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Appendices

Appendix 4-A

Interview Outline Structure

Introduce myself, check that the participant has read the participant information sheet and check if they have any questions. Check that they have read the consent form and if they are happy to go ahead then ask them to sign the consent form (if face-to-face) and for those doing telephone/skype interviews check they have read the consent form and returned it or discuss that the consent process will be audio recorded – then record and read out the consent form verbatim asking the participant to give a verbal response to each item.

Check that the participant understands that the interviews will be recorded and the transcript anonymised. Ask if the participant has a preferred pseudonym.

As mentioned in the participant information sheet I will normally discuss the interviews and analysis with my supervisors, if for any reason you would prefer that the two project supervisors (Dr Anna Daiches and Dr Pete Greasley) do not listen to or read the interview then please let me know.

Discuss whether participants would like to receive a short summary of the themes from our discussion following the interview to check that they are happy that I have captured their experiences accurately. I will check that participants are happy to receive this information by email using the email address we have been using up to present (all participants will have contacted me by email to arrange participation and/or to receive the participant information sheet and consent form prior to interview). The information will be sent in a password protected document attached to the email. Participants will be able to make comments and suggestions on the accuracy of the narrative prior to further analysis.

To outline with participants - As you know from the information sheet I am interested in your experiences of sharing your mental health difficulties with supervisors and tutors during training. As I am interested in hearing your story about this time in your life I won't be asking lots of questions, but I will be listening and may ask you more about something you have mentioned, and I may take some notes.

If it begins to feel too distressing to explore these experiences, please let me know and we can pause or stop the recording. Similarly, if I'm concerned that the interview is feeling quite difficult is it okay for me to pause you and check how you are feeling?

Does that sound ok? are you happy to go ahead?

- When did you first realise that you needed to talk to a tutor or supervisor about your mental health difficulties?
- Please can you tell me about your experiences of sharing your mental health difficulties with tutors or supervisors during training.

Prompts – can you tell me more about… (something discussed by the participant).

Other prompts may include:

- first instance of sharing mental health difficulties (application, interview, during the course, during a decline in wellbeing),
- what influenced you to discuss these difficulties with tutors/supervisors,

- decision making regarding sharing, (who did they choose to talk to, how did they decide)
- hopes for sharing
- concerns prior to sharing
- experience of the discussion itself (how did it feel to have the conversation, how was it facilitated)
- participants perception of the culture of the course/placement around trainee own mental health difficulties,
- response from those they spoke to,
- own emotions following sharing
- support/reasonable adjustments made or proposed,
- did they share on multiple occasions/to multiple people – what was the reason for this? (e.g. ongoing difficulties/expectation of sharing)
- the effect of past sharing on subsequent sharing
- was all sharing done by the trainee or was some information shared on their behalf and how was this experienced?
- Were there times when they did not share?

Thinking back over what we have discussed today, is there an important message or theme from your experience that you want me to take away?

Is there anything else which you feel is important for me to know?

If you would like to talk to me again about your experiences for this research, please get back in touch with me by email and we can arrange a further interview.

Thank for taking part, discuss and provide debrief information and remind about two weeks to withdraw data without giving a reason.

<u>Additional Information to collect during the interview</u>
This can be done at the beginning or the end of the interview as appropriate:

- Age or age range

- Gender

- What year did you finish your doctorate?

- Where did you undertake your doctorate? (Where you undertook your doctorate will not be reported. This information is collected to be able to count the number of different course centers attended by participants),

- How would you describe the mental health difficulties you experienced during training? (This information is collected for demographic information, you do not need to go into detail about these difficulties. Participants can choose not answer this questions, in which case I will check that they feel that they did have a mental health difficulty during training that they discussed with their supervisor).

- Was this a difficulty you also experienced prior to training?

Appendix 4-B

Participant Advertising Material – Recruitment advert for social media

Doctorate in Clinical Psychology | Lancaster University

Are you a clinical psychologist who shared your own mental health difficulties with supervisors during training?

My name is Serena Hannah and I am a trainee clinical psychologist at Lancaster University. I am interested in clinical psychologists' experiences of sharing their own mental health difficulties with tutors and supervisors during training and exploring the benefits, concerns and effect of having these discussions. I am seeking to recruit clinical psychologists who completed their doctorate in the UK within the last five years.

