Exploring the experiences of trainee clinical psychologists who identify as living with a disability: A qualitative study

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ABSTRACT

People with disabilities continue to be underrepresented within the profession of clinical psychology, with attrition rates thought to be one factor contributing to this. There is a striking lack of literature regarding the experiences of disabled trainee psychologists, with the research that does exist indicating that disabled trainees encounter numerous challenges including structural inequalities and discrimination. However, no studies to date have considered the in-depth experiences of disabled trainees. This research aimed to qualitatively explore the lived experience of disabled trainees through the use of semi-structured interviews with six trainee clinical psychologists who self-identified as disabled. Transcripts were analysed using Interpretative Phenomenological Analysis, following which three superordinate themes were developed: ""Everyday Battles", "Identity" and "Silence and Speaking". These themes spoke to the numerous challenges described by participants, many of which arose from a system which appeared to be aimed at those in healthy bodies. Participants frequently made sense of their experiences by drawing on dominant narratives surrounding disability and situated their experiences within the wider sociocultural context. Findings are discussed in relation to existing literature and a number of recommendations are offered for future research and clinical practice.

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As participants may discuss difficult experiences, it is possible that they may become distressed during the interview. Participants will be informed prior to the interview that they are able to

PREFACE

I am a 29-year-old White British female with experience of working with people with physical and learning disabilities (PwD), leading to increased awareness of issues including attitudes towards disability and power imbalances. Furthermore, I live with epilepsy and subsequently have personal experiences with disability. The fluctuating nature of my condition resulted in increased visibility of this at times and, combined with the self-reflection emphasised within training, triggered an exploration of my relationship with disability whilst simultaneously developing my identity as a trainee clinical psychologist (TCP). The lack of literature in this area reflected my experience that disability is not widely spoken about, leading me to consider this as a thesis topic.

Given my proximity to the research, I have brought in first person throughout this thesis. Writing in the third person using only academic language and discounting my own voice would involve separating myself from the issues under discussion. I have experienced strong views and emotions throughout the research and presenting a false disconnection from this would feel untruthful to my role within this and my developing identity. I hope utilising the first person will demonstrate the two-way process between emotions and research, in which emotions play a role in conduction of research (Brannan, 2014) and the research itself carries an emotional impact which changes the researcher (Bell & Shoaib, 2014).

1. INTRODUCTION

This chapter provides an overview of the topic and is composed of two sections. Part one comprises a narrative review generated from reading key articles and books, covering issues including models of disability, prevalence, legislation, ableism, the psycho-emotional experience of disability and identity. Part two involves a more systematic approach focused towards disability within psychology, highlighting themes of neglect and discrimination. It will be argued that further research is needed to develop our understanding of the experience of being a disabled trainee and a rationale for this study is provided.

1.1 Understanding "Disability"

1.1.1 Terminology

The term "disability" carries various understandings, often originating from contrasting epistemological positions (Smart & Smart, 2006). A person is legally considered disabled if they have a long-term impairment which substantially impacts their ability to complete daily activities (Equality Act, 2010). However, this fails to consider the role of identity. Indeed, many people have an impairment which affects their functioning but do not consider themselves disabled (Olkin, 2001).

The language of disability is similarly fraught with debate. The psychology profession encourages person-first language (e.g. PwD) , suggesting this acknowledges disability as a single, non-defining aspect of a person (e.g. American Psychological Association [APA], 2012). It also moves away from implying that the personhood itself is "disabled" (Olkin, 2001). However, within the disability community there has been growing movement towards an identity-first position in which the disability or impairment is given focus (e.g. disabled person). Dunn and Andrews (2015) argue that psychologists should utilise identify-first language as it enables people to claim disability as a point of pride, but acknowledge that people may differ in their willingness to adopt this language depending on their disability identity.

In light of this, I will use a combination of person-first and identity-first language in order to acknowledge these multiple perspectives (Dunn & Andrews, 2015).

<u>1.1.2 Models of disability</u>

1.1.2.1 Medical model: The traditional and prevailing approach to disability is the medical model, which views disability as a physiologically determined state wherein a "condition" leads to functional limitations. Disabilities are therefore viewed as a deficits located within individuals (Mallett & Runswick-Cole, 2014). This has implications for the ways society responds, including attitudes and the organisation of services (Twena, 2008).

1.1.2.2 Social model: The medical model has been challenged by the social model of disability (Oliver, 1990) which locates the "problem" of disability within society and the barriers which disable people. These incorporate economic, material and social barriers, including attitudes. The aim is therefore to expose and remove these barriers, in addition to facilitating the sharing of power between those currently holding it and PwD. The social model therefore recasts disability as a form of oppression (Goodley, 2014).

Whilst the social model has significantly contributed to the disability movement (Shakespeare, 2006), its implementation in practice has been limited and slow to influence societal structures. This is perhaps unsurprising, as barrier removal alone is not sufficient to challenge cultural values and attitudes (Oliver, 2004). Furthermore, the social model has been criticised for focusing on public experience of oppressions (e.g. inaccessible transport) at the expense of personal experiences (relating to emotion) (Thomas, 1999), in addition to neglecting intersectionality (Mallett & Runswick-Cole, 2014).

1.1.2.3 Critical approaches to disability: The above models can be criticised for their failure to acknowledge that disability is a "complex interaction of biological, psychological, cultural and socio-political factors" (Shakespeare, 2014, p. 26). These include interactions between media presentations, (Mallett & Runswick-Cole, 2014),

diagnosis by those with power, self-identity and actions of others. Furthermore, disability is used to describe numerous experiences including sensory and mobility difficulties, health conditions, learning disabilities and mental health difficulties. However, the models outlined above assume that PwD are a homogenous group who share characteristics and experiences (Abberley, 1996; Rapley, 2004). Similarly, the concept of disability has been criticised for categorising people into a simplistic dichotomy of those who "are and are not", wherein disability is viewed as a permanent state as opposed to recognising its often fluctuating nature (Barnartt, 2010). It is important to acknowledge that these categorisations are loaded with differential value (Atkins & Marston, 1999) and do not exist outside of, and cannot be separated from, issues of power (Foucault, 1978).

Critical Disability Theory (CDT) is a political movement and developing framework for the study of disability issues which attends to context, power and oppression. It is not possible to fully discuss CDT within the scope of this thesis. However, it postulates that disability is a social construct best understood as the result of interactions between impairment, individual responses and the environment, with the latter factors causing the social disadvantage experienced by disabled people (Hosking, 2008).

1.1.3 Prevalence Rate

It is difficult to determine precise prevalence rates of disability given the varying definitions and methodologies used, which can be partially understood as a product of the opposing approaches outlined above, and "… underscore the fluidity of the disability concept" (Fujiura & Rutkowski-Kmitta, 2001, p. 69). Nevertheless, an estimated 11.9 million people live with a disability in the UK, incorporating 19% of the population (Department for Work and Pensions, 2014) and PwD have been termed the largest minority group (Cornish & Monson, 2018)..

1.2 Legislation and Professional Guidance

The Equality Act (Her Majesty's Court, 2010) has been a key driver in addressing diversity issues, making disability-based discrimination unlawful including within the

workplace. This includes protecting against indirect discrimination and making reasonable adjustments. However, whilst helpful, adjustments do not address systemic barriers (Lund, Andrews & Holt, 2014). Furthermore, the presence of legislation does ensure implementation. Several government papers have focused on transforming the employment prospects of disabled people (e.g. Department for Work & Pensions and Department of Health & Social Care, 2017). It is, however, important to question the assumptions and motives behind these; are they truly a drive for equality, or is the emphasis on reducing the "burden" posed by PwD?

The British Psychological Society (BPS) has also published reports including "Widening Access" (2004) and "Our Plan for Equality and Diversity" (2008). These promote recruiting students from under-represented populations. A more recent "Inclusivity Strategy" (2015) discusses increasing access to the profession through practises including mentorship schemes. However, the emphasis is primarily on ethnicity and gender, mirroring a tendency for these to be the focus of diversity discourse (Frederickson, Morris, Osborne, & Reed, 2000). This was further reflected within an edition of the Clinical Psychology Forum focusing on "Diversity and Training" but omitting disability (2012). This reflects suggestions that clinical psychology has been guilty of disregarding disability as an aspect of diversity (Andrews, Kuemmel, Williams, Pilarski, Dunn & Lund, 2013).

