The Experience of Counselling Trainees with Mental Health Difficulties

Corinna Ruhl

Paper submitted in partial fulfillment of the requirements for the degree of

Master of Counselling
in the
Division of Arts and Sciences

City University of Seattle
2022

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Michael Kariwo, PhD
Research Supervisor
City University of Seattle

Dedication

This paper is dedicated to all of my fellow counselling trainees with lived experience. I honour your courage and your compassion, and hope that you find a welcoming place for all the gifts that you have to offer. As Youngson et al. (2009) write, we should be aiming for "a mutuality that, in reality, sees, believes and acts as if we are all on a continuum that means that at different times and stages in our lives … we are the helper, and sometimes the helped" (p. 63).

Abstract

This paper is a study of research on the experience of counselling trainees with mental health difficulties. A review of the literature suggests that mental health stigma is prevalent in the counselling profession and that counsellors and trainees with mental health difficulties experience stigma and shame. Current research on this topic, particularly for multiply marginalized individuals, is limited. The author reviewed ten research articles—four quantitative, three qualitative, and three mixed methods—to explore the qualitative research question "What is the experience of counselling trainees with mental health difficulties?" and the quantitative sub-question "What is the prevalence of mental health difficulties among counselling trainees?" Mental health difficulties among counselling trainees were found at rates similar to or higher than the general population. Stigma and self-stigma are common, some trainees experience shame, and many struggle with disclosure. Significant barriers to accessing mental health supports were also noted. The author concludes this study with applications of the research findings for personal practice, the profession of counselling and psychology, and wider society.

Keywords: lived experience, stigma, mental illness, shame, counselling training, recovery

Acknowledgements

I would like to thank my supervisor Dr. Michael Kariwo for his guidance throughout the research and writing process and my clinical reader Dr. Alicia Spidel for her feedback.

I would also like to thank my family and friends for all of your love and support throughout my counselling program. I could not have done it without the heartfelt words of encouragement, the nature walks, the acupuncture, the food hampers, and the financial support. This degree truly took a village!

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The Experience of Counselling Trainees with Mental Health Difficulties

Introduction

Mental health difficulties are common in Canada: one in five people in Canada experiences a mental health problem or illness in any given year (Canadian Mental Health Association, 2021). In terms of lifetime prevalence, one in three Canadians will experience mental illness during their life (Government of Canada, 2020). Despite how common mental health difficulties are, stigma and discrimination are prevalent. The Mental Health Commission of Canada reports that 60% of individuals with a mental health problem or mental illness do not seek supports due to stigma (MHCC, n.d.). While there have been concerted efforts from within the profession of psychology to reduce the stigma of mental illness in society at large, there have not been similar efforts to address stigma within the profession itself (Victor et al., 2022a). In the past few years there has been increased transparency by and about counsellors with lived experience. For example, in 2022, the American Psychological Association published a special section of *Psychological Services* focusing on clinicians with lived experience (Varghese & Boyd, 2022). Some psychological researchers are being transparent about their own status as professionals with lived experience of mental health difficulties (Victor et al., 2022c). And some established counsellors and psychologists are even "coming out" by publicly sharing details of their own history of lived experience (Bhattacharya, 2022; Varghese & Boyd, 2022; Victor et al., 2022c; Vierthaler & Elliott, 2022).

Despite these encouraging developments, research shows that counsellors with mental health difficulties experience stigma (Devendorf, 2022; Elliott & Ragsdale, 2020; Tay et al., 2018; Victor et al., 2022c), shame (Tay et al., 2018; Zamir et al., 2022; Zerubavel & Wright, 2012), and struggle with whether or not to disclose their mental health difficulties (Boyd et al., 2016; Elliott & Ragsdale, 2020; Zamir et al., 2022). Counselling trainees—who are just beginning their journey in the profession—are susceptible to heightened levels of stress (El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012; Richardson et al., 2020) related to

factors such as inexperience, rigorous evaluation, self-criticism, and challenging client material (Hill et al., 2007; Hobaica et al., 2021; Jones & Thompson, 2017; Kannan & Levitt, 2015; Skovholt & Rønnestad, 2003). Like their counterparts already established in the profession, some of these trainees will also experience mental health difficulties.

The broad research question guiding this study is "What is the experience of counselling trainees with mental health difficulties?" This study will review qualitative, quantitative, and mixed methods studies in order to apply a broad lens to the topic and to explore it from different angles. Therefore, a related quantitative sub-question is also asked: "What is the prevalence of mental health difficulties among counselling trainees?" The independent subject variables are professional status—i.e., counselling trainees versus established counsellors, with both being compared against the general population, as well as demographic factors such as race/ethnicity, gender identity, and sexual orientation. The dependent variable is the rate of mental health difficulties. As will be discussed below, counselling training is a stressful time for trainees, and my hypothesis is that trainees will have similar or higher rates of mental health problems than both established counsellors and the general population. My hypothesis is also that counselling trainees that inhabit multiple marginalized identities would have higher rates of mental health difficulties than their peers with more privilege.

Terminology

Counsellor Trainee. In this paper I will use the term "counsellor trainee" or simply "trainee." This study includes research from Canada, the United States, the United Kingdom, and Australia, each of which have different academic designations, requirements, and terminology. The term "counsellor trainee" then, will also encompass "future clinical psychologists," "trainee clinical psychologists," "psychology trainees," "clinical psychology doctoral/graduate students," and "therapists-in-training." When speaking of a specific research study, the term employed by that study will be used. The term "counsellor" will be used, when speaking generally, to describe those who are working in the profession and are no longer

trainees. This term therefore includes “mental health clinicians,” “mental health professionals,” “applied psychologists,” “clinical psychologists,” and “therapists.”

Mental Health Difficulty. This term will be used when speaking generally about a variety of mental health difficulties. The term therefore includes “mental health problem/concern/symptom,” “mental illness,” “psychopathology,” and “lived experience.” When used generally, the term is intentionally broad and will encompass mental health difficulties of different types, diagnosed or undiagnosed, and resolved or ongoing. “Mental health difficulty” was chosen because it appears in several of the core articles in this study and because it is a more general and non-stigmatizing germ. When a specific type of mental health difficulty is being referred to, that specific name will be used. This study might also occasionally use the term “prosumers,” which refers to mental health practitioners with personal lived experience of mental health difficulties (Varghese & Boyd, 2022).

Research Problem

The wellbeing of counselling trainees is important to address in itself; it is also significant because of the vital role counsellors have in assisting others. Mental health difficulties are common among counselling trainees (Grice et al., 2018; Hobaica et al., 2021; Victor et al., 2022a). There is evidence that counselling trainees with mental health difficulties experience stigma (Hobaica et al., 2021; Klein et al., 2022; Wilson et al., 2015) and shame (Dayal et al., 2015; Kannan & Levitt, 2015; Wilson et al., 2015), struggle with issues of disclosure (Dayal et al., 2015; Grice et al., 2018; Turner et al., 2021), and have insufficient access to supports (Klein et al., 2022; Schneider et al., 2021). Knowing what the experience of these trainees is, what barriers they face to disclosure and care, and what supports they require, is critical. Furthermore, the presence of stigma points to the issue of social justice. As Victor et al. (2022a) note, not openly discussing and researching mental health difficulties among psychologists may contribute to stigma, and stigma can lead to unjust exclusion and discrimination (American Psychological Association, n.d.).

Research Question

Linked to the problem identified above, the research question that I will address in this paper is, "What is the experience of counselling trainees with mental health difficulties?" This research will also seek to answer the scope of the problem—i.e., how many trainees experience mental health difficulties—and what might be done to help with this problem.

Justification

This research will throw light on the area of mental health difficulties among counselling trainees. There is secrecy around this topic, and it has even been called taboo (Victor et al., 2022a). Adding to the urgency of understanding the experience of counselling trainees with mental health difficulties is the impact of the COVID-19 pandemic. The pandemic has decreased the mental wellbeing of the population in general (Statistics Canada, 2020) and mental health professionals are not immune (Schneider et al., 2021). Counsellors are also learning the important work of helping others; the wellbeing of counsellors has implications for the wellbeing of their clients (Pakenham & Stafford-Brown, 2012). Additionally, as counselling training can be a particularly stressful time (Richardson et al., 2020), all counselling trainees may benefit from there being a greater understanding of topics such as how to disclose distress or access needed supports.

Researcher's Position

As a researcher, my social location impacts my work. I am a White, cisgender, able-bodied middle class woman speaking English as a first language. These aspects of my social location have accorded me many privileges. This research will explore questions of marginalization in the profession of counselling, but I acknowledge that I am precisely the social category of person who is overrepresented in the profession. I do not claim to speak with authority from a marginalized position but am interested in exploring the operation of power within counselling psychology. I view the world from an intersectional feminist and social justice lens; therefore, I am interested in the social origins and social solutions for problems of stigma

and marginalization. It is my belief that people build strength and resiliency in connection with others and addressing the stigma of mental illness is not a project for individuals to tackle alone.

During my Master of Counselling degree, I experienced mental health problems. Therefore, I am conducting "self-relevant" research—also pejoratively called "me-search" (Devendorf, 2022). Certainly, my own experiences have prompted me to choose this research question. In an effort to reduce researcher bias and not inadvertently seek only results that confirm my own experience, I have made several purposeful choices. First, I sought to include qualitative, quantitative, and mixed-methods research. My hope is that quantitative and mixed methods research will provide information regarding the scope of the topic. Do many counselling trainees experience mental health problems or is it a more limited problem? Second, I made sure to include in my literature review several research studies and articles concerning the counselling student experience in general for broader insights (Hill et al., 2007; Skovholt & Rønnestad, 2003). Lastly, I reviewed my findings with several academics and professionals to check for bias.

Theoretical Framework

Disability is part of the human experience; nearly everyone on the planet will temporarily or permanently experience disability at some point (World Health Organization, 2021). Disability is a broad term that includes physical, behavioral, cognitive, and learning disabilities, as well as mental health difficulties; these disabilities might be visible or invisible, episodic or ongoing (*Canadian Human Rights Act*, 1985). According to critical disability theory, disability is a social construct which is best understood as a complex relationship between several factors: the impairment itself, the individual's response to it, and the social environment (Hosking, 2008). These factors—the impairment itself, the individual's response to it, and the social environment—are an effective framework for situating the findings of this study. As will be discussed later, counsellors and trainees with mental health difficulties may or may not experience professional *impairment* stemming directly from these difficulties. The impact of

counselling trainees' mental health difficulties on their clinical effectiveness is a gap in the research that requires further investigation. What is clear from the research conducted as part of this study, however, is that counselling trainees with mental health difficulties do experience significant negative impacts related to the *social environment* surrounding their mental health difficulties. The social environment, while sometimes reported to be supportive—also includes professional gatekeeping and exclusion, exposure to stigmatizing messages in the profession, secrecy and shame, and barriers to accessing mental health care. As will be discussed in this study, the *individual's response* to their mental health difficulties seems significantly impacted by the social environment and can take the form of self-stigma and shame.

A primary aim of critical disability theory is uncovering, analyzing, and resisting ableism in society (Hall, 2019; Goodley et al., 2019). Ableism is prejudice against those identified as disabled (Hall, 2019) and involves discrimination based on actual or perceived ability (Campbell, 2009, as cited in Hall, 2019). Ableism interacts with other systemic power structures such as racism and sexism (Hall, 2019). Ableism is "the belief that being *without* a physical or cognitive disability, impairment, or chronic illness is the norm" (Procknow et al., 2017, p. 362). Through the critical disability lens, disadvantage results from the ways in which the social environment—including the physical environment, social structures and institutions, and beliefs—does not account for the needs of those falling outside what is considered 'normal' (Hosking, 2008). The findings of this study and the related clinical applications will attempt to account for the needs of those falling outside what is considered 'normal' in the profession, i.e., counselling trainees with mental health difficulties. Indeed, high rates of lived experience among counsellors and counsellor trainees found in this study will call into question our assumptions about what is indeed 'normal' for the profession.

Although the concept of disability is broad and includes mental health difficulties, this study does not address the full range of disabilities. Researching other disabilities in relation to the mental health profession—for example, physical impairments or chronic illness—is an

important and worthwhile endeavor that is outside of the scope of this study. While the term ableism applies to the findings in this study, the term sanism is more specific and appropriate. According to Perlin (2013), "Sanism, an irrational prejudice against people with mental illness, is of the same quality and character as other irrational prejudices such as racism, sexism, homophobia, and ethnic bigotry" (p. 878). Sanism can also be described as the institutional power accorded to the neurotypical ideal which results in discrimination and exclusion of those falling outside this ideal (Simmons University Library, 2021). Cheung (2015) calls for us to notice, name, and resist sanism in our society; this study is a call to notice, name, and resist sanism in the counselling profession. The clinical applications below will provide some practical ideas about how this may be done.

Literature Review

To situate the research on counselling trainees with mental health difficulties, this literature review will explore research on counselling trainees' experience of training, the prevalence of mental health difficulties among counsellors, mental health stigma in the profession, competence in clinical practice, disclosure of mental health difficulties, and finally movement in the profession towards recognizing the value of lived experience.

Stressful Nature of Counselling Training

The journey to becoming a counsellor is intensive and complex, at times exhilarating and at times grueling. Drawing from theoretical and empirical literature, Skovholt and Rønnestad (2003) describe a variety of significant challenges the new counsellor may face. These include acute performance anxiety, rigorous evaluation by supervisors acting as gatekeepers to the profession, and the challenge of maintaining boundaries and regulating emotions when working with clients (Skovholt & Rønnestad, 2003). Novice counsellors might also experience stress related to inexperience and the ambiguity of professional work (Skovholt & Rønnestad, 2003). Trainees report being self-critical, anxious about starting to see clients, and struggling to manage their internal reactions to their clients (Hill et al., 2007). They also report experiencing

imposter phenomenon—secretly feeling incompetent while projecting a professional image and being concerned that one's lack of skill will be discovered (Jones & Thompson, 2017; Kannan & Levitt, 2015).