If you are interested in taking part, or if you have any questions about the study, please get in touch to find out more. My email address is s.hannah@lancaster.ac.uk

Appendix 4-C

Participant Information Sheet

Doctorate in Clinical Psychology | Lancaster University

Participant Information Sheet

Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

My name is Serena Hannah and I am a trainee clinical psychologist undertaking research as part of my Doctorate in Clinical Psychology at Lancaster University, Lancaster, United Kingdom.

What is the study about?
This purpose of this study is to explore individuals' experiences of sharing and discussing their mental health difficulties during clinical psychology training. I am interested to explore individuals' experiences of having conversations with tutors and supervisors across the course of training and explore the benefits, concerns and effect of having these discussions.

Why have I been approached?
I am seeking to talk to qualified clinical psychologists who have experience of sharing their mental health difficulties with supervisors and tutors during their clinical psychology training in the UK. Participants can either have received a diagnosis of a mental health difficulty or self-identify as having had a mental health difficulty during training.

I am looking to recruit individuals who have completed the clinical psychology doctorate in the UK within the last five years, rather than those currently on training, as they will be able to reflect on their experiences across the whole of their training journey.

Do I have to take part?
No. It's completely up to you to decide if you want to take part in this study. If you choose not to take part, there will be no negative repercussions for you.

Can I change my mind?
You can change your mind about participating at any time prior to or while taking part; if this is the case please let me know as early as possible. You can also withdraw your data up to two weeks following participation, however once our discussion has been transcribed and anonymised it will no longer be possible to withdraw your data.

What will I be asked to do if I take part?
If you would like to take part, we will arrange a time to discuss your experiences and agree how best to enable you to participate such as via telephone, skype or meeting face to face depending on your preference and what is practically possible. Please note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication.

It is anticipated that the interview will take approximately one hour of your time depending on how much you would like to discuss. I will audio record our discussion which I will then

transcribe. The transcription of your interview, alongside interviews from other participants, will form the data for the study. Following the interview and transcription, I will develop a narrative of your experiences prior to further analysis. You will be given the opportunity to review this narrative to check that you feel it is an accurate reflection of your experiences or if amendments could be suggested. I will discuss this opportunity with you on the day of the interview. If you would like to review the narrative it will be emailed to you in a password-protected document and you will have the opportunity to provide your feedback.

Will my data be Identifiable?
The information that you provide will be anonymised in any reports of the findings of this study. I may refer to quotes of what we discussed, however this will be anonymised and you will not be identifiable from any reports produced.

The audio recordings of our discussions for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed/deleted once the project has been examined.
- The work area where your data will be stored will be encrypted (that is no-one other than the lead researcher will be able to access them) and the file itself will be password protected.
- The transcription of our discussion will be anonymised by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, however as discussed, your name will not be attached to these quotes.
- Anonymised transcripts may be shared with the project supervisors to support analysis. The project supervisors are Dr Pete Greasley and Dr Anna Daiches, if you would prefer that your anonymised transcripts are not shared with these individuals, please let me know prior to or on the day of the interview.
- All of your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview suggests to me that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to my supervisor about this. If possible, I will tell you if I have to do this.

What will happen to the results?
The results will be summarised and reported in a thesis submission. The findings from this study may also be submitted for publication in an academic or professional journal. Findings may also be circulated to forums for course centres.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress during or following participation you are encouraged to inform the lead researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits to taking part. Findings from this study may be published and/or circulated to course centres which may be of benefit to future trainees.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

How do I take part? Or where can I obtain further information about the study?
If you are interested in taking part, or if you have any questions about the study, please contact the lead researcher, Serena Hannah by email on s.hannah@lancaster.ac.uk

This research is supervised by:
Dr Pete Greasley, Teaching Fellow, Division of Clinical Psychology, Lancaster University
p.greasley@lancaster.ac.uk Tel: 01524 592754

Dr Anna Daiches, Clinical Director, Division of Clinical Psychology, Lancaster University
a.daiches@lancaster.ac.uk Tel: 01524 592754

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researchers, you can contact:

Professor Bill Sellwood, Research Director of Clinical Psychology
Email: b.sellwood@lancaster.ac.uk Tel: 01524 593998
Faculty of Medicine and Health,
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Professor Roger Pickup
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk Tel: 01524 593746
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Resources in the event of distress
Should you feel distressed as a result of taking part, or if the content of this research has raised concerns for you, please consider seeking support from the following resources

- If you are experiencing concerns around your own mental health and feel you need to access specialist support, please contact your GP for further guidance and to discuss referral to support available in your area.