Relating to disability specifically, in 2006 the BPS published good practice guidelines pertaining to clinical psychology training and disability, featuring recommendations regarding the selection and practice of disabled trainees. These included encouraging disclosure and making reasonable adjustments. Perhaps most crucially, and arguably most difficult to achieve, they emphasised creating a culture in which disability is not only accepted but welcomed, for example through inclusive language and promoting disabled role models. It is not clear to what extent trainers and supervisors are aware of these guidelines, or whether recommendations are being followed.

1.3 Ableism and Disablism

Ableism refers to societal practices which seek to promote the normative and "typical" individual, Conversely, disablism involves the discriminatory practices which exclude those with impairments from everyday life (Goodley, 2014), including 19th century freakshows, forced sterilisation in the 20th century and the murder of PwD during the Holocaust (Mallett & Runswick-Cole, 2014).

Whilst practices have changed, disablism remains pervasive. PwD continue to be victims of hate crimes including murder, yet this receives little attention (Roulstone & Mason-Bish, 2013). Within the medical field, debates are rife including withholding medical treatment from those with impairments and abortion of foetuses with impairments. Whilst these are complex issues, they reflect dominant disability narratives including views regarding what constitutes lives worth living (Watermeyer, 2013). Less overt are the comments and actions embedded within daily life. These subtle expressions of bias, known as micro-aggressions, are frequently ambiguous leaving people unsure how to respond (Conover, Israel, & Nylund-Gibson, 2017). For disabled people these include patronisation and the denial of privacy and identities unrelated to disability (Keller & Galgay, 2010).

Relating to employment, the employment gap refers to differences in employment rates between those with and without disabilities. For example, between January and March 2018, 81.1% of people without a disability were in employment compared to 50.7% of disabled people (Powell, 2018). Many factors contribute to this including limitations associated with individual impairments and barriers relating to accessibility, facilities and attitudes (Coleman, Sykes & Groom, 2013). Stereotypes of disabled people are likely to be strongly associated with this final factor, including notions of weakness and incapacity (Pope, 2005a), and PwD frequently face discrimination at an institutional level when attempting to enter the workforce and within it (Robert & Harlan, 2006). For example, many employers hold negative views towards employing PwD including concerns around sickness, support needs and cost (Schneider & Dutton, 2002).

1.3.1 The Role of Psychology

Clinical psychology is not exempt from these issues and has a history of discrimination towards PwD (Andrews et al., 2019). Goodley, Lawthom, Liddiard and Cole (2017) argue that:

"…psychology has damaged disabled people, and this human collateral continues to this day. When disability is defined as a problem and when that problem is located in an individual's body or mind, then there is only really one way we can go with disability and that is pathologisation" (p. 491)

The construction of a bell-shaped curve to represent normal distribution has had a significant role in attitudes towards disability, as the concept of a norm is inevitably accompanied by notions of the extreme. In relation to the body, PwD become viewed as abnormal and, given that "normal" is often conflated with "ideal", disability becomes undesirable (Davis, 2006). As the profession participated in further development and measurement of norms, it inadvertently perpetuated this (Burman, 2008). More recently, disablist assumptions can be seen in the predominance of research and practice centred on loss and tragedy discourses. This neglects the contextual issues which influence the disability experience. Furthermore, the focus on cognitive and emotional factors promotes individualising approaches and perpetuates views of PwD as "other" (Supple, 2005). Disablism is similarly demonstrated through intelligence testing and expert witness roles regarding the suitability of disabled parents. Some have gone further, for example an article published in the APA's official journal advocated legal requirements for couples in which one or both partners are disabled to apply for parental licencing before conceiving or adopting (Lykken, 2001). This is representative of the stigma and discrimination that disabled people regularly encounter and it is concerning that the APA felt it was publishable.

Given the above, it is unsurprising that many disabled people are critical of the profession. Indeed, Stannett, (2006) describes how many "questioned why I wanted to enter what most perceived as a highly discriminatory and unhelpful profession" (p. 75). Despite this, there is some evidence to suggest that those studying psychology

actually hold more positive attitudes towards PwD than the general population (Hollimon, 2008).

1.4 Understanding Disablist Attitudes

1.4.1 Stigma

Many of the attitudes discussed above can be understood in relation to stigma; "an attribute that is deeply discrediting" (Goffman, 1963, p.3). Whilst the attribute itself is not stigmatising, the meanings attached reduce someone "from a whole and usual person to a tainted, discounted one" (p.3). Stigma is commonly understood as involving three components, namely stereotypes (beliefs about people who possess a specific characteristic), prejudice (negative emotional responses towards those believed to fit a stereotype) and discrimination (negative behaviours arising from this) (Jones & Corrigan, 2014). Whilst it is beyond the scope of this thesis to fully explore theories of stigma, a number of concepts will be acknowledged.

Many theorists view stigma as a social construction shaped by historical and cultural contexts, demonstrated by the way a characteristic might be stigmatised within one time period or context but not another (Heatherton, Kleck, Hebl, & Hull, 2000). In Western societies, current cultural standards emphasise bodies that are "whole", "beautiful" and productive. Disability can be viewed as deviating from this, contributing to a view of disabled people as "outsiders" (Livneh, 1982, p.339). Given that dominant narratives around disability include lives characterised by loss, grief and sick roles, it is perhaps unsurprising that categorisation as disabled frequently implies an inferior status (Atkinson & Hackett, 1995). Early personal developmental experiences also play a role in stigma (Hollimon, 2007). Social learning theory postulates that children learn through observation and imitation of others, with reinforcement influencing the likelihood of repeated behaviour (Bandura, 1977). Regarding disability, whilst children are rarely directly taught to like or dislike physical disabilities (Harper, 1999) they may learn prejudicial attitudes indirectly from parents, peers and the media (Byrd, 1989).

Social cognition also has a part within disability stigma. Cognitive categorisation refers to the process of seeing, identifying and labelling visible differences (Jones et al., 1984). Psychological essentialism postulates that such social categories become essentialised, meaning that the difference underlying categorisation comes to be viewed as biologically based and fixed, with members of the category being seen as alike to one another and fundamentally different to those outside the category (Haslam, Bastian, Bain, & Kashima, 2006). For disability, this means that differences between PwDs are obscured and disabled people are perceived as a homogeneous group who are profoundly different to those without disabilities.

1.4.2 Psychodynamic Perspectives

Psychodynamic perspectives understand disablist attitudes as arising from defence mechanisms. Whilst the limitations of this thesis prevent a full exploration of these, a number of examples will be highlighted. Firstly, it has been argued that extreme stereotypes of disablist people as either completely incapable or superhuman are a result of splitting, which occurs in an effort to escape ambiguity when encountering a disabled person (Watermeyer, 2013). Projection, the process of attributing one's own concerns onto others, may also play a role in disablism. For example, Siller (1970) found that greater anxiety regarding being accepted predicted decreased willingness to associate with disabled people. The medicalisation of disability is also a form of defence; adopting a personal tragedy narrative of disability enables focus on the individual rather than issues of social justice allowing uncomfortable issues of inequality and oppression to pass unchallenged (Watermeyer, 2013).

1.5 Psycho-Emotional Experience of Disability

The focus thus far has been discriminatory contexts. The impact of these will now be considered. Numerous studies have highlighted increased levels of distress amongst PwD. For example, a systematic review and meta-analysis concluded that anxiety and depression are more common in people with long term health conditions than the general population (Clarke & Currie, 2007).

As previously noted, psychology has traditionally understood this from an individualistic perspective focusing on loss and adjustment, often drawing on stage models (Fortier & Wanlass, 1984; Livneh & Antonak, 1997). These frequently replicate models associated with grief (e.g. K bler-Ross, 1969), and present adjustment as occurring through stages characterised by shock, denial and loss, before "acceptance" (Kendall & Buys, 1998). Although research has failed to validate such models (Gill, 2001), much of the literature continues this approach and is consequently concerned with examining the effectiveness of individualised interventions. This narrative has been heavily criticised for failing to reflect people's lived experience, pathologising disability (Finkelstein, 1990) and perpetuating stereotypes of disabled people including vulnerability and incompleteness (Watermeyer, 2013). Importantly, within these approaches there are risks of emotional distress being understood as directly caused by impairments, with the personal seen as separate from the political despite suggestions that societal responses can cause most distress. Indeed, according to Shakespeare (1996, p.42-43) "…experiences of rejection and humiliation are among the hardest aspects of being a disabled person". Similarly, (Morris, 1992) states:

> "Our anger is not about having a chip on the shoulder, our grief is not a failure to come to terms with our disability. Our dissatisfaction with our lives is not a personality defect but a sane response to the oppression which we experience." (p.163)

In light of this, there has been increasing recognition of the importance of acknowledging the distress, sense-making and coping that stem from social experiences of disability. This may include feelings of exclusion and difference arising from inaccessible environments, isolation due to being avoided and the emotional cost of being stared at (Reeve, 2006). However, it should be noted that disabled people are not passive victims of oppression; many utilise agency and challenge this through actions of resistance (Reeve, 2002). The psycho-emotional experience of disability is therefore complex and diverse.