Given all of these factors, it is perhaps not surprising that trainees are vulnerable to heightened levels of stress which can negatively impact their own functioning and their care for their clients (Pakenham & Stafford-Brown, 2012). Some research shows that three quarters of psychology graduate students report moderate to high levels of stress (Richardson et al., 2020). Hobaica et al. (2021) also note that students are exposed to unique stressors such as emotionally challenging and high-risk cases as part of their clinical training. In a survey of psychology graduate student stressors, workload, and physical and mental wellbeing, Rummell (2015) found elevated levels of health problems. For example, the prevalence of headaches, fatigue, backpain, and gastro-intestinal symptoms were more than double that seen in the general population (Rummell, 2015). The students also reported mental health difficulties at rates greater than medical students and rates much greater than the general population (Rummell, 2015). El-Ghoroury et al. (2012) also found elevated levels of stress among psychology graduate students, with over 70% reporting stressors that interfered with their functioning. The most common stressors in this group were found to be academic workload, finances, work/life balance, and anxiety (El-Ghoroury et al., 2012).

Despite the many challenges involved in training, it is important to note that trainees also report experiencing resilience (Jones & Thompson, 2017; Roebuck & Reid, 2019), increasing their self-efficacy and progressing in using their helping skills (Hill et al., 2007; Kanaan & Levitt, 2015), and finding support in connecting with supervisors (Kanaan & Levitt, 2015) and fellow students (Dayal et al., 2015).

Prevalence of Mental Health Difficulties

To hypothesize about the prevalence of mental health difficulties among counselling trainees, it is helpful to review the prevalence of mental health difficulties among the general

population and among established counsellors. Prevalence of mental health difficulties can be reported in terms of both lifetime prevalence and prevalence at a specific point in time. One in three Canadians will experience mental illness during their life (Government of Canada, 2020) and about half of people in the United States will experience mental illness at some point in their life (Kessler et al., 2005, as cited in Victor et al., 2022a). The lifetime prevalence of mental health difficulties among the general population in the United Kingdom was estimated in 2016 to be 41% (Mental Health Foundation, 2016; as cited in Tay et al., 2018). In terms of prevalence at a specific time, one in five people in Canada experiences a mental health problem or illness in any given year (Canadian Mental Health Association, 2021). Rates of mental illness are comparable in the United States: in 2020, 21% of adults in the United States had a mental illness (National Institute of Mental Health, 2022).

A significant number of counsellors also experience mental health problems (Boyd et al., 2016; Elliott & Ragsdale, 2020; Tay et al., 2018; Victor et al., 2022a). Tay et al. (2018) conducted a study to assess mental health difficulties among clinical psychologists in the United Kingdom. Among the 678 participants, over 62% reported having at least one mental health problem at some point (Tay et al., 2018). Of those clinical psychologists with lived experience, almost 70% had experienced mild to moderate depression, almost 13% had experienced severe depression, and about 42% had experienced anxiety. Less common, but still represented, mental health difficulties included eating disorders, addiction, psychosis, and bipolar disorder (Tay et al., 2018). Victor et al. (2022a) found similar numbers: among applied psychology faculty, over 70% reported lived experience of mental health difficulties. As part of a continuing education needs assessment among this population, Harris et al. (2016) surveyed clinical mental health providers in a Veterans Affairs medical centre in the Unites States. Among the 101 respondents, 75% reported lived experience of mental health difficulties, the most common of which were depression and anxiety/stress/panic (Harris et al., 2016). These rates of prevalence will be compared against prevalence among counselling trainees below under findings. Tay et al. (2018)

note that unspoken beliefs exist in the mental health profession that practitioners are "experts" and should not be susceptible to these types of personal struggles. Given the research studies cited above, this is clearly not the case.

Mental Health Stigma in the Counselling Profession

Early stigma theorist Erving Goffman defined stigma as an "attribute that is deeply discrediting" (Goffman, 1963, p. 3; as cited in Clair, 2018). Mental illness is one such attribute. Common stereotypes include that those with mental illness are unpredictable, dangerous, or violent; are incompetent; and are responsible for their condition (Corrigan & Bink, 2016). Stigma is an attitude that has real social consequences, for "stigma implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual" (American Psychological Association, n.d.). Discrimination that may result from mental illness stigma includes reduced employment opportunities, unequal medical treatment, and avoidance by others in society (Corrigan & Bink, 2016; Overton & Medina, 2008).

Research shows that counsellors with mental health difficulties experience stigma (Devendorf, 2022; Elliott & Ragsdale, 2020; Tay et al., 2018; Victor et al., 2022c). For example, Elliott and Ragsdale (2020, p. 678) note that while research on mental health stigma among the mental health profession is somewhat mixed, a number of studies show that stigma is similar or worse than the stigma among the general population. Elliott and Ragsdale (2020) interviewed 12 mental health professionals who identify as having a mental illness. The most common type of stigma they reported was indirect prejudice (75%) which mostly involved overhearing coworkers make negative remarks about clients with mental illness (Elliott & Ragsdale, 2020). Twenty five percent experienced direct discrimination that impacted their career.

Writing about her experience with clinical depression, Bhattacharya (2022), a clinical psychologist and qualitative researcher, described concerns about being labeled and judged. Despite her training in mental health, Bhattacharya (2022) experienced self-stigma and was concerned she would be "looked down upon as an incompetent professional who could not even

take care of her mental health" (p. 20). This sentiment was echoed by participants in a study of clinical psychologists experiencing personal distress (Charlemagne-Odle et al., 2012). Participants reported concerns about the reaction of others, appearing weak, being seen as incompetent, and not meeting the ideal of how a clinical psychologist should be (Charlemagne-Odle et al., 2012). Two participants described the distress of clinical psychologists as being "hidden," "underground," and "taboo" (Charlemagne-Odle et al., 2012, p. 245). The theme of stigma being related to holding counsellors to an unrealistic standard of mental health and wellbeing is summarized well by the following communication, sent by a participant to the Tay et al. (2018) research team:

> Stigma…is something as a profession I think we are very bad at acknowledging: The possibility that we…are as vulnerable as the clients we work with…and possibly the mask of the profession is more difficult to remove when we need help…There is an implicit message that we must be more 'normal' than everyone else, and a history of mental health problems (are) a sign of weakness to be kept out of the profession. (p. 1552-1553)

Indeed, the stigma of being a counsellor with mental health difficulties may have been a message received from the very beginning of one's career. In a review of recommendations for clinical psychology graduate school applicants, Devendorf (2022) found that applicants are often warned against disclosing lived experience. Quotes from popular resources include "Never reveal personal struggles, family struggles, or mental health problems in these statements" (Yale University, Department of Psychology, 2019, p. 5; as cited in Devendorf, 2022, p. 51) and "Avoid references to your mental health. Such statements could create the impression you may be unable to function as a successful graduate student" (Indiana University—Purdue University Indianapolis, 2019, p. 4, as cited in Devendorf, 2022, p. 51). Salzer (2022) found similar results in a meta-analysis of studies on mental health and admissions processes: disclosing mental illness may be perceived negatively and could reduce a prospective students' chances of admission.

The Experience of Shame

The experience of shame emerged as a theme in research about both counsellors and trainees with mental health difficulties. Some research shows that shame is a factor that prevents some counsellors and psychologists with lived experience from sharing their struggles with others and pursuing supports (Tay et al., 2018; Zamir et al., 2022; Zerubavel & Wright, 2012). Several prosumers have also publicly referenced their experience of shame. Vierthaler, a psychologist with lived experience, discussed her efforts to reduce the shame of lived experience by speaking out (Vierthaler & Elliott, 2022). Freisen (2022), a psychiatrist with lived experience of bipolar disorder, discusses coming to terms with this diagnosis and eventually establishing a support group for prosumers with the goal of reducing self-stigma and shame among its members. Whitten (2022), a psychology professor, also with lived experience of bipolar disorder, notes that "Shame, the efforts to mask one's symptoms, and self-stigma drain valuable energy that could be better devoted to self-improvement and to building strong families, careers, and communities" (p. 37).

Several seminal works about shame are worth noting, as they might expand our understanding of shame and situate the findings about shame in the core articles discussed later in this study. Shame is a pervasive and acutely painful human experience (Brown, 2006; Lewis, 1971; Scheff, 2014). It is defined by shame researcher Brené Brown (2006) as the "intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p. 45). In this definition, shame is the feeling that comes from believing one's very self is bad or flawed, and that these flaws will result in one's social rejection. In Brown's (2006) groundbreaking research on women and shame, participants described shame with words such as "devastating, noxious, consuming, excruciating, filleted, small, separate from others, rejected, diminished" (Brown, 2006, p. 45).

Despite being felt deeply at the very core of one's self, shame appears to inhabit the outer margins of individual and collective consciousness. Seminal shame literature by Scheff (2014),

Lewis (1971), and Retzinger (1995) suggests that shame is ubiquitous, suppressed, and misunderstood in modern Western society. Thomas Scheff has written extensively about shame and argues that it is easily the most commonplace emotion experienced in modern societies (Scheff, 2014; Scheff, 2016). Despite its ubiquity, Scheff (2014; 2016) argues that shame is nearly invisible—due to linguistic ambiguity and a social taboo around discussing it. The experience of shame is inextricable from belonging and connectedness, and modern Western societies are highly individualistic, resulting in ignoring and hiding shame (Scheff, 2014). Scheff (2014) notes that in some non-Western societies such as Māori and Japanese, the experience of shame is recognized as central to everyday life. Emphasizing the rational over the emotional and relational world, central to modernization, results in the experience and discussion of shame moving underground (Scheff, 2014).

Research psychologist and psychoanalyst Helen B. Lewis (1971) systematically coded emotions in transcripts of hundreds of therapy sessions. Lewis (1971) found that the emotions of shame and/or embarrassment occurred more frequently than all other coded emotions combined. Lewis (1971) also noted that when shame arose within a session, it was almost always ignored by both client and therapist. While shame may be avoided, it may also appear in various other guises. Sociologist and counsellor Suzanne Retzinger (1995) argues that there are in fact hundreds of words that represent shame. These include direct cognates such as humiliated and embarrassed; words that relate to belongingness, such as abandonment, isolation, and rejection; and words that related to not measuring up to an ideal image, such as inadequate, failure, unfit, and worthless (Retzinger, 1995).

It is beyond the scope of this study to explore shame in this more expansive and nuanced way; however, a hypothesis will be made here regarding how shame connects to stigma and, therefore, why shame is relatively common among the population under study. As discussed above, mental health stigma is prevalent within the counselling profession. When people internalize stigma—stereotypes and prejudice about a social label to which they belong—they are

experiencing self-stigma, which can result in lower self-esteem and feelings of incompetence (Corrigan & Bink, 2016). Self-stigma involves negative attitudes about mental illness and feelings of shame that reside within the person (American Psychiatric Association, 2020). Given the prevalence of mental health stigma in profession, it is perhaps unsurprising that literature shows that some counsellors with mental health difficulties also experience shame. Ferguson et al. (2000) argue that the primary cause of shame is an undesirable identity. They write that, "People perceive themselves as possessing an unwanted identity when they self-attribute, or when they perceive others ascribing to them, a characteristic that undermines their self-ideals" (Ferguson et al., 2000). Having mental illness is stigmatized (Corrigan & Bink, 2016; Overton & Medina, 2008); therefore, being "mentally ill" could be considered an unwanted identity. Perhaps being a counsellor with mental health difficulties is an identity that is doubly unwanted.

Some evidence for this hypothesis exists in the literature reviewed as part of this study. Charlemagne-Odle et al. (2012) note that the social role of a psychologist is to be a helper and also a mental health role model. When distressed, some clinical psychologists seem to compare themselves to an ideal image (Charlemagne-Odle et al., 2012). As one participant asked, "What's wrong with me that I'm feeling this . . . other psychologists are really together" (p. 245). Another noted that "People have this fantasy of what the psychologist is like . . . posh well-off, really stable" (p. 245). Tay et al. (2018) note that the psychologist role and binary concepts of mental health as being "us versus them"—i.e., the helper and the helped—may explain psychologists' resistance to being viewed as needing mental health support. The phrase "Physician, heal thyself" appeared in several articles reviewed as part of this study (Charlemagne-Odle et al., 2012; Dayal et al., 2015). Variations of this proverb appear in classical Greek texts as well as the Bible ("Physician, heal thyself," 2022). The meaning of the proverb is that one should address one's own problems before assisting with the problems of others; it has connotations of hypocrisy ("Physician, heal thyself," 2022). Some counsellors appear to be struggling under the

belief, bolstered by mental health stigma in the profession, that being a counsellor with mental health difficulties is an identity that is shameful.

Competence in Clinical Practice

Counsellors have an ethical duty to maintain their competence to practice (Canadian Psychological Association, 2017), and it is possible for personal distress to impact one's ability to do so. Counsellor distress may be the result of life events such as loss, change, or physical illness, and it may be the result of mental health difficulties. Charlemagne-Odle et al. (2012) conducted qualitative research on the experience of clinical psychologists' experiences of distress. The eleven clinical psychologists in Britain who responded to the research advertisement had a range of events that had precipitated distress, including relationship problems, bereavement, moving, financial problems, and pregnancy/birth (Charlemagne-Odle et al., 2012). About half of participants were diagnosed with a mental health disorder. Distress was experienced variously by these participants as problems with sleeping and appetite, panic attacks, weight loss, emotional numbness, and exhaustion (Charlemagne-Odle et al., 2012). These clinical psychologists were impacted at work in a variety of ways, for example, becoming more tearful and emotional, having anxiety, feeling useless or helpless, or experiencing work as an escape from their problems. The issue of competence in clinical practice includes, but certainly is not limited to, mental health difficulties.