- Further support may be available through your employer and you may want to consider the Occupational Health resources available through work.

- Alternatively, listening support is also offered by a number of helplines, such as SANE and the Samaritans as well as other more specific diagnosis-based helplines. For more information please see https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

- If this has brought up some work-based issues you may want to consider approaching your line manager or clinical supervisor to discuss and access support.

Thank you for taking the time to read this information sheet, if you have any questions or concerns please email me on s.hannah@lancaster.ac.uk to discuss this prior to participating.

Appendix 4-D

Participant Consent Form

Doctorate in Clinical Psychology | Lancaster University

Consent Form

Study Title: Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

I am approaching clinical psychologists to ask if they would like to take part in my research project exploring their experiences of sharing their mental health difficulties with supervisors during training. Before you consent to participating in the study please read the participant information sheet and the below consent information. If you have any questions or queries about the study please speak to the lead researcher, Serena Hannah. If you are happy to participate in this study, please initial the statements and sign the consent form.

	Please initial each statement
1. I confirm that I have read the information sheet and fully understand what is expected of me within this study	☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.	☐
4. I understand that audio recordings will be kept until the research project has been examined.	☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time up to two weeks following the interview without giving any reason.	☐
6. I understand that once my data have been anonymised and analysed to identify themes it might not be possible for it to be withdrawn.	☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published.	☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events.	☐
9. I understand that the researcher will discuss data with their supervisor as needed.	☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal researcher will need to share this information with their research supervisor.	☐
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	☐
12. I consent to take part in the above study (please sign below)	☐

Name of Participant_____ **Signature**_____ **Date** _____

Name of Researcher _Serena Hannah__ Signature _____**Date** _____

Appendix 4-E

Participant Debrief Sheet

Doctorate in Clinical Psychology | Lancaster University

Participant Debrief Sheet

Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

Thank you for taking part in this study.

As discussed prior to taking part in the study, if you would like to withdraw your data from the study please email me at s.hannah@lancaster.ac.uk within two weeks of participation; you do not need to give a reason for withdrawing your data.

Should you feel distressed as a result of taking part, or if the content of this research has raised concerns for you, please consider seeking support. Below are suggestions of places you could access support:

- If you are experiencing concerns around your own mental health and feel you need to access specialist support, please contact your GP for further guidance and to discuss referral to support available in your area.

- Further support may be available through your employer and you may want to consider the Occupational Health resources available through work.

- Alternatively, listening support is also offered by a number of helplines, such as SANE (tel. 0300 304 7000) and the Samaritans (tel. 116 123) as well as other more specific diagnosis-based helplines. For more information please see https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

- If this has brought up some work-based issues you may want to consider approaching your line manager to discuss and access support.

Appendix 4-F

Ethical Approval December 2018

Applicant: Serena Hannah
Supervisor: Anna Daiches and Pete Greasley
Department: Health Research
FHMREC Reference: FHMREC18021

18 December 2018

Dear Serena

Re: Exploring clinical psychologists' experiences of discussing their own mental health difficulties with supervisors during training

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC).** The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix 4-G

Ethical Approval January 2019

Applicant: Serena Hannah
Supervisor: Anna Daiches and Pete Greasley
Department: Health Research
FHMREC Reference: FHMREC18053

29 January 2019

Dear Serena

Re: Exploring clinical psychologists' experiences of discussing their own mental health difficulties with supervisors during training

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC).** The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix 4-H

Ethical Approval May 2021

Lancaster University

Applicant: Serena Hannah
Supervisor: Anna Daiches and Pete Greasley
Department: LMS
FHMREC Reference: FHMREC20145 (amendment to FHMREC18053/18021)

18 May 2021

Re: FHMREC20145 (amendment to FHMREC18053/18021)
Exploring clinical psychologists' experiences of sharing their own mental health difficulties with supervisors during training

Dear Serena,

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC).** The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Tom Morley,
Research Ethics Officer, Secretary to FHMREC.