<u>1.5.1 Internalised Oppression</u>

More recently, particular attention has been paid to internalised oppression. This refers to the process by which members of marginalised groups may unconsciously internalise attitudes held by dominant groups. Negative cultural representations of disability therefore impact how PwD are perceived by both others and themselves. For example, disability language within media frequently includes phrases such as "suffering", presenting disability as inherently negative (Andrews et al., 2019). Within barrier-filled contexts, narratives of victimhood and a reality of dependence on others at times, some PwD may come to consciously or unconsciously experience themselves as burdensome (Watermeyer, 2013). Conversely, media depictions may perpetuate narratives of bravery and overcoming, commonly referred to as "inspiration porn" (Grue, 2016). This results in impossible standards for disabled people in which they may experience a need to be consistently positive, agreeable and grateful (Serlin, 2015). Disablism can thus operate through internalisation of polarised attitudes towards disability (Reeve, 2006).

1.6 Disability and Identity

Identity refers to how one conceptualises the self, including characteristics and roles in addition to group affiliations (Oyserman, Elmore, & Smith, 2012). Relatively little has been written about disability in comparison to other identities, perhaps reflecting its complexity given that disability is heterogeneous, cross-cultural and occurs across the lifespan (Forber-Pratt & Zape, 2017). It therefore challenges development models such as Erikson's (1963) stages of psychosocial development, which portrays identity development as a task of adolescence. However, given that changes to the body can impact sense of self (Kelly & Millward, 2004), a new diagnosis or increased realisation of one's differences may lead to role confusion outside this time. This may be further complicated by the fact that PwD may be the only person in their family with a disability, so may experience marginalisation within their own family (Olkin, 2002) and connecting with other PwD may require active seeking out (Forber-Pratt & Zape, 2017). Furthermore, disability may be a difficult identity to claim, particularly within Western cultures which value individual achievement and power (Mona, Cameron, & Cordes, 2017).

1.6.1 Theories of Disability Identity Development

Several models of disability identity formation have been developed, for example Gibson's (2006) "disability identity model". However, this has been criticised for assuming that identity development is a linear process in which people pass through discrete stages ending in "acceptance". More recently, Forber-Pratt & Zape (2017) developed the "model of social and psychosocial disability development" (Appendix A). Unlike previous models, this consists of "statuses" as opposed to stages in order to reflect fluidity in transitioning back and forth between positions, in addition to the possibility of being simultaneously situated in multiple statuses. Strengths of this model include its consideration of external dynamics of identity development such as community and its recognition of individual differences, acknowledging that not everyone passes through all statuses. It is however notable that the model was developed based on a small sample of college-level students which did not reflect the full range of heterogeneity within disability, potentially biasing the findings.

1.6.2 Passing

The concept of passing is familiar within literature pertaining to ethnicity and sexuality and refers to concealing a stigmatised aspect of the self to appear "normal" (Coleman, 2006). Passing as able-bodied may involve concealing impairments, deciding not to disclose or limiting activities to avoid revealing them (Linton, 2006). Passing may also involve minimising the significance of impairments and adapting to the environment instead of requesting adjustments (Devlin & Pothier, 2006). These may be deliberate attempts to avoid negative consequences associated with disability, or an unconscious effort to deny one's reality (Linton, 2006). Those who choose to pass may encounter numerous consequences. This may require substantial work (Devlin & Pothier, 2006) and take an emotional toll including self-doubt and loss of community (Linton, 2006) in addition to the fear of being discovered (Coleman, 2006). Furthermore, passing may mean that needs are not understood by others and are consequently not met.

1.6.3 Personal and Professional Identities

Ashforth (2001) conceptualises professional identity as defining oneself as belonging to a profession, including "the goals, values, beliefs, norms, interaction styles and time horizons that are typically associated with a role" (p.6). Tan & Campion (2007) suggest that becoming a clinical psychologist involves incorporating this professional identity into an existing sense of self. This may involve pressure to adopt "unwritten rules" (p.14) of clinical psychology including those pertaining to self-presentation and language. This can significantly impact other identities, particularly for those in minority groups for whom developing a professional identity may risk excluding the strengths and experiences associated with subjugated personal identities (Butler, 2004). For example, Adetimole, Afuape and Vara (2005) describe re-establishing their identities as black women after having these removed by clinical training. Similarly, an analysis of interviews with black therapists suggested that trainees held a split between personal and professional identities, possibly as a result of not being encouraged to discuss blackness and whiteness during training (Patel, 1998). In relation to disability, in an analysis of advice from disabled trainees and psychologists to trainees with disabilities (TwD), one participant recommended:

"Develop yourself as a professional person and do not make the disability your identity... If they often "forget" that you have a disability, you have succeeded in being viewed as a competent professional". (Lund et al., 2016, p.211).

Here, a distinction is made in which one cannot be viewed as both disabled and a "competent professional", perhaps implying disability does not fit with the "unwritten rules" of psychology. Thus, trainees are advised to sacrifice their disability identity in order to fit the professional identity of a psychologist. This is particularly ironic given that one of the requirements of clinical psychology is personal and professional reflection and the interaction between these.

1.7 Minority Groups in Clinical Psychology Training

In relation to training itself, whilst disability has been comparatively neglected the experiences of TCPs from several minority groups have been explored including ethnicity, sexuality, and gender.

1.7.1 Ethnicity

A number of psychologists have reflected on personal experiences of being black trainees, including overt and covert racism and "othering" (Adetimole et al., 2005). Researchers have also interviewed black and minority ethnic (BME) trainees, highlighting multiple important themes. Many trainees have raised the ethnocentricity of psychological models and the incongruence of being taught theories that did not reflect their experiences. Furthermore, they have shared their discomfort at being positioned as "experts" on ethnicity issues and navigating a responsibility to speak out versus the fear of being misunderstood or marginalised (Rajan & Shaw, 2008). Trainees have also described encountering resistance when attempting to raise issues of ethnicity (Shah, Wood, Nolte, & Goodbody, 2012). Trainees in both studies raised identity issues including the challenges of integrating personal and professional identities and the costs incurred, including subjugating parts of one's cultural identity in order to assimilate into the profession. This negotiation of identities has been portrayed as an ongoing, cyclical process; a lonely journey during which there is little support from programmes (Paulraj, 2016).

Importantly, Shah and colleague's (2012) research also highlighted the strengths and resources associated with being a BME trainee, such as versatility and utilising personal experiences to connect with clients. Trainees also emphasised the importance of finding safe and supportive spaces, which for many involved other BME trainees.

1.7.2 Sexuality

Daiches (1998) reflected on her experience as a homosexual trainee including the lack of discussion of sexuality and likened disclosure to removing a "cloak of protection" (p. 9). This was further explored with psychologists with minority sexual

orientations via interviews regarding their experiences during and following training. Several themes were developed, linked by a focus on disclosure including when, how and to whom to disclose, perceived safety of disclosing and navigating personal and professional roles. Perhaps unsurprisingly, permanence was a contributing factor within decision-making and thus the transient nature of training was seen as particularly difficult (Daiches & Anderson, 2012). Butler (2004) interviewed gay and lesbian TCPs about the challenges of personal and professional integration and found they experienced conflict between their own experiences and knowledge and psychological teaching and practice. They also monitored self-disclosure and experienced a lack of support from course staff.

1.7.3 Gender

Men are significantly underrepresented within clinical psychology and the experiences of male trainees have been relatively neglected. However, multiple issues have been raised which overlap with themes highlighted above. These include being placed in the role of a representative and encountering stereotypes, such as assumptions of a lack of skills typically viewed as feminine, for example empathy. Male trainees have also highlighted vulnerability to accusations of professional misconduct and having their sexuality or traditional masculinity questioned, including querying this themselves (Caswell & Baker, 2008).