There are ample indications that counsellors with lived experience of mental health difficulties excel in their work (Boyd et al., 2016; Elliott & Ragsdale, 2020; Harris et al., 2016; Victor et al., 2022a). Participants in Boyd et al.'s (2016) sample of mental health professionals with lived experience have published articles, created new programs, been trainers and supervisors, presented at conferences, and held leadership positions. Among the mental health professionals with lived experience surveyed in the study by Boyd et al. (2016), the most common qualitative theme coded (at 44%) was that lived experience is an asset on the job. Specific qualitative responses included "Individuals with a lived experience have a higher level

of compassion for veterans who are struggling" and "Your experience is a precious gift that contributes to your efficacy as a clinician" (Boyd et al., 2016, p. 615). Along similar lines, Bhattacharya (2022) notes that her experience surviving clinical depression allowed her to empathize with her clients not only cognitively, but emotionally as well. About half of participants in Charlemagne-Odle et al. (2012) reported that their distress helped them develop a deeper understating of their clients and deepened their clinical work. In a study by Elliott and Ragsdale (2020), 11 of the 12 therapists interviewed indicated that their experience of mental illness was an asset for them on-the-job—for example, by increasing their empathy and understanding, avoiding judgment, and believing strongly in their modality because they use it themselves. These accounts connect to the archetype of the wounded healer. Zerubavel and Wright (2012) note that the archetype, which has been in existence for over 2500 years, indicates that one can be both *wounded* and a *healer*. This conceptualization is a duality (Zerubavel & Wright, 2012) rather than a dichotomy of *us* (the healers) and *them* (the wounded) represented above in the unwanted identity of "counsellor with mental health difficulties."

Zerubavel and Wright (2012) emphasize that it is important to distinguish between the wounded healer and a practitioner who is impaired. The insight and potential of woundedness comes from the process of recovery, not the woundedness itself (Zerubavel & Wright, 2012). However, stigma surrounding wounded healers in the profession can lead to shame, self-stigma, and secrecy (Zerubavel & Wright, 2012), which prevents transparent discussions about woundedness, recovery, and competence. Zerubavel and Wright (2012) note that there is an absence of both research and professional discussion regarding how woundedness impacts the provision of therapy. A variety of factors should be addressed related to woundedness, such as current level of functioning, anticipated recovery trajectories, and risks and benefits of healer woundedness for the client (Zerubavel & Wright, 2012). Differentiating between practitioner distress and impairment is challenging, however an atmosphere of stigma and tendency towards

avoidance means these nuanced understandings remain unexplored (Zerubavel & Wright, 2012). As Zerubavel and Wright (2012) note,

> "With wounded clients, we normalize the struggles and guide them through a process of growth, recovery, or healing. We encourage the unshrouding of silence and offer responses of empathy and support. Yet, we do not approach our wounded colleagues with the same warmth and support." (p. 488)

Elliott and Ragsdale (2020) point out that it is unethical to stigmatize mental health professionals who themselves have mental illness, and there is clear evidence that counsellors with lived experience can be successful (Boyd et al., 2016; Elliott & Ragsdale, 2020; Harris et al., 2016; Victor et al., 2022a). However, it is important to raise ethical concerns if a mental health professional's competency is impacted by their mental illness (Elliott & Ragsdale, 2020; Zerubavel & Wright, 2012). Distress and mental illness may or may not impact one's ability to practice ethically (Charlemagne-Odle et al., 2012; Victor et al., 2022a), however counsellors may fear disclosure if they perceive others will equate mental distress with incompetence (Zamir et al., 2022; Zerubavel & Wright, 2012).

Disclosure of Mental Health Difficulties

Disclosure of mental health difficulties is critical for a variety of reasons. Disclosing is necessary in order to access supports, have transparent discussions around competence, and to building connections and community. However, stigma and shame negatively impact disclosure. Shame is an emotion that is closely connected to secrecy and a wish to hide (Brown, 2006; Dayal et al., 2015; Herman, 2007). And stigma is an attitude that has real social consequences, including disapproval, discrimination, and exclusion (American Psychological Association, n.d.). Because some stigmatized attributes may be invisible unless purposely revealed (Clair, 2018), counsellors with concealable mental health difficulties are faced with the choice of disclosure. Experiencing direct prejudice and discrimination as a mental health professional with mental illness is only possible if others in the workplace know (Elliott & Ragsdale, 2020), therefore it is

perhaps unsurprising that counsellors are less likely to disclose to coworkers and supervisors than friends and family. Zamir et al. (2022) systematically reviewed studies of mental health professionals disclosing psychological distress in the workplace. Mental health professionals generally reported that they were more likely to disclose in their social circles rather than in their workplace. They identified anticipated stigma, discrimination, and negative career impacts as barriers to disclosing at work (Zamir et al., 2022). In many studies, self-stigma, which included shame and embarrassment, were identified as disclosure barriers (Zamir et al., 2022). Zamir et al. (2022) emphasize that their meta-analysis indicates that structural stigma may exist within workplaces.

In a convenience sample of 77 mental health professionals with lived experience working for the Veterans Health Administration (VHA), respondents on average had disclosed to 16% of their colleagues (Boyd et al., 2016). About one third reported not disclosing to any colleagues (Boyd et al., 2016). Over a third of respondents advised the use of caution regarding disclosure, noting that stigma and bias exist, not everyone will be supportive, and disclosure could result in professional punishment or termination (Boyd et al., 2016). As one participant noted, "The culture is still to hide it" (Boyd et al., 2016, p. 615). A culture of non-disclosure has several implications for the profession. It may perpetuate the illusion that mental health practitioners are generally free from mental health difficulties (Harris et al., 2016). Not being able to see others in the same role modeling discussing and/or managing mental health difficulties prevents practitioners from identifying with like others—which is a significant method for reducing stigma (Harris et al., 2016).

"Coming Out" and Recognizing the Value of Lived Experience

Corrigan et al. (2013) point to the practice of "coming out" among the LGBTQ2S+ community, which involves proudly sharing one's gender and/or sexual identity to claim control over one's life. Although Corrigan et al. (2013) acknowledge that the experiences of those with mental illness are not identical to those of LGBTQ2S+ persons—for example, those with mental

illness may experience symptoms or disabilities that impact their functioning—the theory and research on "coming out" is nevertheless helpful for addressing self-stigma among those with mental illness. Because neither LGBTQ2S+ identity or mental illness are as readily identifiable to others, unlike skin colour or body size for example, both groups have the experience of whether or not to hide a stigmatized identity from others (Corrigan et al., 2013).

In the past few years, counsellors have published academic articles in which they reveal their own lived experience. Bhattacharya (2022) revealed her lived experience of clinical depression; Devendorf (2022) writes of his experience of depression in his family; mental health professionals Vierthaler and Elliott (2022) write of Vierthaler's experience of mania and psychosis and Elliott's support. In their article *Leveraging the Strengths of Psychologists with Lived Experience of Psychopathology* (Victor et al., 2022c), the eleven authors write, "We, the authors and signatories, have personal lived experience of psychopathology" (p. 2). The American Psychological Association recently published a special section of the journal *Psychological Services* that focuses on clinicians with lived experience that includes both empirical articles as well as first person narratives (Varghese & Boyd, 2022). Articles and special sections such as these perhaps represent the beginnings of a sea change in the field of psychology. Victor et al. (2022c) write that psychologists can serve as role models and help destigmatize mental health problems in society by being open and acknowledging their own experiences. This is echoed by Corrigan and Bink (2016) and Boyd et al. (2016) who argue that individuals who share their stories of recovery from mental health difficulties have a powerful impact on others. Corrigan and Bink (2016) acknowledge that revealing one's mental health difficulties might have both positive and negative consequences. Although there may be negative impacts, disclosure may result in higher quality of life, improved self-esteem, and a sense of empowerment (Corrigan & Bink, 2016).

Vierthaler, a psychologist specializing in major mental illness, experienced an episode of mania several years after becoming licensed to practice (Vierthaler & Elliott, 2022). Although

describing the episode as “chaotic, terrifying, and destructive” (p. 46), Vierthaler was able to receive treatment, return to work, and achieve a variety of professional accomplishments, including becoming a director of clinical training and an assistant professor in addition to her clinical work in a large health care system (Vierthaler & Elliott, 2022). Vierthaler felt the impact of stigma in the messages that she received from others, including colleagues and her treatment providers, that disclosure would negatively impact her career and that she should not speak publicly about her mental health problems (Vierthaler & Elliott, 2022). Vierthaler instead chose to share her experience openly in order to resist internalized stigma and feelings of shame (Vierthaler & Elliott, 2022). Vierthaler writes that, “Finding my voice within my illness helped to decrease my depression, anxiety, and other symptoms. It has been one of the most freeing parts of my recovery” (Vierthaler & Elliott, 2022, p. 47).

Corrigan & Bink (2016) note that one way to combat mental health stigma is to increase affirming attitudes, expectations, and beliefs about people with mental illness, for example, emphasizing that people with mental illness can realize a broad range of positive outcomes in life. Within the counselling profession, there is clearly some movement towards “coming out” and placing value on lived experience; however, more needs to be done to address mental health stigma in the profession (Turner et al., 2021; Victor et al., 2022c).

Summary of Literature Review

This literature review described how lived experience is prevalent among counsellors, and that mental health stigma—i.e., sanism—exists in the profession. Experiencing mental health stigma, and perhaps inhabiting the unwanted identity of “counsellor with mental health difficulties,” contributes to the experience of shame. Mental health difficulties do not necessarily reduce one’s level of competence, but if and when they do, it is critical to discuss these difficulties openly. Stigma and shame, however, reduce the likelihood of disclosure. Given the results of the above literature review, I expect that counselling trainees will experience high

rates of mental health difficulties, will also experience stigma and shame, and will also struggle with disclosure for the reasons explored above.

Methodology

To answer the research question, "What is the experience of counselling trainees with mental health difficulties?", I searched the City University of Seattle library database as well as Google Scholar. Inclusion criteria were that studies were about (1) counselling trainees with (2) mental health difficulties. Many variations of those search terms were used (see section on terminology above). Other inclusion criteria were that the studies were published in English and were published in the last ten years. In order to mitigate researcher bias, as described above under researcher's position, this study includes research articles representing three of the main research paradigms: positivism, constructivism, and pragmatism. Ten core articles were selected (see Appendix). Of these ten articles, four are quantitative, three are qualitative and three are mixed methods.

Quantitative Studies

Four articles in this study use a quantitative methodology (Grice et al., 2018, Hobaica et al., 2021, Kotera et al., 2021, Victor et al., 2022a). The research paradigm underlying quantitative studies is positivism.

Positivism

A research paradigm is the lens through which the researcher views the world, including how they determine which research methods to use and how to analyze the data (Kivunja & Kuyini, 2017). It is a belief system about the nature of reality and how we can study it (Rehman & Alharthi, 2016). The research paradigm impacts every part of the research process, including the research methodology and research methods (Kivunja & Kuyini, 2017).

Positivism was first proposed by French philosopher Auguste Comte in the mid-1800s and is grounded in the scientific method of investigation (Kivunja & Kuyini, 2017). Systematically observing the world, using reason, and conducting experiments was, according to

Comte, the only way to increase human knowledge (Kivunja & Kuyini, 2017). According to positivism, reality exists independent of human beings (Rehman & Alharthi, 2016). Positivist researchers value objectivity, seek cause-and-effect relationships, and strive to produce stable laws and facts about nature and the social world (Rehman & Alharthi, 2016). A positivist paradigm is appropriate for all four of these studies because they all attempt to quantify the presence of mental health difficulties among the population under study.

Roles of the Researchers

In line with positivism, the role of the quantitative researcher is to be objective and unbiased (Creswell & Creswell, 2018). The quantitative researcher might administer instruments or observe participants but has limited interaction with research participants (Creswell & Creswell, 2018). Researchers seek to conduct empirical measurement and observation (Creswell & Creswell, 2018). The bias of the researcher should not be allowed to impact the study (Creswell & Creswell, 2018).

Quantitative Methodology

Quantitative research designs include experimental, non-experimental, and longitudinal designs (Creswell & Creswell, 2018). The four quantitative studies discussed here are all non-experimental survey designs. This type of design is appropriate for the research questions of all four research studies, which is, at least in part, to determine the prevalence of mental health difficulties among a particular population. Four criteria are used to validate quantitative research: internal and external validity, objectivity, and reliability (Burns, 2000, as cited in Kivunja & Kuyini, 2017). These criteria will be discussed below.

Participant Recruitment and Sampling

Participants in all four quantitative studies were counselling trainees. The trainees were from the United Kingdom (Grice et al., 2018; Kotera et al., 2021), the United States (Hobaica et al., 2021), and the United States and Canada (Victor et al., 2022a). Sample sizes in the studies ranged from 145 participants (Kotera et al., 2021) to 1,172 participants (Victor et al., 2022a).

Three studies recruited participants from a variety of training programs across their country/countries (Grice et al., 2018; Hobaica et al., 2021; Victor et al., 2022a) while one study recruited from a single university (Kotera et al., 2021). The studies which recruited from many programs and had larger sample sizes showed greater external validity, meaning the research results can be generalized to other contexts (Prochaska, 2017, as cited in Kivunja & Kuyini, 2017). The study by Kotera et al. (2021) had the smallest sample size and drew from a single program, and therefore had less external validity.

In two studies, researchers sent information to the directors of the training programs who then disseminated the request (Grice et al., 2018; Hobaica et al., 2021). One study sent recruitment emails directly to both staff and students (Victor et al., 2022a). In the fourth study, program tutors recruited participants (Kotera et al., 2021). Although the study by Kotera et al. (2021) may be less generalizable, as noted above, it had the highest response rate, with 145 of 166 students completing the survey. This is contrasted, for example, with the study by Victor et al. (2022a) in which 22.8% of participants who were contacted agreed to participate.

All four quantitative studies used convenience sampling, because participants were chosen based on their availability to the researcher and their willingness to participate (Faculty of Public Health, 2018). All four studies have the risk of volunteer bias, in particular the studies with a lower response rate. Those who chose to take part may be different than those who do not (Faculty of Public Health, 2018). To mitigate this, Victor et al. (2022a) did not mention that their study involved personal experiences of mental health problems in their advertisements and consent form. Instead, they described the study as focusing on “research and clinical interests” (Victor et al., 2022a, p. 4). This could eliminate self-selection bias among participants. Grice et al. (2018) and Hobaica et al. (2021) did not specify the content of their recruitment information; therefore, these studies are possibly more prone to volunteer bias. Mental health difficulties are stigmatized (Corrigan & Bink, 2016), which may impact participants’ willingness to participate. The study by Kotera et al. (2021) had such a high response rate that volunteer bias is unlikely.

The majority of participants in all four studies were women and cisgender. This is likely due to the overrepresentation of White cisgender women in the counselling profession. However, Victor et al. (2022a) noted their sample had a higher percentage of cisgender women than is seen in the population under study. Several studies collected broader demographic information in addition to gender, such as race/ethnicity, sexual orientation, region of the country and/or program type; the study by Grice et al. (2018) alone did not. Grice et al. (2018) indicated they did not collect demographic information other than gender to preserve participant anonymity; however, this is a weakness, as it means that no data can be compared across race/ethnicity, gender identity, sexual orientation, etc.

Data Collection

All four quantitative studies discussed here are cross-sectional survey designs. Three surveys were online (Grice et al., 2018; Hobaica et al., 2021; Victor et al., 2022a) and one was administered in-person and on paper (Kotera et al., 2021). Three studies employed pre-existing validated measures, sometimes with adaptations (Grice et al., 2018; Hobaica et al., 2021; Kotera et al., 2021), and in one study, the researchers developed their own self-report survey instruments (Victor et al., 2022a). Using validated measures increases the reliability of the research findings (Kivunja & Kuyini, 2017).

All four studies collected data about the presence of mental health difficulties among counselling trainees. The measures used by Hobaica et al. (2021) were by far the most comprehensive, using separate measures for depressive symptoms, anxiety symptoms, drug abuse problems, alcohol use disorders, suicidality, and non-suicidal self-injury. In contrast, two studies (Grice et al., 2018; Victor et al., 2022a) asked yes or no questions about whether participants have experienced a mental health problem; if participants answered yes, further questions were asked about type of mental health problem. Regardless of whether measures for mental health were simple or more complex, given that the population under study have training in mental health, we can be fairly confident in their self-assessments.

Based on their research questions, three studies also used instruments to measure other items: perfectionism, anticipated stigma, and anticipated likelihood of disclosure (Grice et al., 2018); access to mental healthcare (Hobaica et al., 2021); and mental health attitudes, self-criticism, self-reassurance, self-compassion, and caregiver identity (Kotera et al., 2021).

Data Analysis

In Grice et al. (2018), the data were analyzed using a variety of statistical analyses, including exploratory factors analysis, principal axis factor analysis, two-way repeated measures analysis of variance (ANOVA), multilevel linear model analysis, and one-way repeated measures ANOVAs. Kotera et al. (2021) used Pearson's correlation analyses to calculate the relationships among the six measures. They also conducted a stepwise multiple regression analysis to identify independent predictors of mental health. They used SPSS version 25 to complete correlation and regression analyses.

Victor et al. (2022a) conducted descriptive analyses to characterize the sample and to identify the prevalence of both mental health difficulties and diagnoses. Researchers also compared variables of interest across gender, race/ethnicity, age, professional status and more. Researchers found significant differences related to demographic characteristics, most notably between students and faculty. In Hobaica et al. (2021), data was analyzed using Statistical Package for the Social Sciences 26.0. Differences between subgroups were analyzed, i.e., between LGBTQ+ and non-LGBTQ+ and between ethnic minority vs. White. The authors report that due to the small sample of multi-marginalized identities (i.e., participants who were both LGBTQ+ and an ethnic minority), there was not enough power to analyze mental health outcomes (i.e., depression, anxiety, alcohol use, and drug use) for these intersectional identities.

Strengths and Limitations

All four of the studies are quite recent, and in particular the study by Victor et al. (2022a) provided more current findings on the topic. Victor et al. (2022a) write that information about the prevalence of mental health problems among applied psychologists is a gap in research, and

all four quantitative studies contribute to filling this gap. Three of the four studies also sampled from a large number of training programs, as noted above, which adds to the generalizability of their findings. The demographic homogeneity of the samples is a potential limitation in all four studies. Furthermore, some studies did not even collect robust demographic information (e.g., Grice et al., 2018). The study by Hobaica et al. (2021), however, did measure and compare among significant demographics such as race, ethnicity, sexual orientation, and gender identity. In Grice et al. (2018), the survey was piloted with trainees and revised according to feedback, which adds to the objectivity of the research. One aspect of objectivity is being receptive to suggestions from research participants (Kivunja & Kuyini, 2017).

The studies also contain a variety of limitations. All four studies may be prone to self-selection bias in the sample; however, Victor et al. (2022a) took specific steps to mitigate this, as noted above. Victor et al. (2022a) acknowledge that self-report measures are subject to being inaccurate or incomplete, which is a limitation that could affect all four studies. Other notable limitations relate to particular constructs exist within the studies. Grice et al. (2018) measured the hypothetical likelihood of disclosure, not disclosure that had actually occurred, which may be different. Kotera et al. (2021) acknowledge that measures of shame may be prone to bias because people may respond in socially desirable ways.

Qualitative Studies

Three articles in this study use a qualitative methodology (Dayal et al., 2015; Turner et al., 2021; Wilson et al., 2015). The research paradigm underlying qualitative studies is constructivism.

Constructivism

Constructivism acknowledges that people create their own subjective meanings from their experiences (Creswell & Creswell, 2018). These meanings are impacted by society, culture, and history and are created through interacting with others (Creswell & Creswell, 2018). Research informed by constructivism acknowledges that meaning is co-created and context-

specific (Creswell & Creswell, 2018). Rather than looking for objectivity, researchers are interested in the unique perspectives of the individuals and situations that are being studied (Creswell & Creswell, 2018). In contrast to positivism, in constructivism, theory follows from research (Kivunja & Kuyini, 2017).

Roles of the Researchers

Qualitative researchers often use open-ended questions to solicit detailed personal meanings from participants (Creswell & Creswell, 2018). Qualitative researchers engage directly with participants, which can impact and shape the data itself (Creswell & Creswell, 2018). Meaning is generated from the process of collecting and interpreting this rich, complex data in the field (Creswell & Creswell, 2018). Qualitative researchers also acknowledge that their own worldview and context impact their interpretation of the data (Creswell & Creswell, 2018). It is acknowledged that the qualitative researcher will interact in meaningful ways with subjects (Kivunja & Kuyini, 2017).

Qualitative Methodology

Qualitative research designs include phenomenology, grounded theory, narrative, ethnography, and case study (Creswell & Poth, 2018). Two studies reviewed in this study used narrative analysis (Dayal et al., 2015; Wilson et al., 2015) and one used grounded theory (Turner et al., 2021). The focus of narrative research is on exploring the life of individuals (Creswell & Poth, 2018). Narrative research pays close attention to the specific context in which the stories are embedded, for example, the context of culture, society, family, or societal institutions (Creswell & Poth, 2018). Narrative research is a collaboration between researcher and subject and the researcher will often shape stories into a chronology (Creswell & Poth, 2018). This method is appropriate for Dayal et al. (2015) and Wilson et al. (2015) because they both seek to understand their subjects' experiences and the meaning generated by the subjects in their specific contexts.

Grounded theory seeks create a theory which is grounding in data discovered from the field (Creswell & Poth, 2018). In contrast to narrative research, which shines a light on individual stories, grounded theory seeks to generate a unified theory out of the experiences of a variety of individuals (Creswell & Poth, 2018). Grounded theory is used when researchers want to explain a process that the subjects have experienced (Creswell & Poth, 2018). Grounded theory was an appropriate choice for Turner et al. (2021), because they sought to investigate the process of disclosure.

Qualitative research has different criteria for validating research than quantitative research; these criteria are dependability, transferability, credibility, and confirmability (Kivunja & Kuyini, 2017). These criteria will be discussed below.

Participant Recruitment and Sampling

While the quantitative studies reviewed above studied a population of counselling trainees to investigate the presence of mental health difficulties, participants in all three of the qualitative studies were counselling trainees with mental health difficulties. In Dayal et al. (2015), they were trainees in Canada with eating issues and in Turner et al. (2021) they were trainees in the United Kingdom who had disclosed mental health difficulties to peers, supervisors, or tutors during training. The United Kingdom study by Wilson et al. (2015) did not explicitly solicit trainees with mental health problems, but rather those who had used personal therapy as a trainee. However, crises that precipitated therapy among participants in this study included "'panic attacks,' 'an eating disorder,' and 'feeling suicidal'" (Wilson et al., 2015, p. 39), which can certainly be considered mental health difficulties. Sample sizes ranged from seven (Dayal et al., 2015) to 12 (Turner et al., 2021). These sizes are adequate for qualitative research, as the findings do not need to be generalizable as in quantitative research (Creswell & Poth, 2018).

The scope of recruitment was robust in all studies; researchers recruited participants from university programs across their countries. Prospective participants were contacted

through institutionally distributed emails. None of the studies indicate how many students were contacted, therefore response rate cannot be evaluated by the reader. All three studies used purposive sampling, a type of non-probability sampling, in which individuals are chosen deliberately because they can contribute information on the topic under study (Maxwell, 1996, as cited in Taherdoost, 2016). This is appropriate for the research questions in all three of these studies, which seek to learn more about the experiences of a particular demographic of individuals, specifically counselling trainees with mental health difficulties.

As with the quantitative studies reviewed above, the samples in these three qualitative studies were also homogenous demographically; between 75% and 100% of participants in the studies were cisgender women. The sample in Dayal et al. (2015) was mostly White and all participants identified as heterosexual. Turner et al. (2021) and Wilson et al. (2015) did not collect demographic information on race/ethnicity, sexual orientation, or other identities, which is weakness of these studies. This raises questions about the transferability of findings in all of these studies. We cannot know if the findings apply to counselling students who inhabit multiple marginalized identities.

Data Collection

All three studies collected data using one-on-one interviews with participants. All studies used a pre-planned interview schedule with open-ended questions related to the research question. This method is appropriate and consistent with a qualitative methodology. The interviews took place via telephone or videoconferencing (Dayal et al., 2015), videoconferencing (Turner et al., 2021), and face-to-face at the subjects' home or place of work (Wilson et al., 2015). Interviews in Dayal et al. (2015) and Wilson et al. (2015) lasted approximately one hour to one and a half hours. Although Turner et al. (2021) indicate that theoretical saturation was reached, one of their interviews lasted only 24 minutes, which seems particularly short. In line with grounded theory, Turner et al. (2021) conducted interviews until no new themes emerged.

The researchers themselves conducted the interviews and were in some cases the same target demographic as the subject under study. In the case of Dayal et al. (2015), the first author was the interviewer and also a counsellor trainee with an eating issue. Prior to the interview, the interviewer disclosed this identity to participants and indicated they were welcome to inquire about the interviewer's experience after the interview. The interviewer wrote that this was done to build trust and rapport with interviewees (Dayal et al., 2015). In Wilson et al. (2015), the first author conducted the interviews and was a trainee therapist herself. The author maintained a reflective diary to note assumptions and met regularly with supervisors (Wilson et al., 2015). Efforts to be transparent increase the credibility of the research findings.

Turner et al. (2021) also collected quantitative data in the form of a validated measure of mental well-being. The tool was used to inform debriefing and to screen participants, as the study's exclusion criteria included significant difficulties with mental health. Integration of the quantitative data was not part of the data analysis.

Data Analysis

Interviews were recorded and transcribed. Dayal et al. (2015) and Wilson et al. (2015) used narrative analysis, which involved extracting narrative segments, organizing them, comparing them across cases, and finally developing a shared story or core plot. Turner et al. (2021), using grounded theory, coded line-by-line and then used selective coding to identify core categories. The author also used qualitative analysis software and modelled categories visually.

A variety of methods were used to ensure the reliability and validity of the findings. Wilson et al. (2015) note that rigour was maintained by comparing coding across researchers and maintaining a paper trail. In the study by Dayal et al. (2015), the first author engaged in a debriefing process with the other authors in order to attempt to minimize the effect of the first author's insider stance on the data analysis. This helps increase the credibility of the research, defined as whether research findings can be validated by others working in the same field (Guba, 1981, as cited in Kivunja & Kuyini, 2017). Dayal et al. (2015) also used member-checking: four of

the seven participants agreed to review, elaborate, and provide feedback on the collective core story. Turner et al. (2021) describe documenting the analysis process and adhering to established principles and standards of qualitative research.

Strengths and Limitations

These three articles generated rich qualitative data regarding counsellor trainees' experience of mental health difficulties and fill a gap in the research. Dayal et al. (2015) and Turner et al. (2021) both generated visual models as a result of their research, which helps consolidate and clarify the results for the reader. Turner et al. (2021), however, acknowledge that their model does not provide much understanding about how individual elements interact and more research would be needed to test it. All three studies include direct quotations from participants, which adds to the credibility (Kivunja & Kuyini, 2017) of the studies: they seem authentic and believable.

These three studies have several limitations, including possible self-selection bias during recruitment. Also, due to the small, demographically homogenous samples in these three studies, it is not clear how much these experiences are representative of other counsellor trainees. In other words, the studies may not meet the criterion of transferability (Guba, 1981, as cited in Kivunja & Kuyini, 2017) of qualitative research. In two of the studies (Dayal et al., 2015; Wilson et al., 2015), the authors are transparent as belonging to the demographic under study. It is possible that the researchers being very close to the topic could bias the data analysis. Conversely, it is also possible that the researchers' insider experience and insights might help organize and elucidate the subjects' experiences.

Mixed Methods Studies

Three articles in this study used mixed methods (Joseph et al., 2022; Klein et al., 2022; Schneider et al., 2021). The research paradigm underlying mixed methods studies is pragmatism.

Pragmatism

The pragmatic paradigm argues that research is best served by a pluralistic approach rather than the mono-approaches of positivism and constructivism (Kivunja & Kuyini, 2017). Pragmatism argues that research should use whatever methods are most appropriate for investigating the particular topic under study (Kivunja & Kuyini, 2017). Therefore, pragmatism involves combining qualitative and quantitative research methods with the goal of workability in research (Kivunja & Kuyini, 2017). Pragmatism focuses on how research will be applied to the real world and is concerned with addressing specific problems through research (Patton, 1990; as cited in Creswell & Creswell, 2018). Pragmatism acknowledges that all methods of research have limitations; by collecting both quantitative and qualitative data, their respective weaknesses might be neutralized (Creswell & Creswell, 2018).

Mixed Methods Methodology

Because of their flexibility, mixed methods research combines quantitative and qualitative methods in a variety of ways (Creswell & Creswell, 2018). Pragmatic researchers have the choice and freedom to use methods that meet their needs in the best way (Creswell & Creswell, 2018). Examples of mixed methods include convergent mixed methods, explanatory sequential mixed methods, exploratory sequential mixed methods, and complex designs with embedded core designs (Creswell & Creswell, 2018). The three studies discussed here use convergent mixed methods, in which both types of data are collected at the same time and then merged in the overall interpretation of the research results (Creswell & Creswell, 2018).