1.7.4 Disability in Relation to Other Minority Groups

Whilst there are important differences, many parallels exist across the experiences of minority groups with a key similarity being encountering stigma and oppression. Other similarities include under-representation, pressure to emulate the majority group, fewer role models and being considered a representative (Olkin, 2001). These reflect many of the issues raised above, thus it is likely that they may be similarly experienced by disabled trainees. For example, repeated placement changes may make training an especially challenging period for TwD, whilst decisions regarding disclosure may be particularly pertinent to trainees with invisible disabilities. Similarly to BME trainees, disabled trainees may feel responsible for raising disability issues within teaching, whilst simultaneously fearing implications of

doing so including eliciting discomfort in others. Finally, disabled trainees may also experience challenges in negotiating identity during training.

Conversely, the experiences of those with disabilities are distinct from other minority groups in numerous ways. Firstly, unlike other minority groups, disability often encompasses pain and fatigue. This can require daily work including pain management, activity monitoring and acquiring adjustments. In relation to clinical training, the real or imagined costs associated with this may result in a negative bias towards PwD (Olkin, 2002). It may also mean the transient nature of multiple placements is particularly burdensome, given the need to repeatedly attempt to acquire appropriate adjustments. Secondly, and similarly to those with minority sexual orientations, disabled people are often the only person in their family with a disability and may have limited connections with other PwD. As such, they may experience increased isolation and families may not be fully equipped to support them through the minority experience (Olkin, 2002). Other important differences include the need to engage in supplementary tasks such as researching accessibility and the fact that disability may be acquired at any time (Olkin, 2001).

1.7.5 Intersectionality

Thus far, minority statuses have been discussed as discrete categories. It should be noted that this is not the case and disabled people hold multiple intersecting identities which influence their experiences (Mallett & Runswick-Cole, 2014). For example, disabled women encounter a double disadvantage; they are less likely to be in employment than their male peers and, if they are employed, earn less. They are more likely to experience sexual and physical violence and the mortality rate for girls with impairments is higher (Frohmader & Meekosha, 2012). Belonging to multiple oppressed groups therefore carries a cumulative effect (Mallett & Runswick-Cole, 2014).

1.8 Representation of PwD

Attempts to understand the prevalence of disabled people within the profession have been inconsistent, partially due to varying definitions. However, Andrews and Lund

(2015) reviewed the available evidence and concluded that PwD continue to be underrepresented and are perhaps one of the most marginalised groups within the profession. For example, American-based research suggests that approximately 4.2% of those within the profession identify as disabled (Michalski, Mulvey, & Kohout, 2010) compared to 18.7% of the US population (Brault, 2012).

Two key factors contribute to this, namely admission and retention in training programmes (Callahan et al., 2018). Regarding admission, figures collated within equal opportunities monitoring capture the number of disabled applicants to UK training courses over recent years.

Table 1

Clearing House data on disabled applicants for clinical psychology training

Year	Number of applicants with disabilities (%)	Number of successful applicants with disabilities (%)
2005	126 (6)	24 (4)
2006	141 (6)	24 (4)
2007	172 (8)	38 (7)
2008	179 (8)	44 (8)
2009	196 (9)	43 (7)
2010	238 (8)	51 (7)
2011	261 (8)	40 (7)
2012	317 (9)	52 (9)
2013	301 (8)	38 (7)
2014	316 (9)	52 (9)
2015	317 (9)	61 (10)
2016	338 (9)	67 (11)
2017	363 (10)	59 (10)

The figures above demonstrate an increase in disabled applicants and successful disabled applicants between 2005 and 2017 (Clearing House for Postgraduate Courses in Clinical Psychology, CHPCCP, 2019a). Nevertheless, the highest rate of admission (11% in 2016) remains below the 19% of the UK population estimated to

be living with a disability (Department for Work and Pensions, 2014), demonstrating the underrepresentation of PwD. The figures show similar proportions of disabled applicants applying and being offered places, suggesting this is due to lower numbers of disabled applicants as opposed to discrimination within selection processes. Nonetheless, the proportion of PwD admitted to courses consistently remains below the 15% threshold at which token status is said to reduce (Kanter, 1977; Neimann, 2003). This is important as it increases distorted perceptions of minority groups, leading to hostile environments and influencing admission and retention rates (Gutierrez y muhs, Niemann, Gonzales, & Harris, 2012). However, it should be acknowledged that CHPCCP figures are estimates; it is likely that many PwD chose not to disclose. Furthermore, the figures do not convey that some may develop a disability during training.

Regarding retention, significant differences have been found in attrition rates between trainees with and without disabilities (Callahan et al., 2018). It has been argued that this is likely to be a result of systematic discrimination which ultimately forces TwD out of the profession (Lund, 2018). The lived experience of TwD is particularly pertinent to understanding attrition and will be the focus of the literature review below.

1.9 Literature Review

This section describes a review of the literature pertaining to disability within psychology training programmes. A literature search was conducted using the following search terms in an attempt to identify literature relating to disability and psychology training. The key words were combined using Boolean operators 'AND' or 'OR'. Whilst searches uses "experience" and synonyms were attempted, this provided results which were too broad in scope and produced a vast number of irrelevant papers. The final terms were therefore selected as they appeared to bring up the most relevant literature, whilst allowing for synonyms and varying presentations of words. These terms were: clinical psychology train*, psychologist, clinical psychology students, disability, disabilities, disabled, discrimination prejudice, stereotype, bias, stigma, diversity and inequality.

The database 'EBSCO' was used to search Academic Search Complete, CINAHL Plus and PsycINFO for all years. Publications not written in English were excluded. Given the paucity of literature available, research regarding both trainee and qualified psychologists and both clinical and counselling psychology was included in the search. Articles were therefore generally included if they discussed issues relating to disabled trainee or qualified clinical or counselling psychologists. Articles were excluded if they did not relate to disability and/or psychology training, trainees or qualified psychologists. Articles focusing on the lived experiences of disabled trainees were prioritised.

After removing duplications a total of 328 papers were identified, of which 13 were deemed to be relevant. Reference lists in relevant articles were then hand searched in order to identify additional relevant literature resulting in a "snowballing" effect. Grey literature was also searched. These additional strategies resulted in a cumulative total of 37 relevant studies.

1.10 Neglect of Disability

1.10.1 Disability in Teaching

Despite its allegiance to social justice issues, advocates have argued that the field of psychology has overlooked disability (Andrews et al., 2019). In addition to the previously discussed neglect of disability within professional guidelines, this is also evident within training programmes with many omitting training on disability-related issues (Olkin, 1999). Indeed, upon considering her position as a disabled trainee, Ingham (2018) reflected, "there has been little discussion (or even acknowledgement) of issues of disability unless I have instigated them. Whilst other issues of 'difference and diversity' have been thoroughly explored… disability has consistently been noticeably absent" (p.10-11). Others have emphasised that, even when disability is broached, training and research conceptualise disability as a medical status rather than recognising it as a complex aspect of identity (Mona et al., 2017). This focus on a medical model may contribute to increased alienation and marginalisation amongst disabled trainees and clinicians (Olkin, 1999).

Several empirical studies support these claims. Green, Callands, Radcliffe, Leubbe and Klonoff (2009) surveyed students on clinical psychology graduate programmes in the United States and Canada and found that participants had a narrow conceptualisation of diversity; very few referred to disability in their definitions, instead prioritising ethnicity, culture and gender, and only a small minority had gained clinical or research experience with PwD during their training. Whilst this study had a low response rate, the neglect of disability can similarly be seen within responses to a survey sent to Canadian programme directors regarding diversity training on their programmes. Worryingly, only 55% of respondents perceived disability to be an essential aspect of diversity training (Hertzsprung & Dobson, 2000).

1.10.2 Invisibility of Disability

More recently, Hough & Squires (2012) reviewed the literature and concluded that the psychology profession in America has made inadequate progress in addressing all aspects of diversity. They made multiple recommendations for programmes and supervisors, including regularly assessing diversity competency, openness to feedback and acknowledging that it may feel unsafe for individuals to raise experiences of belonging to a minority group. Lund and colleagues (2014) also argued that disability is neglected within the profession, with an "us and them" approach in which disabled clients are focused on at the expense of acknowledging disabled professionals. They suggest that increased visibility of disabled lecturers and supervisors may help address this, in addition to fostering an environment in which students feel safe to disclose their own disabilities. Indeed, currently trainees may complete their entire training without knowingly encountering a disabled psychologist (Andrews et al., 2013). Moreover, there can be a reluctance to even use the term disability and a tendency to utilise euphemisms. Whilst this may be well-intentioned, many within disability culture experience these labels as patronising and they further erase disability identity (Andrews et al., 2019).