A major aim of the study by Schneider et al. (2021) was to generate data-driven recommendations about how to assist trainees during unprecedented events such as global pandemics. This pragmatic goal indicates that mixed methods is appropriate. The other two mixed methods studies also had, at least in part, pragmatic goals: assessing barriers to mental health treatment for trainees (Klein et al., 2022) and determining what resources might be helpful for supervisors receiving a disclosure from a trainee (Joseph et al., 2022).

Participant Recruitment and Sampling

Participants in two of the mixed methods studies were 74 counselling trainees in the United States (Klein et al., 2022) and 400 across the United States and Canada (Schneider et al., 2021). Similar to the four quantitative studies discussed above, these two mixed methods studies (Klein et al., 2022; Schneider et al., 2021) used convenience sampling. As noted previously regarding convenience sampling, these two studies have the risk of volunteer bias. Schneider et al. (2021) contacted directors and administrative staff at 1379 programs across the United States and Canada. This is a much broader sample than in Klein et al. (2022), where only 859 students from a single student organization were contacted.

The study by Joseph et al. (2022) is notably different from the other nine studies reviewed in this study in terms of both population and sampling. The sample in Joseph et al. (2022) were 35 Veteran's Affairs mental health professionals with lived experience in the United States reflecting on their experience as students. This is the only study of the ten reviewed which was retrospective, i.e., the population was no longer students. Caution should be used when comparing this study with the others, as those who progress in the profession may be different than those who are currently students. This study was also different than the other two mixed method studies in that it used snowball sampling. Snowball sampling is commonly used when researchers want to access hard-to-reach groups (Creswell & Poth, 2018), of which mental health professionals with stigmatized identities certainly are. Snowball sampling, however, involves a major risk of selection bias, where researchers end up with participants who are overly similar to the initial individuals (Faculty of Public Health, 2018). In this case, the researchers approached a group of mental health providers with Veterans Affairs who participated in an organizational monthly meeting. This represents a much more limited sample than other studies such as Victor et al. (2022a) and Schneider et al. (2021), who sampled very widely.

Klein et al. (2022) provided demographic information for the entire student population that was solicited for the study; however, they did not collect demographic information from

participants. This is a weakness, as noted in other studies, because differences across demographic categories cannot be analyzed. Schneider et al. (2021) collected robust demographic information. Participants in their study were mostly women and mostly White.

Data Collection

All three mixed methods studies used surveys with quantitative and qualitative questions. Survey questions in Klein et al. (2022) focused on the process of trainees accessing mental health services in their program and what resources would be helpful in addressing gaps in access to treatment. Participants in this study were not assessed for mental health difficulties. In contrast, participants in Schneider et al. (2021) completed brief two-item validated scales for depression and anxiety, as well as robust demographic questions, including age, race and ethnicity, gender, education, marital status, training site, work status, and telehealth status. Participants were also asked two open-ended questions about program support and how support could be improved and whether they have felt unsafe during training. Because the participants in Joseph et al. (2022) were already professionals, survey questions were asked retrospectively.

Data Analysis

In Klein et al. (2022), the survey's first five questions were analyzed according to what percentage of students indicated yes. The sixth question was analyzed by two independent coders and broad categories were developed. The coders met, discussed, and revised until consensus was reached. In Schneider et al. (2021), qualitative data was analyzed by two researchers who consulted with each other and were then supported by two additional independent researchers. The authors report strong inter-rater reliability. Quantitative data was analyzed using methods including Pearson's *r* correlations, several one-way multivariate analyses of variance (MANOVA), and several one-way ANOVA. Joseph et al. (2022) provided a fairly limited description of their analysis. They noted that due to their topic and population,

they did not have access to external benchmarks. Therefore, Joseph et al. (2022) reported using descriptive statistics and also internal comparison.

Strengths and Limitations

A strength of all three articles is that they provide recent data on the research subject. A strength of the study by Schneider et al. (2021), which is in line with the pragmatic approach, is that the authors conducted a literature review to provide helpful tables summarizing both recommendations for training programs and recommendations and resources for trainees. Another significant strength in Schneider et al. (2021) is the time period at which the data was collected, specifically three months into the COVID-19 pandemic. This is a critical historical moment, and it is helpful to have data on the experience of counselling trainees at that time. The authors note that longitudinal data should be collected about the long-term effects of the pandemic on trainee wellbeing.

A weakness of both Klein et al. (2022) and Joseph et al. (2022) is that they sample from single organizations, limiting the generalizability of their results. Klein et al. (2022) did not collect robust demographic information, which is a weakness previously discussed with other studies. We cannot know for certain what the demographic makeup was of this sample, let alone contrast responses according to salient demographic factors such as race/ethnicity, gender identity, and sexual orientation. Joseph et al. (2022) did collect robust demographic information, and still their sample was quite homogenous. They note that this lack of diversity makes it impossible to assess for how intersectional identities might impact disclosure. The homogeneity of the participants under study is a limitation that affects many of the articles explored in this study.

Findings

This study, guided by the qualitative research question “What is the experience of counselling trainees with mental health difficulties?” and the quantitative sub-question “What is the prevalence of mental health difficulties among counselling trainees?” reviewed articles from

the three main research paradigms: positivism, constructivism, and pragmatism. The findings, therefore, contain quantitative results, for example, on the prevalence of mental health difficulties in this population, and also rich qualitative results, for example on the first-person experience of experiencing shame and navigating the process of disclosure. They also contain results related to solving particular problems, such as how to assist counselling trainees during unprecedented events such as global pandemics. The findings are presented below.

Quantitative Studies

Grice et al. (2018), Hobaica et al. (2021), and Victor et al. (2022a) all sought to investigate the prevalence of mental health difficulties among counselling trainees. Grice et al. (2018) also studied the mechanisms that underlie trainees' decisions to disclose mental health difficulties. Hobaica et al. (2021) also studied the barriers to care for this population. The study by Kotera et al. (2021) investigated the relationships between five variables: mental health, mental health attitudes, self-criticism/self-reassurance, self-compassion, and caregiver identity. The findings are presented below.

Prevalence of Mental Health Difficulties Among Counselling Trainees

In terms of lifetime prevalence, Grice et al. (2018) found that 67% of trainees indicated they had past and/or current lived experience of a mental health problem. In the study by Victor et al. (2022a), over 88% of trainees reported a mental health difficulty in their life. Nearly 37% of trainees in Hobaica et al. (2021) reported mental health problems that pre-existed graduate school. However, as these rates do not include current mental health status, the numbers in Kotera et al. (2021) are not equivalent to lifetime prevalence. These three studies also reported on prevalence at a particular time (Grice et al., 2018; Hobaica et al., 2021; Victor et al., 2022a). In Grice et al. (2018), 29% of trainees reported experiencing at least one mental health problem at the time of the study. In the study by Victor et al. (2022a), over 52% of trainees reported current mental health difficulties.

Hobaica et al. (2021) used self-report instruments to assess for current depressive symptoms, anxiety, drug use and abuse, alcohol use and abuse, and suicidality and nonsuicidal self-injury. They found that almost 25% of participants had moderate to severe symptoms of anxiety and 20% had moderate to severe symptoms of depression or suicidal intent. Additionally, more than 10% had problems with substances. In this study by Hobaica et al. (2021), each of these types of mental health difficulties were measures independently. Participants in this study might have co-occurring mental health difficulties, e.g., depression as well as anxiety, and as Hobaica et al. (2021) do not provide data regarding the total presence of absence of mental health difficulties, the most we can say is that *at least* 25% of participants have current mental health difficulties. In sum, the percentage of counselling trainees experiencing mental health problems at the time of the study was at least 25% or more in Hobaica et al. (2021), 29% in Grice et al. (2018), and 52% in Victor et al. (2022a).

Review of Quantitative Hypothesis. The results of these studies can be compared to the prevalence of mental health difficulties among the general population and among counsellors. As outlined above in the literature review, the lifetime prevalence of mental health difficulties in the general population is between 33% and 50% (Government of Canada, 2020; Kessler et al., 2005, as cited in Victor et al., 2022a; Mental Health Foundation, 2016; as cited in Tay et al., 2018). The prevalence at a specific time is around 20% (Canadian Mental Health Association, 2021; National Institute of Mental Health, 2022). For counsellors, the lifetime prevalence is higher than the general population, between 62% and 75% (Harris et al., 2016; Tay et al., 2018; Victor et al., 2022a). For counselling trainees, the lifetime prevalence is even higher than both of these groups, with studies showing between 67% and 88% (Grice et al., 2018; Victor et al., 2022a). In terms of prevalence at a specific time, research shows rates of between 29% and 52% (Grice et al., 2018; Victor et al., 2022a), which is significantly higher than the general population. In sum, whether lifetime prevalence or a specific point in time, rates of mental

health difficulties among counselling trainees are at least comparable to the general population, if not much higher.

Therefore, my initial hypothesis, that counselling trainees would have higher rates of mental health difficulties than both counsellors and the general population, is supported. Reasons for this are not clear from the research conducted as part of this study. There are several possible reasons why rates of mental health difficulties are higher among counselling trainees. One may be the stressful nature of counselling training as discussed above in the literature review. Some authors also note that mental health professionals may be drawn to the career because of their own experiences of distress (Aina, 2015, as cited in Zamir et al., 2022). Others note that the work itself may intensify distress and mental health problems due to exposure to trauma narratives (Engle et al., 2017, as cited in Zamir et al., 2022). The directionality of the relationship between the independent subject variable (i.e., counselling trainee) and the dependent variable (mental health difficulties) could be explored in further research. Are individuals with mental health difficulties more drawn to this career? Does the training itself generate or exacerbate mental health difficulties? Victor et al. (2022a) provided some findings about onset of mental health difficulties, with about 88% of trainees reporting onset before graduate school and about 11% reporting onset during graduate school. Without further research, however, it is not clear whether onset during graduate school was a result of school pressures, other factors, or a combination of both.

Types of Mental Health Difficulties

Quantitative studies also provided results regarding type of mental health difficulty. In Grice et al. (2018), the most prevalent mental health difficulties in this group were anxiety (43 percent past and/or current, 16 percent currently experiencing), depression (39 percent past and/or current, 7 percent currently experiencing), and social phobia (16 percent past and/or current, 5 percent currently experiencing). Depression and anxiety were also the most common types of mental health difficulties found in Hobaica et al. (2021). At lower rates, but still

represented, were a wide range of other mental health difficulties including eating disorders, social phobia, drug and alcohol abuse, suicidality, nonsuicidal self-injury, panic disorder, post-traumatic stress disorder, and obsessive-compulsive disorder (Grice et al., 2018; Hobaica et al., 2021).

Differences Among Demographic Groups

As previously noted, the population under study is relatively homogenous, with women, White, and heterosexual individuals being overrepresented in the counselling profession. Hobaica et al. (2021) note that students who are marginalized may face additional stressors and therefore may be at higher risk for developing mental health problems. Three studies collected robust demographic information that allowed them to analyze for differences among demographic groups: two qualitative studies (Hobaica et al., 2021; Victor et al., 2022a) and one mixed methods study (Schneider et al., 2021). The two quantitative studies did find notable differences related to diversity.

Victor et al. (2022a) collected robust demographic data among their sample of applied psychology faculty and trainees and found some differences. Compared to cisgender men, cisgender women were more likely to have a diagnosis and were less likely to have reported no mental health difficulties. This pattern was the case for homosexual and bisexual participants in relation to heterosexual participants (Victor et al., 2022a). Hobaica et al. (2021) found that compared to White students, ethnic minority students endorsed more depressive symptoms. Ethnic minority students were also 1.57 times more likely than White students to have experienced suicidal ideation. Compared to non-LGBTQ+ students, LGBTQ+ students endorsed significantly more depressive symptoms, were 1.83 times more likely to have experienced suicidal ideation, and 2.38 times more likely to engage in non-suicidal self-injury. The authors also found that compared to ethnic minority students, White students endorsed significantly more use of alcohol (Hobaica et al., 2021). The authors report that due to the small sample of multi-marginalized identities (e.g., participants who were both LGBTQ+ and an ethnic

minority), there was not enough power to analyze mental health outcomes (i.e., depression, anxiety, alcohol use, and drug use) for these intersectional identities. In sum, my hypothesis is tentatively supported by these two quantitative studies: marginalized groups may experience more mental health difficulties (Hobaica et al., 2021; Victor et al., 2022a) and therefore programs should address issues of justice and equity within their training (Victor et al., 2022a).

Impact of Mental Health Difficulties

What is less clear from these studies is the impact of mental health difficulties on counselling trainees. Only one of these four studies collected data on professional problems related to mental health difficulties. Among trainees with mental health difficulties, Victor et al. (2022a) found almost 88% reported having "none" or "mild" professional problems. Almost 10% reported "moderate" problems and just over 2 percent reported "severe" problems. The results from this study show that the vast majority of trainees with mental health difficulties experience at most mild professional problems. It should be noted that this assessment is from the perspective of the trainees themselves and cannot be used to assess fitness for practice. But it does provide information from their perspective about the impact of mental health difficulties on their professional experience. Of the 12% that report either "moderate" or "severe" professional problems, we might wonder what can be done to support them in their programs.

Stigma

Two of the quantitative studies provided findings about stigma (Grice et al., 2018; Hobaica et al., 2021). Stigma can be defined as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency" (American Psychological Association, n.d.). Hobaica et al. (2021) reported that nearly 25% of students in their sample indicated possible stigma was a barrier to seeking mental health support. The study by Grice et al. (2018) showed that anticipated stigma differed by type of mental health problem. Trainees in their study anticipated the most stigma for schizophrenia, then major depression, then specific phobia. Trainees also anticipated greater stigma for current

mental health problems, rather than past (Grice et al., 2018). Although more research would be needed to explore these findings, it appears that certain types of mental health difficulties among trainees are perceived as more stigmatizing than others, and that having a current difficulty is viewed more negatively than having difficulties that are resolved.

Shame

Kotera et al. (2021) sought to measure and understand the relationships among the following in a group of therapeutic students: mental health, mental health attitudes, self-criticism, self-reassurance, self-compassion, and caregiver identity. Their results provided granular information about types of shame and their relationship to mental health. Mental health attitudes were measured using the 35-item Attitudes Towards Mental Health Problems (ATMHP) scale. The scale has four sections which measured the following: one's community and family attitudes towards mental health problems; external shame, i.e., how one believes one's community and family would perceive them if they had mental health problems; internal shame, i.e., how one would perceive oneself if one had mental health problems; and finally family reflected shame, i.e., how one believes their family would be perceived if they had mental health problems. In their analysis, Kotera et al. (2021) found that mental health problems—which were also assessed via self-report measure—were positively associated with all three types of shame—external, internal, and family reflected—as well as perceived negative family attitudes. The only aspect that was not positively correlated with mental health problems was community attitudes. In this study, community was defined as other students at the university. The authors note that internal shame and self-criticism were significant predictors of mental health problems in this population (Kotera et al., 2021). The authors conclude that therapeutic students with mental health problems may hold negative attitudes towards mental health problems and may not treat themselves with compassion and understanding (Kotera et al., 2021). These findings are perhaps not surprising given the prevalence of stigma noted throughout the findings.

Accessing Mental Health Supports

Hobaica et al. (2021) studied the barriers to care for counselling trainees. Students reported significant barriers to obtaining mental health support, such as lack of confidentiality or dual relationships (i.e., other counsellors or counsellor trainees one knows working at the very sites where one might seek help), stigma, cost, and lack of time (Hobaica et al., 2021). Importantly, participants who wanted mental health support, but were not able to access it, endorsed significantly higher rates of mental health difficulties than those who were able to (Hobaica et al., 2021).

Mixed Methods Studies

The study by Joseph et al. (2022) explored common reasons for counselling trainees to disclose mental health difficulties, as well as what resources might be helpful in assisting supervisors navigate disclosure by trainees. Klein et al. (2022) studied counselling trainees' perceptions of the availability and accessibility of mental health supports provided by their training program. And finally, Schneider et al. (2021) studied the experience and needs of counselling trainees during the COVID-19 pandemic and developed recommendations to support them.

Prevalence of Mental Health Difficulties Among Counselling Trainees

In addition to the three quantitative studies described above, one mixed methods study also collected quantitative data on the prevalence of mental health difficulties among counselling trainees (Schneider et al., 2021). In terms of prevalence at the time of the study, Schneider et al. (2021) found that over 40% of participants reported clinically significant symptoms of anxiety and almost 25% reported clinically significant symptoms of depression. These rates fall within the range of rates in the quantitative studies reviewed above. In contrast to Hobaica et al. (2021) and Victor et al. (2022a), results in this study showed that age, gender, and racial minority status were not related to depressive or anxiety symptoms (Schneider et al., 2021). Therefore, this study does not support my hypothesis that marginalized groups would

experience more mental health difficulties. Schneider et al. (2021) found that participants who had to work on-site full-time during the beginning of the COVID-19 pandemic experienced significantly more anxiety.

It seems likely that unprecedented events, such as the COVID-19 pandemic, initiate or exacerbate mental health difficulties among counselling trainees. Schneider et al. (2021) found that trainees providing care on-site who felt their health or safety was at risk during the early stages of the pandemic experienced significantly more symptoms of anxiety and depression. About 43% of participants reported feeling unsafe or afraid to complete tasks required by their training program at some point during the pandemic. Some themes that emerged in participant concerns included inadequate protection against risk, experiencing pressure and disregard of their concerns, and unknowingly contributing to the spread of the COVID-19 virus. Findings also revealed that trainees wanted to have more emotional support, to experience better communication with their program, and have flexibility in terms of training and remote work. It is important to note, however, that the majority of trainees reported feeling at least somewhat supported by their programs (Schneider et al., 2021). Schneider et al. (2021) argue that the results show that psychology trainees need increased support during current and future public health crises.

Disclosure

Joseph et al. (2022) surveyed mental health professionals with lived experience about their disclosure experiences while students. Some participants disclosed in order to seek social support from their supervisor or team and to seek accommodations related to their clinical work. Other reasons for disclosure included to attempt to reduce stigma (Joseph et al., 2022). Joseph et al. (2022) note that their findings show that disclosures for trainees were not often related to a reprimand or requirement. It seems that trainees choose to disclose for internally motivated reasons, and not because of concerns noted by others that compel trainees to disclose. The authors also noted that disclosure is a concern for trainees, but it is also a concern for their

supervisors (Joseph et al., 2022). This study was retrospective; therefore, the subjects were no longer trainees but professionals, and more than half of them were supervisors who had received a disclosure from a student. The majority of these participants were interested in knowing more about how others handled trainee disclosure, suggesting that supervisors may not have enough knowledge or experience in navigating disclosures by students (Joseph et al., 2022).

Accessing Mental Health Supports

Along with the quantitative study by Hobaica et al. (2021) discussed above, the mixed methods study by Klein et al. (2022) studied access to mental health supports. Klein et al. (2022) studied clinical psychology graduate students' perception of the availability of mental health resources provided by their graduate program or department. Over 50% of students indicated that there is not a clear way in their program to get information about mental health support that may be available. For those whose programs did provide resources, over 20% of students reported the resources were out-of-date, and nearly 35% indicated that these resources were not affordable (Klein et al., 2022). Similar to the quantitative study by Hobaica et al. (2021), students in this mixed methods study by Klein et al. (2022) reported significant barriers to obtaining mental health support, including concerns about confidentiality, stigma, cost, and lack of time. Participants in this study also reported that stigma related to seeking help for mental health problems within their program was widespread, with multiple students reporting either perceived or explicit stigma perpetuated by students or faculty (Klein et al., 2022).

Qualitative Studies

Dayal et al. (2015) sought to explore the meaning of shame and resilience among counselling trainees with mental health difficulties. Turner et al. (2021) explored the process of self-disclosure of mental health difficulties by counselling trainees. And finally, Wilson et al. (2015) researched students' experience of accessing personal therapy during counselling training.

Stigma

Stigma emerged as a theme in two of these qualitative studies (Turner et al., 2021; Wilson et al., 2015). Stigma was a significant part of the experience of accessing therapy during training for participants in the study by Wilson et al. (2015). As one participant noted, "we're clinical psychologists, we're the experts, we don't need therapy" (p. 38). Participants described concerns about judgment by others, for example, others in their program or even from their personal therapist (Wilson et al., 2015). One participant noted that their program framed personal therapy as professional development, which led to the implied understanding that there might be something wrong with accessing therapy for other reasons (Wilson et al., 2015). Clearly, a significant number of counselling trainees have been impacted by negative social attitudes related to trainees utilizing mental health support. Stigma also impacted trainees' decisions to disclose mental health difficulties. In Turner et al. (2021), some trainees identified internalized stigma as a barrier to disclosure. It is worth noting that this is in contrast to the mixed methods study by Joseph et al. (2022) which found that some practitioners identified destigmatizing mental health difficulties as a reason they *did* disclose as trainees. In both cases, however, those participants were impacted by the experience of stigma and chose to either conceal or reveal their mental health difficulties because of it.

Shame

Shame emerged as a theme in two of the three qualitative studies reviewed (Dayal et al., 2015; Wilson et al., 2015). The study by Wilson et al. (2015) focused on the experience of accessing personal therapy during training. Although the experience of shame was not specifically being studied, nine of the ten participants spontaneously indicated they felt shame about utilizing personal therapy as a trainee. Regarding attending therapy, one participant said, "Oh my god it's so shameful" (Wilson et al., 2015, p. 38). Dayal et al. (2015) specifically sought to investigate shame, therefore their study contains a great deal of qualitative data on the subject.

Dayal et al. (2015) conducted qualitative narrative research to explore the experience of shame and resilience among seven counsellor trainees with historical or current eating issues. The authors found that among this small sample, the experience of shame was significant. As noted above, shame is the feeling that comes from believing one's very self is bad or flawed (Brown, 2006). This definition is echoed by participants in Dayal et al. (2015). One participant described shame as a "negative feeling about who I am . . . [that] revolves around innate parts of myself that I think are bad, wrong, or ineffective" (Dayal et al., 2015, p. 158). Others described shame as "a sense of failure" and a "threat to your sense of self" (Dayal et al., 2015, p. 158). For all participants, shame related to the mental health difficulty itself, in this case, eating issues. Trainees also reported shame regarding their role as a counsellor. Most, but not all, trainees described feeling hypocritical. As one trainee said, "I still haven't figured stuff out. And now I'm trying to help this person" (Dayal et al., 2015, p. 160). Participants who identified as being recovered from their mental health difficulty did not report experiencing hypocrisy.

The experience of shame involved a variety of related feelings, behaviours and experiences for participants, including secrecy, minimizing, perfectionism, avoidance, impression management, and disconnection from self and others (Dayal et al., 2015). Participants reported being concerned with the perceptions of others, including worrying about being judged or misunderstood, appearing weak, and revealing imperfections. One participant shared, "I don't want people to know, because I don't want them to look at me differently" (Dayal et al., 2015, p. 160). The fear of exposure to others in these narratives revealed the social nature of the shame experience (Dayal et al., 2015). Similar fears were expressed by participants in Turner et al. (2021), including feeling anxious about disclosing, worrying that others will think of them differently, and being concerned with appearing weak. One participant described it as follows: "I guess it was kind of embarrassing as well when you feel like you should not have these sorts of problems if you are a trainee clinical psychologist" (Turner et al., 2021, p. 738). In the study by Dayal et al. (2015), participants developed resilience to shame in personal ways, for

example by rejecting perfectionism, choosing authenticity, working on accepting themselves, and developing more realistic goals and ideals. Resilience was also cultivated through connection with others, which will be discussed further below (Dayal et al., 2015).

Disclosure

Two of these three qualitative studies provided information regarding why students might or might not disclose. In Dayal et al. (2015), shame was an important factor that prevented trainees from disclosing to others and seeking help. One participant described shame as "the main issue limiting my disclosure" (p. 158). In Turner et al. (2021), a main reason for disclosure was to access support, specifically to manage active mental health difficulties. As one participant described, "I did not want to stop work, but if I wanted to continue the work, it felt like I'd need to, like be able to go in and talk to someone" (Turner et al., 2021, p. 736). Other reasons for disclosure were ethical considerations and professional duty as well as to influence the narrative around mental health within their program (Turner et al., 2021).

Safety, trust, and the culture of the training program were also important factors impacting disclosure. In Dayal et al. (2015), the majority of participants did not disclose to their supervisors or to faculty. Trainees described a lack of emotional safety in their programs and were reluctant to share about their experiences publicly within their training program (Dayal et al., 2015). However, several participants in this study did report being willing and interested in disclosing if they knew faculty or supervisors also had lived experience. One participant disclosed to her supervisor after the supervisor shared her lived experience first (Dayal et al., 2015). Safety and trust were also identified as enablers of disclosure in Turner et al. (2021). As one participant noted, "trust in my supervisor, that they would be helpful that they would be accepting, that they care, that they would not be dismissive or they would not be concerned, was obviously a big thing" (Turner et al., 2021, p. 737). Trainees in Turner et al. (2021) noted that lived experience was not discussed in their programs and without a model for this, it was unclear whether or not it was acceptable. One participant reported, "I know other people having

similar difficulties that are part of psychology but, we do not really talk about it" (Turner et al., 2021, p. 738). These findings connect to the quantitative study by Grice et al. (2018), which found that trainees anticipated being more likely to disclose to friends and family than to supervisors and peers in their program.

Findings in Turner et al. (2022) also provide insights into what was helpful for trainees when disclosing. One theme was listening with openness and acceptance rather than rushing to fix things, assess risk, and come up with solutions (Turner et al., 2022). Being heard first and discussing solutions later was supportive. Asking questions and being curious about the trainees' experience and perspective was also identified as being helpful (Turner et al., 2022). Having a supportive response made it easier to disclose in the future (Turner et al., 2022).

Connecting to Others

Connecting with others with lived experience was a theme in two studies. In Dayal et al. (2015), connecting with others with similar experiences cultivated a feeling of belonging and reduced feelings of shame. One participant noted that this type of connection "brought comfort [and] made it okay to feel this way, because someone else gets me" while another said, "I don't feel shame when I'm talking to someone that I feel really understands" (Dayal et al., 2015, p. 160). Disclosing to others sometimes deepened the relationship with the respondent, helped to build trust, and created opportunities to form connections with others with similar experiences (Turner et al., 2021). As one participant noted, "I think opening that up as a conversation has meant other people have opened up to me in return" (Turner et al., 2021, p. 739). Connecting to others, whether inside or outside of their program, was meaningful for some trainees with mental health difficulties.

Accessing Mental Health Supports

As reviewed above, one quantitative study (Hobaica et al., 2021) and one mixed methods study (Klein et al., 2022) researched accessing mental health supports. One qualitative study investigated this as well. Wilson et al. (2015) studied the first-person experience of accessing

support, specifically, individual therapy. Wilson et al. (2015) conducted research on the experiences of ten clinical psychologists who used personal therapy during their training. For six of these trainees, their training itself was the trigger for seeking personal therapy. One participant noted that training involved "being stretched and being a bit more vulnerable to, to your weaknesses, because you're being scrutinised and… assessed" (Wilson et al., 2015, p. 37). Benefits of personal therapy shared by participants included support with the stress of training, assisting with personal development, increasing emotional resilience, and being able to empathize with the client role (Wilson et al., 2015). One participant said that "the more open we can be to ourselves, the more of ourselves there will be to bring into the room, and therefore the greater our capacity will be to imagine others' distress" (Wilson et al., 2015, p. 40). Another referred to the responsibility of being a competent therapist, saying "we owe it to the patients to have been able to at least know our own weaknesses or vulnerabilities and not put them on them" (Wilson et al., 2015, p. 40). Some negative impacts were also noted, including worsening mood and sleep and the danger of uncovering a great deal of emotional material without time to resolve it. All participants in the study reported that their experience in therapy had a positive influence on both themselves and on their professional practice (Wilson et al., 2015).

Recommendations

Several clusters of recommendations emerged among these ten studies. Most recommendations relate to changes at the macro level, i.e., recommendations for the profession and for training programs, while some recommendations apply to individual trainees. Macro-level recommendations include addressing stigma within the profession, supporting disclosures by trainees, increasing the availability of supports for trainees, increasing transparency about how mental health difficulties are handled within programs, and promoting diversity including lived experience.