It is notable that the research discussed above was based on American and Canadian training programmes. Caution must therefore be taken in generalising the

results to the UK. Furthermore, attitudes to diversity may have broadened since the earlier of these studies, although recent reports suggest disability continues to be neglected within the profession (e.g. Lund, 2018). Taken as a whole, the above literature sets the stage for a profession which has historically placed little emphasis on disability. As a result, those currently expected to provide culturally competent services and education are those whose own training may have been lacking.

The invisibility of disability within psychology raises important questions about how TwD experience a profession where they are not represented and in which there appears to be a neglect of acknowledging or discussing an aspect of one's identity. This may have numerous implications, such as messages about acceptability of disability and how safe TwD feel to disclose or explore their experiences.

1.11 Barriers to Securing a TCP Role

Following a review of the literature, Gaskin (2015) concluded that more effort is needed to encourage diversity within clinical psychology. As previously discussed, differences in admission rates is one factor contributing to the underrepresentation of disabled people (Callahan et al., 2018) and PwD continue to be underrepresented in the numbers applying for and awarded places on UK clinical psychology programmes (CHPCCP, 2019a). This can be understood in a number of ways.

The uncertain path into clinical training and the programme structure can pose a barrier to all, regardless of minority group status (Helm, 2002). However, these factors may prove more challenging for those with disabilities. Twena (2008) conducted research with disabled psychology undergraduates and graduates and identified numerous factors at play when considering a psychology career. Whilst those that appealed included the opportunity to utilise personal expertise gained through living with a disability, beliefs about barriers to entering the profession were also identified. These included concerns about negative attitudes of others and a lack of role models. Structural barriers were also identified, such as selection and application procedures and organisational barriers including the structure of training and the emphasis on academic excellence. Indeed, disability may have a negative

impact on academic results at undergraduate level resulting in fewer disabled applicants with the prerequisite upper second class degree (BPS, 2006). However, it is worth noting that Twena's research materials were not available in all formats, such as Braille. This may have resulted in the exclusion of potential participants and the results may not be generalisable to all impairments.

PwD may experience greater difficulty obtaining relevant experience for several reasons, including discrimination. It has been suggested that American pre-doctoral internship programmes may be less inclined to take applicants with hearing impairments and find it harder to locate services willing to offer them placements (Hauser, Maxwell-McCaw, Leigh, & Gutman, 2000). PwD may also find it challenging to secure assistant psychologist posts; many of these unlawfully specify driving requirements, thus excluding some disabled people (Singer, 2004; Smith, 2005). These factors may discourage those with disabilities from pursuing a psychology career.

Potential trainees may also be limited in terms of which training programmes they are able to apply for. In one survey, 44% of participants reported that disability had influenced their programme choice due to factors including accessibility (including parking, transportation and campus size) and programme attitudes towards disability (Lund et al., 2014). As such, disabled trainees face the double challenge of not only securing a place on a competitive course, but securing one on a suitable programme.

1.11.1 Understanding Barriers

It has been argued that barriers to accessing psychology can be understood through three broad categories, including physical barriers and communication barriers. These are underlined by cognitive and affective barriers, and Pope (2005) states that "A profession's values - including its ethical values - are reflected in the degree to which its structures are accessible to PwD" (p.50). It is telling that only 40% of UK clinical psychology training programmes are part of the 'Disability Confident' scheme which guarantees interviews for disabled candidates who meet minimum entry criteria (CHPCCP, 2019b). This possibly stems from concerns regarding

competence; in surveys of attitudes towards deaf trainees, some supervisors (Dent & Atherton, 2004) and training programmes (Atherton & Dent, 2003) reported concerns about the ability of disabled trainees to meet competence criteria. Whilst these surveys pertained specifically to deaf trainees, these attitudes likely generalise to other impairments (BPS, 2006).

1.12 Experiences during Training

Whilst relatively little is known about the experiences of disabled TCPs (Olkin, 2002), available research suggests they are likely to encounter numerous barriers whilst pursuing their career. For example, a survey of American disabled psychology students across postsecondary education found that more than 80% had encountered barriers during their education (APA, 2009). These experiences form the primary focus of this literature review and are discussed in further detail below.

1.12.1 Attitudes and Discrimination
1.12.1.1 Experiences with professionals: PwD may encounter numerous additional challenges during training, with more than two thirds of disabled trainee and qualified psychologists reporting discrimination during their graduate programme and the application process (Lund et al., 2014). However, it is worth noting that this figure is based on a relatively small sample in which those with physical and sensory impairments were overrepresented and chronic health conditions underrepresented. Discrimination during training may include barriers to accessing the curriculum, disabling physical environments and factors arising from staff themselves such as attitudinal barriers (Hardell, 2013) and lack of knowledge regarding disability legislation (Leyser, Vogel, Wyland, & Brulle, 1998; Olkin, 1999) and the specific needs of students (Graham-Smith & Lafayette, 2004).

Discriminatory attitudes can arise from stigma, ignorance and anxiety. Narratives of disabled people as a burden requiring help frequently evoke feelings of pity or discomfort. This may result in awkward encounters which colleagues may attempt to manage through avoidance of the trainee. Conversely, disabled trainees may receive positive feedback or become viewed as exceptional for doing very little, due to

underlying assumptions that disabled people are not generally high achievers. Consequently it can be difficult for TwD to know how to interpret praise (Andrews et al., 2013).

Discrimination may take the form of inappropriate questions and concerns regarding the cost of adjustments (Hauser et al., 2000). There are also risks of assumptions regarding a trainee's position. For example, one author describes repeatedly being directed towards lifts provided for patients (Hohmann, 1972; Levinson & Parritt, 2006). Supervisors may also erroneously assume that TwD will automatically understand the experiences of disabled clients or, conversely, that they will be unable to hold an objective position when working with disabled clients. These could both influence the evaluation of a trainee's abilities (Andrews et al., 2013). Issues of bias and discrimination therefore become particularly pertinent in the context of supervisor-trainee relationships, in which there are significant power imbalances.

Disabled trainees may also encounter disabling environments, namely the physical contexts in which teaching (Hardell, 2013) and placements are held. Barriers surrounding these may arise from sites themselves or inaccessible transport links (Andrews et al., 2013). Indeed, it has been found that many services offering placements are unreachable to PwD, particularly mobility or sensory impairments (Olkin and Bourg, 2001), although it is not known if this has since improved.

1.12.1.2 Experiences with peers: TwD must also navigate peer relationships, in which they may experience disability-related rejection. This may occur for several reasons, including stereotypes of disabled people as less capable. This, in conjunction with receiving adjustments, may mean that TwD are viewed as receiving "special treatment" and elicit resentment. Alternatively peers may offer inappropriate sympathy or help. At another extreme, peers who experience feelings of disgust or fear when confronted with disability may respond to this by ignoring or denying its presence (Andrews et al., 2013; Levinson & Parritt, 2006).

1.12.1.3 Experiences with clients: Despite evidence that trainees may encounter difficult experiences with professionals and peers during training, this pattern may not persist with clients and anecdotal reports suggest that disabled psychologists

generally experience positive interactions. As such, concerns from supervisors regarding the acceptability to clients of disabled psychologists is likely a projection of their own anxieties (Levinson & Parritt, 2006).

1.12.2 Disclosure and Adjustments

Hardell (2013) notes that disabled trainees may need to strongly advocate for themselves in order to access the adjustments required to complete their training. However, this necessitates trainees to understand their impairment, strengths and areas of difficulty in addition to possessing skills in self-advocacy (Graham-Smith & Lafayette, 2004; Lang, 2002). It also requires students with invisible disabilities to disclose, which many may not do. A survey of trainee and qualified clinical and counselling psychologists with disabilities found that the majority of participants did not disclose this during the doctoral application process and less than half disclosed to a university disability service during training (Lund et al., 2014). This is perhaps unsurprising given that PwD are frequently advised against disclosure due to genuine risks of discrimination (Sayette, Mayne, & Norcross, 2010). Indeed, those who do disclose during the application process may be viewed less favourably or rejected due to concerns regarding accessibility or funding (Andrews et al., 2013). Moreover, a survey of disabled psychology students found that approximately one third of those who disclosed their disability to faculty staff received a mixed or negative response (Association of Psychology Postdoctoral and Internship Centers, 2009).