Wilson et al. (2015) note that the experience of shame among their participants reflects broader stigma about mental health difficulties in the profession that still needs to be addressed.

Implications identified by the authors include the need for more explicit and open dialogue about struggles and support in training programs and the valuable personal and professional role that therapy can play for trainees. Grice et al. (2018) concur, writing that minimizing the importance of mental health among trainees may contribute to secrecy in the profession. Grice et al. (2018) note that mental health professionals disclosing mental health difficulties may serve to normalize these challenges and help reduce stigma. Self-disclosure of lived experiences by faculty might help with reducing stigma, as well as creating opportunities for supervisors and faculty to openly discuss self-care and mental health treatment (Klein et al., 2022).

Opportunities for peer connection and support within programs could also be considered. Dayal et al. (2015) recommend that programs develop opportunities for trainees to build community within their programs to promote safety and connection around these issues. Turner et al. (2021) echo this call, arguing that programs should consider how to create environments for trainees to safely discuss their lived experiences. This might take the form of peer-led groups, reflective practice, and supervision to specifically address this (Turner et al., 2021). Programs should also contemplate incorporating discussions of lived experience into the educational curriculum, with participation of course being voluntary (Turner et al., 2021).

Dayal et al. (2015) emphasize that further research should explore how practices might be improved to create safety around disclosure. Students may be more likely to disclose if they are clear on the possible outcomes of disclosure. Some participants in Turner et al. (2021) reported being concerned with having to stop their training if they disclosed, therefore being transparent with students about the connection between lived experience and ethical guidelines about fitness to practice would be helpful. Another avenue for bolstering safety around disclosure is equipping supervisors and faculty with the tools they need to respond. As Joseph et al. (2022) write, their findings highlight a need for resources for supervisors related to trainee disclosure. Compiling and distributing stories of navigating trainee disclosure could be an important resource for supervisors with and without lived experience (Joseph et al., 2022). It

may also help to normalize lived experience and reduce stigma among both trainees and supervisors (Joseph et al., 2022). The model developed by Turner et al. (2021) offers a possible blueprint for disclosure that could be considered by both supervisors and trainees to approach lived experience conversations. Their grounded-theory model includes motivations, barriers, and enablers—all of which contributed to whether disclosure occurred. The model also includes features of, responses to, and impact of disclosure.

Increasing availability of supports and reducing barriers to access was another recommendation. This could involve providing resource lists to students (Klein et al., 2022), including telehealth options (Klein et al., 2022), addressing financial barriers (Hobaica et al., 2021; Klein et al., 2022), addressing issues of dual-relationships and confidentiality (Hobaica et al., 2021; Klein et al., 2022), and taking active steps to reduce the stigma of help-seeking (Klein et al., 2022). In the case of global health crises, Schneider et al. (2021) recommend initiating open discussions with trainees to gauge their needs, concerns, and level of wellbeing. They also recommend being flexible with training and educational requirements, including providing options for telehealth, and promoting emotional support and self-care for trainees.

Several studies provide insight into the types of individualized mental health supports that could assist counselling trainees with mental health difficulties. Because they found that internal shame and self-criticism were significant predictors of mental health problems, Kotera et al. (2021) recommend self-compassion interventions to ameliorate student mental health difficulties. Grice et al. (2018) found that maladaptive perfectionism was consistently negatively associated with likelihood of disclosure, therefore it is possible that interventions to target perfectionism would also be helpful for this population.

Finally, several authors provided recommendations around diversity. Victor et al. (2022a) argue that lived experience among clinical psychologists should be discussed as a matter of diversity and inclusion. The profession should advocate for the inclusion of those with lived experience as a matter of justice and equity, much the same as other types of diversity such

as race, ethnicity, gender, and sexual orientation (Victor et al., 2022a). Furthermore, because LGBTQ+ and ethnic minority students reported higher rates of mental health concerns, Hobaica et al. (2021) argue that programs should assess their culture with respect to diversity and treatment of minority students and cultivate affirming and inclusive environments.

Summary of Findings

The research question, "What is the experience of counselling trainees with mental health difficulties?" was explored by analyzing ten research articles. Findings from the quantitative sub-question, "What is the prevalence of mental health difficulties among counselling trainees?" were discussed above under quantitative findings.

Findings indicated that counselling trainees perceived stigma in relation to their identity as a counselling trainee with mental health difficulties (Wilson et al., 2015) and also in relation to seeking or using mental health supports (Klein et al., 2022; Hobaica et al., 2021; Wilson et al., 2015). Shame was experienced by participants in relation to being a trainee with mental health difficulties (Dayal et al., 2015; Kotera et al., 2021) and receiving mental health support was also experienced as shameful (Wilson et al., 2015). Counselling trainees with mental health difficulties are faced with the decision of whether or not to disclose. Shame was a significant factor that contributed to a lack of disclosure for some trainees (Dayal et al., 2015), while perceiving safety and trust helped some trainees to disclose (Dayal et al., 2015; Turner et al., 2021). Seeking support and accommodations from their program was one of the most common reasons trainees disclosed (Joseph et al., 2022; Turner et al., 2021), however, the majority of supervisors in one study had inadequate training on responding to disclosure (Joseph et al., 2022).

Connecting with others with lived experience was important for some trainees (Dayal et al., 2015; Turner et al., 2021). Access to formal mental health supports is lacking for this population, and significant barriers include time, finances, stigma, and lack of confidentiality (Hobaica et al., 2021; Klein et al., 2022). Most of the recommendations provided by these ten

studies relate to changes that should be made within training programs, including addressing stigma, supporting disclosures, and increasing the availability of supports for trainees (Dayal et al., 2015; Hobaica et al., 2021; Joseph et al., 2022; Klein et al., 2022; Turner et al., 2021; Victor et al., 2022a).

Ethics

A variety of ethical issues are relevant to this study. In the area of professional practice, ethical issues include responsible caring and the duty to report. In terms of research ethics, issues include informed consent, incomplete disclosure and deception, privacy and confidentiality, ethical committee approval, and conflict of interest.

Professional Ethics

Counsellors and clinical psychologists belong to professional associations that guide their practice. This study includes research about counsellors and trainees from Canada, the United States, the United Kingdom, and Australia; each of these countries has their own professional associations and sets of ethical guidelines. Because I reside in Alberta, Canada, I will be focusing on two professional associations, the Canadian Psychological Association and the College of Alberta Psychologists, and their ethical guidelines, the *Canadian Code of Ethics for Psychologists* (CPA, 2017) and the *Standards of Practice* (CAP, 2019).

Responsible Caring

The *Code of Ethics* (CPA, 2017) emphasizes that psychologists should protect the wellbeing of their primary clients and avoid doing them harm. This broad ethical aim involves a variety of factors, including seeking out support and/or ceasing practice if one's abilities are compromised due to physical or psychological reasons (CPA, 2017). Practitioners should also engage in appropriate self-care to avoid impairment that could harm their clients (CPA, 2017). The *Standards of Practice* (CAP, 2019) also emphasizes that practitioners must maintain their competence, including discontinuing their professional activities if their judgment is impaired because of psychological factors. The results of this study show that stigma and shame decrease

trainees' willingness to disclose mental health difficulties and access supports. Therefore, addressing stigma in the profession is critical to support trainees in carrying out their duty to provide responsible care, should they be impaired by mental health difficulties. Trainees should also be aware of their ethical duty to provide competent care and assess their own level of wellbeing regularly.

Duty to Report

Ethical guidelines also stipulate that practitioners have a duty to report a colleague to their professional body if they believe that person is experiencing an impairment—i.e., mental, emotional, or physical—that puts clients at risk (CAP, 2019). The *Code of Ethics* (CPA, 2017), however, provides additional detail regarding how such concerns might be addressed. The *Code of Ethics* (CPA, 2017) indicates that if the harm is not serious, a colleague may choose to speak informally with the person, obtain additional objective information, and determine in what way the harm will cease. As discussed in other areas of this study, there are many indications that a culture of secrecy around practitioner lived experience exists within the counselling and psychology profession. The silence around discussing lived experience, as well as related stigma, complicate the ethical duty to report. Suggestions that will be discussed below in clinical applications include that training programs create guidelines around disclosure and provide disclosure resources to both trainees and supervisors. Equipping trainees and supervisors with the tools they need to discuss lived experience and its potential—but not inevitable—impact on practice will help facilitate the realization of these ethical principles.

Research Ethics

Research in Canada is guided by the *Tri-Council Policy Statement* (Canadian Institutes of Health Research et al., 2018). The *Canadian Code of Ethics for Psychologists* (CPA, 2017) also contains ethical guidelines for conducting psychological research.

Informed Consent

Both the *Code of Ethics* (CPA, 2017) and the *Tri-Council Policy Statement* (CIHR et al., 2018) emphasize the importance of informed consent in research, specifically that consent is an ongoing process and can be withdrawn at any time, research participants should be made fully aware of the risks and benefits of participating, consent should be thoroughly documented, and consent should not be coerced or unduly rewarded. Some studies provided no incentives for research participation (Dayal et al., 2015; Klein et al., 2022; Kotera et al., 2021) and some provided small incentives, for example, being entered to win a raffle for a $25 or $50 gift card (Hobaica et al., 2021; Victor et al., 2022a). Half of the studies reviewed did not mention incentives at all (Grice et al., 2018; Joseph et al., 2022; Schneider et al., 2021; Turner et al., 2021; Wilson et al., 2015).

Most of the studies only briefly indicated that they obtained consent (Dayal et al., 2015; Hobaica et al., 2021; Kotera et al., 2021; Victor et al., 2022a; Wilson et al., 2015). Some did not discuss consent at all (Grice et al., 2018; Joseph et al., 2022). Schneider et al. (2021) provided more detail than others about their consent documents, noting that their forms described the anonymous and voluntary nature of their study, the purpose, the risks and benefits, and confidentiality. Turner et al. (2021) described the most robust consent process. They explained that a qualified clinical psychologist who also had experience with disclosing lived experience during training provided feedback on the study consent form and adjustments were made accordingly (Turner et al., 2021). Their participants received the consent form as part of recruitment communication, and researchers also verbally reviewed consent with participants before commencing their qualitative interviews (Turner et al., 2021).

Several studies had additional strengths related to informed consent and participant wellness. Schneider et al. (2021) and Victor et al. (2022a) specifically noted that students were able to skip any survey questions. Kotera et al. (2021) noted that they provided participants with information about mental health supports should they feel distressed following the study. Turner et al. (2021) assessed participant wellbeing after the interviews, both by asking verbally

and by administering a brief wellness instrument. They also noted sending a debrief document to their participants (Turner et al., 2021).

Incomplete Disclosure and Deception

Partial disclosure or deception in research is sometimes necessary. The *Code of Ethics* (CPA, 2017) cautions researchers to use the minimum amount of deception possible and to not use deception if there are alternative methods available. Researchers should also thoroughly debrief participants as soon as possible after deception is used (CPA, 2017). One study described using incomplete disclosure. To mitigate the risk of volunteer bias, Victor et al. (2022a) indicated in their recruitment materials and consent form that the study was about trainees' "research and clinical interests" (p. 4); they did not mention they would be asking about personal experience of mental health difficulties. While in this case, the purpose of incomplete disclosure is important, i.e., reducing bias in research, it is perhaps ethically questionable to not be transparent on the consent form. The authors did not describe if or how they debriefed participants after the study to explain this incomplete disclosure. Their study was, however, approved by the relevant ethical review board.

Privacy and Confidentiality

The data provided by research subjects must also be kept private and confidential, using practices such as protecting it from unauthorized access, collecting only information relevant to the purpose of research, and obscuring identifying information (CIHR et al., 2018; CPA, 2017). It is important to note that mental health difficulties are stigmatized (Corrigan & Bink, 2016), therefore protecting this research data is critically important. Some studies reviewed collected data about participants' mental health status (e.g., Grice et al., 2018; Hobaica et al., 2021; Victor et al., 2022a), which if revealed could have serious negative impacts for those individuals personally and professionally. Grice et al. (2018) and Klein et al. (2022) noted that they did not collect participants' demographic information to preserve their anonymity. For example, if data collected on mental health difficulties were broken down by race/ethnicity and there were only a

small minority of racially marginalized individuals in the sample, these individuals may be identifiable and therefore personal information about them compromised.

Turner et al. (2021) were the only researchers to describe how their research data was protected. This is a significant omission by all of the other studies, especially due to the sensitive nature of the data collected, as noted above. Turner et al. (2021) outline their procedure as follows: raw data was stored separately from identifiable participant information, password protection was used for electronic data, locked storage was utilized for hard copies of data, gender-neutral pseudonyms were assigned to participants, and identifiable information was redacted from audio recordings as they were transcribed. This a robust practice of data protection that all studies would do well to emulate.

Committee Approval

Researchers should seek out ethical review and approval for their activities from the relevant ethics board (CIHR et al., 2018; CPA, 2017). Eight of the ten studies reviewed indicated that they had received the necessary research ethics board approval (Dayal et al., 2015; Hobaica et al., 2021; Wilson et al., 2015; Kotera et al., 2021; Schneider et al., 2021; Grice et al., 2018; Victor et al., 2022a; Turner et al., 2021). One did not mention ethical review (Joseph et al., 2022). Finally, Klein et al. (2022) noted that because their anonymous survey was sent to student members of a professional organization, and the survey was regarding how programming could be developed for that same organization, informed consent and ethical approval were not required.

Conflict of Interest and Dual Relationships

The *Code of Ethics* advises researchers to avoid dual relationships with participants if there are reasonable alternatives (CPA, 2017). If dual relationships do exist, these should be managed so that risk of harm, bias, and lack of objectivity are minimized (CPA, 2017). Dayal et al. (2015) conducted qualitative research involving researchers directly interviewing participants. They noted that they excluded students from the researchers' home institutions to

avoid dual relationships with participants (Dayal et al., 2015). Researchers must also disclose conflict of interest in terms of any sources of funding that might bias their results (CIHR et al., 2018). None of the studies disclosed a conflict of interest, financial or otherwise.

Clinical Applications

Critical disability theorists are not solely academics, but also activists working to create justice in society for people with minds and bodies that are stigmatized (Minich, 2016, as cited in Hall, 2019). Thus, critical disability theory is also social justice work (Hall, 2019). It asks how disability is socially and politically constructed and seeks to emancipate subjects from oppressive forces (Hall, 2019). Many of the clinical applications described below can be understood as methods to begin to emancipate counsellors and trainees from the oppressive forces of sanism that they encounter in the profession. Because this study is informed by critical disability theory, particular attention will be paid to how individuals with mental health difficulties can be included and supported in the field as a matter of equity and social justice.

It is also important to note that issues of stigma, shame, and inclusion apply more broadly than mental health difficulties. As Zerubavel and Wright (2012) note in their discussion of wounded healers, woundedness might result not only from mental health difficulties, but also traumatic life experiences, physical health problems, and discrimination on the basis of one's marginalized racial, religious, gender, or sexual minority identity. Therefore, some of the clinical applications below, including those around shame, connection, and culture change, could apply to a variety of types of wounding.

Personal Practice

As noted above, counselling trainees are susceptible to elevated levels of stress irrespective of whether or not they have mental health difficulties. Furthermore, mental wellbeing is on a continuum (Mental Health Commission of Canada, 2018). For counselling trainees, mental health difficulties could be pre-existing, could arise during or be exacerbated by training, and could be intensified by unexpected factors such as a global pandemic. Applications

discussed below might be of benefit to trainees more generally, including those without lived experience who have peers with mental health difficulties. Several clinical applications for personal practice that flow from this study are detailed below. These include accessing individual supports, making decisions about disclosure, developing shame resilience, connecting to others, and resisting stigma.

Findings from this study revealed that cost, lack of time, stigma, and issues of confidentiality are all potential barriers to counselling trainees being able to access individual mental health supports (Dearing et al., 2005; Hobaica et al., 2021; Klein et al., 2022). However, if these avenues are available, several suggestions emerged from the literature. Corrigan et al. (2013) note that on the individual level, cognitive behavioural therapy, acceptance and commitment therapy, and narrative therapy have all been used to address self-stigma. Kotera et al. (2021) recommend the use of self-compassion interventions, as their findings indicated that both self-criticism and internal shame predicted mental health difficulties.

Counselling trainees with mental health difficulties might consult a model of disclosure such as the one in Turner et al. (2021) to consider all facets of disclosure, including motivations, barriers, possible responses, and impact. It might also be helpful for trainees to gain insight about their current experience of mental health difficulties and level of functioning, using models such as the mental health continuum (Mental Health Commission of Canada, 2018) and the recovery trajectories model (Zerubavel & Wright, 2012), where functioning ranges from optimal to impaired. Victor et al. (2022b) describe a disclosure model that involves four steps: determining one's desired outcomes of disclosure; carefully consider the disclosure logistics, i.e., who, where, what, when, how; anticipate a range of responses from the recipient; and seek out support and engage in self-care.

Counselling trainees can experience shame, regardless of whether they experience mental health difficulties. In a grounded theory study by Kannan and Levitt (2015) on self-criticism in therapist training, most trainees reported feeling shame regarding their perceived

level of competence. Fears about being viewed as incompetent led some trainees to hide their insecurities and were reluctant to be their true selves in supervision (Kannan & Levitt, 2015). Trainees, irrespective of lived experience, might benefit from developing an awareness of what shame is, how it might impact them in their training, and how to develop shame resilience.

As discussed above, Brown (2006) conducted grounded theory research to develop shame resilience theory. In Brown's (2006) study, 215 women were interviewed about their experiences of shame and how they combat shame—i.e., develop shame resilience. In Brown's (2006) theory, shame resilience emerged as a continuum made up of four skills: acknowledging personal vulnerability to shame, having critical awareness of shame, reaching out to others, and speaking shame. Being unaware of one's shame triggers can lead to being overwhelmed with emotion and uncertain as to what they are feeling and why (Brown, 2006). As shame can be related to unrealistic societal expectations and critical messages, consciousness-raising about shame is also helpful for contextualizing and deconstructing shame (Brown, 2006). Reaching out to others about shame experiences allows one to experience empathy—both giving and receiving—and reduces the isolation that shame promotes (Brown, 2006). Indeed, research of counsellor trainees with mental health difficulties found that connection with others was a key aspect in overcoming shame (Dayal et al., 2015).

Several authors indicate that connecting with others in the form of peer support, lived experience groups, or having a buddy system can help counsellors with mental health difficulties (Boyd et al., 2016; Harris et al., 2016; Rummell, 2015; Vierthaler & Elliott, 2022). Vierthaler and Elliott (2022) discuss the practice of having a "battle buddy"—a relationship in which peers in the field can partner with each other, care for and attend to one another's wellbeing, and also intervene if called for.

Because research shows that counsellors are exposed to stigmatizing messages about mental health while in the profession (Devendorf, 2022; Elliott & Ragsdale, 2020; Tay et al., 2018; Victor et al., 2022c), one might consider resisting stigma on an individual level, for

example, by naming sanism and stigma where one encounters it. Of course, there may be consequences for this, particularly for students inhabiting multiple marginalized identities. Furthermore, as this study is informed by critical disability theory, the onus should not be solely on the individual to effect such changes.

Professional Applications

Professional applications that flow from this study include emphasizing a recovery model of care in training, creating guidelines for addressing mental health difficulties, promoting shame resilience, encouraging professional peer support, and fostering diversity and inclusion in the profession.

Several authors reviewed as part of this study discussed promoting recovery-oriented care in the psychology and counselling profession (Boyd et al., 2016; Byrne et al., 2022; Harris et al., 2016; Harris et al., 2019; Koch, 2022). Recovery-oriented care views recovery as a process that is lifelong and includes remissions as a normal part of the process (Koch, 2022). Each person can and should chooses their own unique path to recovery (Koch, 2022). In this model, receiving support from others is part of recovery and getting professional support is not a weakness but a sign of strength (Koch, 2022). According to Harris et al. (2016), the recovery-oriented care model "recognizes lived experience of a mental health challenge as a potential asset and frames recovery as an achievement and source of pride" (p. 605). Promoting this model in counsellor training would assist trainees, as well as supervisors and instructors, to maintain hope in practitioners' abilities to overcome mental health difficulties that interfere with their functioning and be successful in their chosen career.

In addition to promoting the recovery-oriented care model, training programs could also create guidelines around disclosure, promote shame resilience, and foster peer support. Zamir et al. (2022) note that workplaces should be supported in creating guidance and structures that facilitate disclosures if desired by the disclosing individual. Guidelines should be developed by training programs to provide guidance to both trainees and supervisors about navigating the

process of disclosure, and ensuring all parties are clear about the professional consequences of disclosure. Programs might also consider implementing training that addresses shame and shame resilience. For example, Bynum et al. (2019) delivered a two-and-a-half-hour shame resilience seminar for medical students. The results of the pre/post survey that was implemented immediately following the seminar showed a statistically significant increase in student's self-reported ability to distinguish shame from guilt, recognize shame in themselves and others, and recover from a shame reaction (Bynum et al., 2019). As a number of authors acknowledge the importance of peer support for counsellors or trainees with mental health difficulties (Boyd et al., 2016; Harris et al., 2016; Rummell, 2015; Vierthaler & Elliott, 2022), programs could encourage the formation of support groups for graduate students to facilitate peer support among trainees (Rummell, 2015).

Finally, the findings of this study clearly indicate that counselling programs and the profession at large must consider addressing mental health stigma and promote greater diversity and inclusion. Writing about mental health practitioners with mental health difficulties, Victor et al. (2022a) state, "The common nature of these experiences… underscores the need to finally root out outmoded stigmatizing and silencing views toward mental disorders within psychological science" (p. 12). There are some ideas from the literature about how this might be accomplished. Several authors discuss the possibility of experienced and established practitioners being more open about their own mental health struggles (Harris et al., 2016; Victor er al., 2022c; Zerubavel & Wright, 2012). Victor et al. (2022b) provide a detailed breakdown of ways to foster the professional inclusion of psychologists with lived experience of non-suicidal self-injury; their recommendations could apply to other types of mental health difficulties as well. Their list, which includes recommendations for those with lived experiences as well as those without, includes avoiding using language that separates people with mental illness from counselling or psychology professionals; creating diversity, equity, and inclusion statements; and promoting mentoring and allyship programs (Victor et al., 2022b). Professional

programs and organizations could also support the election or appointment of psychologists and counsellors who are open about their lived experience to positions of leadership (Victor et al., 2022b).

Victor et al. (2022a) note that consideration for how individuals with mental health difficulties may be excluded from the profession of applied psychology is lacking. The profession must grapple with this, as well as inclusion of those with other and multiple marginalized identities. For example, in their meta-analysis of studies of mental health professionals disclosing psychological distress in the workplace, Zamir et al. (2022) found a lack of discussion of how mental health stigma intersects with other forms of marginalization such as race, class, and gender. Whitten (2022), an African American psychology professor with lived experience of bipolar disorder, points out that almost no African American professionals have come forward about their mental health difficulties—in the field of psychology or otherwise. Of the ten core studies reviewed, several did not collect robust demographic information (e.g., Grice et al., 2018; Klein et al., 2022), and for those who did, sample sizes were too small to gain insights about multiply marginalized groups (e.g., Hobaica et al., 2021). Intersectionality emphasizes that "people do not neatly sort into individualized stigmatized conditions" (Corrigan et al., 2018, p. 827). Therefore, a queer counselling student with mental health difficulties would not necessarily have the same experience of a straight counselling student with mental health difficulties with the addition of queerness. Intersectionality means that our identities and experiences are not merely additive (Corrigan et al., 2018); therefore, the results of this study are limited in their application to, and elucidation of, the experience of those inhabiting multiple marginalized identities.

Applications to Wider Society

The findings from this study have several applications to wider society. Reduced trainee wellbeing has implications for the service they are able to provide to clients (El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012; Schneider et al., 2021). Having healthy helpers has

direct and potentially significant positive impacts for the members of society whom they serve. Also, efforts to reduce stigma among those in the psychology and counselling profession with lived experience would also serve to reduce mental illness stigma among the general population. As Victor et al. (2022a) and Harris et al. (2016) argue, silence and secrecy within the profession about practitioners with mental health difficulties may ironically end up contributing to mental health stigma—which the field of psychology aims to reduce.

Conclusion and Future Research

This study sought to answer the research question, "What is the experience of counselling trainees with mental health difficulties?" Ten research articles were reviewed, and findings show that mental health stigma is a common occurrence, related feelings of shame might be experienced, disclosure is a fraught and complex process, and accessing mental health supports can be challenging. Clinical applications that flow from this study include: confronting and resisting sanism and mental health stigma in the profession, for example, by "coming out" about lived experience, recognizing the significant professional contributions of prosumers, and developing mentorship/allyship programs; promoting shame resilience among counselling trainees; facilitating opportunities for connection, for example, forming peers support groups for trainees; developing disclosure guidelines and resources for training programs; and improving trainee access to mental health supports.

A critical gap that remains in research is how to address mental health difficulties in clinical supervision and training (Victor et al., 2022a). This study highlighted the lack of openness and transparency around practitioner lived experience that exists for both trainees and their supervisors. According to Elliott and Ragsdale (2020), there is little research regarding the experience of caring for others with mental illness while experiencing mental illness oneself. Do mental health difficulties always impact practice? And if so, in what ways and to what extent? Does lived experience provide the practitioner with valuable insights and abilities that benefit their clients? And importantly, to what degree do stigma and shame exacerbate mental

health difficulties? These are fruitful avenues for further exploration. I will conclude this study with the following research questions related to gaps noted by Victor et al. (2022a):

1. How do experiences of mental health problems impact clinical work?
2. How should we address mental health difficulties in clinical supervision and training?
3. What are the experiences of counselling trainees with mental health difficulties that also inhabit other marginalized identities, such as BIPOC, queer, and physically disabled trainees?
4. What strategies can we employ at both micro and macro levels to bolster equity and inclusion of those with mental health difficulties?

Finally, to current counselling trainees and those considering joining them, attend to these words from Varghese & Boyd (2022): “We hope that trainees with a lived experience of mental health challenges will find encouragement to join our field, and that their mentors will find wisdom to support them” (p. 2).

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Appendix

Table 1: Summary of Research Articles

Authors	Title	Year	Research Method
Dayal, H., Weaver, K., & Domene, J. F.	From shame to shame resilience: Narratives of counselor trainees with eating issues.	2015	Qualitative
Grice, T., Alcock, K., & Scior, K.	Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism.	2018	Quantitative
Hobaica, S., Szkody, E., Owens, S. A., Boland, J. K., Washburn, J. J., & Bell, D. J.	Mental health concerns and barriers to care among future clinical psychologists.	2021	Quantitative
Joseph, K. M., Barnes, T., Harris, J. I., & Boyd, J.	Disclosure of lived experience of mental illness in training: Reasons for disclosure.	2022	Mixed Methods
Klein, A. B., Barnes Horowitz, N. M., Tran, I., Rabasco, A., Steele, E. H., & Breaux, R.	Perceived barriers to seeking mental health treatment among clinical psychology graduate students.	2022	Mixed Methods
Kotera, Y., Green, P., & Sheffield, D.	Mental health of therapeutic students: Relationships with attitudes, self-criticism, self-compassion, and caregiver identity.	2021	Quantitative
Schneider, M. B., Greif, T. R., Galsky, A. P., Gomez, D., Anderson, C., Edwards, D. S., Cherry, A. S., & Mehari, K.	Giving psychology trainees a voice during the COVID-19 pandemic: Trainee mental health, perceived safety, and support.	2021	Mixed Methods
Turner, K., Moses, J., & Neal, A.	'I think it does just opens it up and… you're not hiding it anymore': Trainee clinical psychologists' experiences of self-disclosing mental health difficulties.	2021	Qualitative
Victor, S. E., Devendorf A. R., Lewis, S. P., Rottenberg, J., Muehlenkamp, J. J., & Stage, D. L., Miller, R. H.	Only human: Mental health difficulties among clinical, counselling, and school psychology faculty and trainees.	2022	Quantitative
Wilson, Weatherhead, S., & Davies, J.	Clinical psychologists' experiences of accessing personal therapy during training: A narrative analysis.	2015	Qualitative