In addition to disclosure to programmes, TwD face multiple decisions on placement regarding supervisors, colleagues and clients. In these settings, external forces may influence decision making. For example, supervisors may subject trainees to pressure to share their disability with clients (Taube & Olkin, 2011).

TwD must also make decisions regarding adjustments. Whist some may hold concerns about trainees taking advantage of "unnecessary" adjustments, it has been suggested it is more likely that trainees underuse these. This may result from concerns regarding perceptions of others, particularly relating to competency (Olkin, 2010).

1.12.3 Support

According to Andrews and colleagues (2013), it can be beneficial for disabled trainees to receive mentorship from disabled psychologists. However, the availability of this appears to be limited; Lund and colleagues (2014) found that just 29% of respondents to their survey had been supported by a mentor with disabilities, with the vast majority indicating this was experienced positively. Supervisors without disabilities may also form an important source of support, acting as allies. However, this is reliant on a willingness to reflect on and develop their own practice including learning to anticipate barriers and becoming familiar with legislation (Andrews et al., 2013).

1.12.4 Advice to TwD

In the only qualitative study identified, Lund and colleagues (2016) asked disabled trainee and qualified clinical psychologists what advice they would give to other TwDs via an online survey. Data was analysed using grounded theory, following which several themes were developed. These covered disclosure, self-advocacy, support, adjustments and areas of difficulty, in addition to general advice and encouragement. Support could take a number of different forms, for example trainees were encouraged to seek a mentor with a disability, form peer support groups or seek support outside of training, such as personal therapy. The importance of self-advocacy and seeking adjustments was also emphasised, including familiarising oneself with legal rights.

In regards to disclosure, advice was mixed; whilst many participants advocated openness with programme staff and peers, others recommended caution. These participants viewed disclosure as leading to assumptions in others, consequently limiting progress during the application process, training and thereafter.

Overall, the advice given portrays training with a disability as a difficult journey during which one might encounter numerous challenges. Indeed, several participants directly cautioned about this, with one stating: "As is the case in the 'Real World,' one will run in to multiple disability-related barrier[s]" (p.210). They also highlighted

the need for trainees to take responsibility for getting their needs met as opposed to relying on programmes. Despite acknowledging the many challenges ahead, participants also offered encouragement, emphasising the importance of persistence and underlining the need for greater representation. However, it should be noted that the survey methodology prevented the use of follow-up questions or clarification and the labour involved in completion may have affected the depth of responses provided. There was also a lack of diversity within the sample in relation to ethnicity and the majority of participants were female. As such, intersectionality between disability and other marginalised identities could not be considered.

1.13 Conclusions

The above review identified a paucity of literature regarding the experiences of disabled trainee and qualified psychologists and much existing research was US-based. As such, caution must be taken when generalising to UK training programmes. Furthermore, a self-selection bias may have operated within many studies with those who were particularly passionate about disability issues, possibly due to their own difficult experiences, were more inclined to participate. The extent to which this may have influenced findings is unknown.

Despite these issues, the research presents psychology as a field in which disability continues to be neglected and TwD face discrimination and barriers both to entering the profession and throughout training. Trainees frequently find themselves invisible and unrepresented, and the common concerns regarding disclosure can be viewed as a reflection not only of enduring shame, fear and prejudice but also as a symptom of how little the profession values disability (Andrews et al., 2019).

1.14 Reflections

During the process of conducting the above review I encountered several of my own experiences reflected within the literature, including being advised against disclosing to potential employers (Sayette et al., 2010), barriers to obtaining roles due to driving requirements (Singer, 2004; Smith, 2005) and struggling to accept adjustments

during training (Olkin, 2010). This validated my experiences whilst simultaneously inciting anger and sadness. I went through a retrospective sense-making process involving placing my experiences within contexts of an ablest society and critical approaches to disability. This promoted further reflection on my own relationship with disability, in addition to advancing my commitment to the research.

1.15 Current Research

1.15.1 Rationale
This study aims to explore the experiences of TCPs who self-identify as disabled.

Clinical psychology training has historically neglected disability as an aspect of diversity (Andrews et al., 2013) and a similar pattern is reflected within research. The experiences of TCPs have been explored in relation to aspects of diversity including ethnicity (Adetimole et al., 2005; Shah, 2010) and sexuality (Daiches & Anderson, 2012), with findings suggesting that those from minority groups may experience a number of challenges. However, disability continues to be comparatively neglected. Whilst one study explored factors influencing PwD's consideration of a career in clinical psychology (Twena, 2008), literature regarding training experiences remains limited. Nevertheless, there are indications that disabled trainees encounter multiple challenges including individual and systemic discrimination (Andrews et al., 2019) with little support (Lund et al., 2014). These conclusions are predominantly drawn from surveys conducted in America. To the best of my knowledge no studies have focused on this within the UK nor provided an in-depth exploration of the experiences of TwD. Indeed, authors have highlighted the need for further research which develops our understanding of how discrimination manifests within training and how programmes can better support TwD (Lund, 2018). Calls have also been made for studies that utilise interviews or focus groups to further explore issues previously raised (Lund et al., 2016).

It is hoped that the proposed research will draw attention to the currently neglected experiences of disabled TCPs, subsequently influencing future support for trainees and guidance for training providers.

<u>1.15.2 Research Question</u>

In line with the study's aim to explore the experiences of TCPs who self-identify as having a disability, the research question was framed as:

"How do TCPs who identify as living with a disability experience clinical psychology training?"

Drawing on the literature review, this was seen as encompassing the following areas:

- How are the academic and clinical components of training experienced by trainees living with a disability?
- How do trainees experience the dual identities of "living with a disability" and "TCP"?
- What systems of support are available to and desired by trainees living with a disability?

2. METHOD

This chapter outlines the method used within this study including the epistemological and ontological positions influencing this. An argument is made for the adoption of a reflexive qualitative approach and the use of interpretative phenomenological analysis. Key ethical considerations are highlighted and the process of data collection and analysis are discussed.

2.1 Ontology and Epistemology

Ontology refers to beliefs regarding the nature of the world, reality and what can be known about it (Ritchie & Lewis, 2003). Epistemology on the other hand is concerned with the theory of knowledge, including how we conduct research to create knowledge and the validity and reliability of claims to knowledge (Willig,

2013). The differing positions in relation to this are often viewed as lying on a continuum ranging from realism (there is a knowable world that is directly observable, therefore the researcher directly collects information which reflects this reality) (Braun & Clarke, 2013) to relativism (a single observation can be interpreted in multiple ways, so data is not a direct reflection of an objective reality). Between these lies the critical-realist position. This assumes that whilst there is a 'reality', data collected through research is not an exact mirror of this (Harper, 2012). Instead, a person's experience is influenced by varying factors including their immediate and wider context (Braun & Clarke, 2013). As such, this position maintains an attentiveness to situational, historical, political and sociocultural contexts (Pilgrim & Rogers, 1997).

Within this study I adopted a critical realist position, recognising that difficulties such as mobility issues, sensory impairments and long term health conditions do exist. I felt that acknowledging and attending to the embodied experience of participants in relation to the realities of disability (such as pain, fatigue and physical barriers) was crucial to giving justice to participants' experiences (Sims-Schouten, Riley, & Willig, 2007). However, the view was also taken that the way in which participants understood, experienced and responded to circumstances encountered during training was dependent on their own interpretations, biases and contexts. These in turn sit within a wider social context including the dominant discourses available to us regarding disability. Furthermore, as outlined in the introduction, I held the position that the concept of disability itself can be seen as constructed and involves interactions between biological, psychological, and socio-cultural factors (Tom Shakespeare, 2014). As such, the ways in which PwD are positioned in society will influence how they experience their reality.

2.2 Method

2.2.1 Selecting a Qualitative Approach
A qualitative method was selected to explore participants' experiences of training. Qualitative approaches aim to understand both the experiences of participants and the contexts in which these are located (Robson, 2002), and were thus considered

well suited to the research question. They typically generate richer, more detailed information and are interested in the patterns and differences within and across individual accounts of experiences (Braun and Clarke, 2013). This was considered more suitable than a quantitative approach as it would enable collection of data that would provide the depth required in order to fully explore participants' individual experiences. A qualitative approach was also deemed more suitable as it was in keeping with the critical realist epistemological stance.

I selected interviews over focus groups for a number of reasons. Firstly, whilst focus groups carry several benefits such as creating open, supportive spaces for the discussion of sensitive issues (Wilkinson, 1988) and enabling new ideas to arise (Fusch & Ness, 2015), I felt that individual interviews would be more effective in providing space to generate the depth required to explore individual experiences. Secondly, some people may feel less comfortable discussing sensitive topics in a group setting such as focus groups (e.g. Braun & Wilkinson, 2003), thus inhibiting collection of in-depth data.

Semi-structured interviews, in which an interview guide is prepared but used flexibly, were selected over structured interviews. It was thought that this would allow a more open exploration of participants' perspectives than structured interviews due to the flexibility to adapt question order and language, in addition to allowing participants to raise novel issues that I might not have anticipated. I also hoped that this would enable participants to take a more active role in the research process (Frith & Gleeson, 2012). However, in line with the critical realist stance, the interpretations of the data that were made were not assumed to directly reflect participants' experiences and perspectives (Harper, 2012).

2.2.2 Selecting Interpretative Phenomenological Analysis (IPA)
IPA's primary aim is to develop a detailed, 'insider' perspective of participants' lived experiences and how they make sense of these (Smith & Osborn, 2008). It therefore closely fitted with the aim of the research, namely to explore how TCPs who identify as disabled experience clinical psychology training. IPA's focus on providing an in-depth analysis of idiographic accounts and individual perspectives and experiences

as opposed to generalising to the wider population also fits with the research aims. Furthermore, the epistemological position of IPA fits with the critical realist approach of this research. IPA is also particularly aligned with considering the embodied experience, that is to say the physiological components of human experience and the way we come to know the world through our bodies and make sense of our experiences according to its ability to sense, feel and interact (Merleau-Ponty, 1962). As such, IPA is particularly fitting for research exploring experiences relating to disability and it has commonly been used in this area (e.g. Osborn & Smith, 1998; Smith & Osborn, 2007).

2.2.3 Considering Alternative Approaches

A number of approaches to qualitative data analysis were considered before selecting IPA. The reasons behind this will be presented below.

Thematic analysis (TA) is used to identify, analyse and interpret patterns within qualitative data and I initially considered this as a possible approach for several reasons. Its flexible epistemological stance allowed for the use of a critical-realist approach (Braun & Clarke, 2006) and so was in accordance with the research's position. TA also carries the advantage of a clear protocol to follow in order to undertake a meaningful analysis (Braun & Clark, 2013). Furthermore, the theoretical openness of TA lends itself to areas in which there is little prior research, as was the case for this research. However, as TA is primarily focused on patterns occurring across data sets it can result in a less in-depth analysis and individual voices risk becoming lost (Braun & Clarke, 2006). Given that the research question focused on individual experiences, this was considered a significant drawback.

Glaser and Strauss's (1967) grounded theory approach had several advantages including flexibility in relation to epistemology and being well-suited for areas in which there is little previous research. However, it is interested in developing theories of social processes and relies on relatively large samples in order to do so (McLeod, 2011). This was not in keeping with the research's aim.

Discourse analysis was excluded as the research was not focusing on the use or role of language. Furthermore, discourse analysis is typically a fully constructionist approach (Burr, 2003) and so did not fit with the research's epistemological position.

2.3 Theoretical basis of IPA

IPA is a qualitative approach to analysing data which draws upon three central theoretical ideas, namely phenomenology, hermeneutics and idiography.

Phenomenology can be understood as the study of human experience. Several philosophers have been key to the development of this approach; Husserl emphasised the importance of both experience and an individual's understanding of this, whilst Merleau-Ponty focused on the role of the embodied physiological experience. These notions were further developed by Satre and Heidegger, who argued that human experience is embedded within an external world and cannot be considered in isolation. IPA therefore maintains a view of the individual as existing not in a vacuum but within a world of culture, relationships, language, objects and concerns (Smith, Flowers, & Larkin, 2009).

Hermeneutics on the other hand is concerned with interpretation. Within IPA, the person is viewed as a self-reflective being who both has experiences and subsequently reflects on these, attempting to attach meaning to them. However, IPA also acknowledges that researchers cannot directly access a participant's internal world. Experiences are therefore considered to be interpreted at two stages. Firstly, the participant interprets their experience through recalling and articulating their understanding of this. Secondly, the researcher interprets the data through analysing transcripts, which involves drawing upon their own interpretative resources and context. In this study, this includes my experience as a TCP with epilepsy. As such, I approach the process of analysis with my own preconceptions and assumptions. This is known as the double hermeneutic (Smith & Osborn, 2003). IPA therefore acknowledges participants as the experts of their experience whilst simultaneously recognising and allowing the researcher to take an active role in interpreting how participants make sense of this experience (Osborn & Smith, 1998). Reflexivity is

therefore crucial in order to increase the researcher's awareness of their own role within the analytical process (Smith et al., 2009).

Finally, idiography is concerned with the particular, working at the idiographic level of as opposed to generalising or making claims at the level of the population. In IPA, this translates firstly to a commitment to the detail and depth of analysis and secondly to a focus on how a specific experience is understood and perceived by a particular group of people within a specific context. As a result, IPA samples are small and purposively selected (Smith et al., 2009).

2.4 Procedure

2.4.1 Participants

2.4.1.1 Inclusion criteria: All participants were current TCPs and were required to be attending training programmes in London or the surrounding area. This decision was made in light of the possible differences in experiences between participants based within Greater London and those training in rural locations. More specifically, it was thought that those in more rural locations may encounter different barriers, for instance in relation to physical accessibility. This would have introduced notable differences between participants and as such would not have fitted with the use of IPA, which requires a homogenous sample.

As previously discussed, "disability" is a very broad term. Given the personal and fluctuating nature of disability, rather than imposing a definition or list of accepted impairments, I asked participants to self-identify as disabled. Participants were included if they identified as living with a disability due to a physical impairment or learning difficulty. People who identified their disability as relating to mental health were excluded from the study unless this was in addition to a physical and/or learning difficulty. This decision was made due to the recognition that mental health is a broad area in its own right with its own associated experiences and research literature.

No restrictions were imposed in relation to gender, ethnicity, religion, sexual orientation or age. However, given that clinical psychology training requires previous completion of an undergraduate degree, all participants were aged over 21.

2.4.1.2 Recruitment: In order to focus on the particular characteristics of interest (TCPs with disabilities), participants were identified and selected using purposive criterion sampling. This means the sample was specifically selected according to pre-determined criteria (Patton, 1990), as outlined above. Recruitment was undertaken in two ways. Firstly I contacted directors of clinical psychology training programmes via email (Appendix B). This included information outlining the research, the full information sheet (Appendix C), my contact details and a request to share this information with trainees. Only courses within London and the surrounding area were contacted. Secondly, personal contacts, word-of-mouth and social media were used to publicise the research. Brief information outlining the aim of the research and the population being sought (Appendix D) was shared via social media, specifically my own Facebook page and within Facebook groups of training cohorts. After potential participants contacted me to express interest, they were sent the information sheet and given the opportunity to ask questions including being offered a telephone call. If participants continued to express interest and met the inclusion criteria, an interview was arranged.

2.4.1.3 "Coming out" during recruitment: It is notable that the information shared via both email and social media included a personal disclosure regarding my position as a TCP with a long-term health condition. There are many suggested benefits of self-disclosure in qualitative research, such as enhancing rapport, validating the stories of participants (Dickson-Swift, James, Kippen, & Liamputtong, 2007) and minimising the researcher-participant hierarchy (Oakley, 1981). However, this entailed a commitment to my own "coming out" (Paterson, 2008) to both strangers and known others. I was particularly conscious that I could not know who would read this information or what their perceptions and attitudes towards disability, and subsequently myself, might be. This therefore evoked both anxiety and a sense of vulnerability. Nevertheless, my insider status appeared to have a positive impact on recruitment with several participants naming this as a factor influencing their participation.

The final sample consisted of six TCPs who indicated that they identified as living with a disability. It has been suggested that a sample size of three to six participants is appropriate for a project using IPA, allowing for both a detailed micro-analysis of each case and the development of meaningful similarities and differences across cases (Smith et al., 2009). All participants described having a physical health condition. One participant identified as male and the remainder identified as female. In order to stay as close to participants' own experiences as possible they were asked to identify and describe their disability, gender and ethnicity in their own words. This information, in addition to further demographic characteristics, can be seen in Table 2.

Table 2

Demographic details of participants

Participants	Description of Disability	Year of training	Gender	Age range	Ethnicity
1: Daniel	Bone condition	3	Male	25-29	White British
2: Leanne	Joint condition	2	Female	30-34	White British/other
3: Kate	Epilepsy	3	Female	25-29	White British
4: Charlotte	Arthritis	3	Female	30-34	White British
5: Holly	Irritable bowel syndrome	3	Female	25-29	White British
6: Sophie	Chronic pain and chronic fatigue	3	Female	30-34	White British

2.4.2 Data Collection

2.4.2.1 Developing the interview schedule: The interview schedule (Appendix E) was developed using guidance from Braun and Clarke (2013) including sequencing of questions, prompts and wording. It was influenced by key issues identified within relevant literature, the research question and specific areas of exploration which arose from these, as outlined in the introduction. The draft interview schedule was shared with the research supervisor, but no changes were made following this.

No substantial issues were encountered during the first interview and positive feedback was received from the participant, so no changes were made to the interview schedule. Feedback was sought after each interview and the guide was regularly reviewed to ensure it was generating the information needed to address the research question. The semi-structured nature of the interview schedule also meant that it could be used flexibly, ensuring any novel areas of interest that emerged could be explored further.

2.4.2.2 Conducting interviews: Prior to beginning interviews participants were asked to re-read the information sheet (Appendix D) and given the opportunity to ask questions. If they felt comfortable proceeding, participants were then asked to sign a consent form confirming that they understood the nature of the research and their rights (Appendix F). Participants were asked to answer some brief demographic questions regarding their age and how they would describe their gender and ethnicity. All participants had volunteered information regarding their year of training prior to the interview taking place. However had they not, this information would also have been collected. Two interviews took place in a neutral location (the University of East London). Due to participant requests, four interviews were completed via video calling (Skype). These interviews followed the same procedure and participants were asked to sign the consent form electronically.

Interviews lasted between 73 and 96 minutes and were audio recorded. The prepared interview schedule was broadly followed but, in line with the semi-structured approach, was used flexibly in order to be guided by the issues raised by

participants and allow further exploration of these through prompts and follow-up questions. Each interview was completed on a separate day to aid concentration and focus and to ensure that content and process issues from interviews did not merge (Rubin & Rubin, 2005).

Following the interview, participants were provided with a verbal and written debrief. This including the opportunity to ask any questions, the provision of information regarding sources of support and my contact details. Participants were also asked to confirm whether they would like to receive a summary of the research findings upon completion.

2.4.2.3 Transcription: Interviews were transcribed as soon as possible following completion, usually within one week. Interviews were transcribed orthographically, meaning that focus was on the words that were spoken as opposed to the paralinguistic aspects of the speech (Gibson & Hugh-Jones, 2012). An adapted version of Braun and Clarke's (2013) notation system was utilised (Appendix G) and all identifying information was changed or removed. In addition to preparing the data for analysis, the process of transcribing interviews also served to facilitate my familiarity with the data and promote reflection.

2.4.3 Analysis
Data was analysed using IPA following the approach outlined by Smith and colleagues (2009). The process followed is outlined below.

2.4.3.1 Reading and re-reading: This involved ensuring that the participant was the focus of the analysis by actively engaging with the data. In order to facilitate this, audio-recordings of interviews were listened to several times, including during the process of transcription itself. I read transcripts multiple times and initial observations, thoughts and reactions were noted.

2.4.3.2 Initial noting: This allowed for a growing familiarity with the data and I began to recognise the ways in which the participants understood and discussed the issues

being explored. Detailed comments were written on the transcript including descriptive, linguistic and conceptual comments (Appendix G).

2.4.3.3 Developing emerging themes: This involved an analytic shift in which the exploratory comments discussed above became the focus. The aim here was to capture and reflect what was important in the initial comments within concise statements which were both grounded and conceptual. The emergent themes developed therefore incorporated both the participant's initial thoughts and my own interpretation. An extract of analysis demonstrating the above processes can be found in Appendix H.

2.4.3.4 Searching for connections across emerging themes: This involved mapping how I believed the themes identified fit together to produce a structure which pointed to the most significant aspects of a participant's account. In order to do this, themes were transferred onto post-it notes. Patterns between these were explored and themes were manually arranged into clusters. A name was developed for each of these clusters, comprising a super-ordinate theme. Finally, a table was produced demonstrating the structure of the super-ordinate and emerging themes and linking this back to transcripts through the inclusion of line numbers and key words.

2.4.3.5 Moving to the next case: The above process was repeated for each participant. Whilst I recognised that I would inevitably be partially influenced by findings from previous participants, I aimed to bracket ideas from previous participants and treat each case on its own terms.

2.4.3.6 Looking for patterns across cases: After all interviews had been analysed my analysis moved to a group level. I allocated each participant a colour to enable me to follow them throughout this process. The tables of super-ordinate and subordinate themes developed for each participant were printed and used to examine connections, similarities and differences across the dataset. During this process, some sections of individual transcripts were revisited and recoded if due attention had not been paid to an idea initially. The printed themes were manually arranged with similar themes being clustered together, and thus processes of abstraction led to the development of subordinate and super-ordinate themes at the group level.

Themes were also clustered according to contextual elements and incidences of polarised accounts were considered.

The resultant themes were shared and discussed with my supervisor, following which one proposed superordinate theme was dropped and was instead seen as weaving throughout the three remaining superordinate themes. The previous and final arrangements of subordinate and superordinate themes can be seen in Appendix I. Following this process tables were developed demonstrating the overall relationships between themes and superordinate themes, with examples for each participant (Appendices J). A tabulated overview of recurrences of themes across participants was also developed (Appendix K).

2.5 Reflexivity

Within qualitative research, it is recognised that analysis is not a neutral process and our experiences will inevitably shape our understanding of phenomena raised. As such, rather than 'discovering' existing themes, the researcher plays an active role in identifying and selecting these (Taylor & Ussher, 2001). As discussed above, within IPA there is particular acknowledgement of the dynamic role the researcher plays in data analysis through the double hermeneutic (Smith & Osborn, 2003). The importance of epistemological and personal reflexivity have therefore been emphasised. Epistemological reflexivity refers to the assumptions about knowledge and the world that have been made during the research and considers the impact of these (Willig, 2013). Personal reflexivity on the other hand refers to the way our experiences, beliefs and values influence and shape the research and how the research in turn affects us. In the opening of this thesis I discussed my own position as a TCP living with epilepsy and how my training journey drew me to the research topic. It is important to note that I had much in common with my research participants who, in addition to also being TCPs with disabilities, were predominantly White British females of a similar age. Whilst this does not necessarily mean that our perspectives would be the same, I wondered how gender may have shaped differences in perspectives between the one male participant and the female participants and myself.

Participants were aware of my position as a TCP with a long-term health condition, and this insider status is likely to have affected the experiences participants shared with me. Conversely, my position as someone with a fluctuating and invisible condition at times led me to question both the validity of my difficulties and my disability identity and I wondered how I might be perceived by participants. This may in turn have affected the questions I felt able to ask.

Given my proximity to the research topic, reflexivity was particularly important and was attended to through the use of a reflective diary (Appendix L). This was used regularly including after each interview. I also held open and transparent conversations throughout the research process with my both my academic supervisor and other trainees utilising IPA.

2.6 Ethical Considerations

2.6.1 Informed consent
Informed consent was obtained by providing participants with a detailed information sheet outlining the aim of the study, what participation would involve and how data would be used (Appendix D). Participants were given the opportunity to discuss the study and to ask me any questions both prior to arranging an interview and at the beginning of the interview meeting. I then sought their written consent (Appendix F).

2.6.2 Confidentiality
Participants were informed about how confidentiality would be maintained and the limits to this both verbally and within the written information sheet. In order to protect anonymity, all identifying information was removed or changed within transcripts and the write-up of the study. Identifying information and transcripts were stored securely at my home address. Participants were informed that audio recordings would be destroyed following the Viva and that transcripts would be destroyed after three years. Quotes were carefully chosen to minimise the likelihood that contributions would be identifiable by readers, for example course programme staff. This was given particular attention given that it was a concern raised by one the participants.

2.6.3 Right to Withdraw

Participants were informed that they were able to withdraw from the research at any time without providing a reason and that this would not disadvantage them. Participants were also informed that should they withdraw from the study after the analysis had begun, their anonymised data may still have been used.

2.6.4 Potential for Distress

Whilst some participants may experience the opportunity to reflect on previous experiences as "therapeutic" (Birch & Miller, 2000), given the nature of research question I recognised that some participants could become distressed during the interviews when describing difficult experiences. Participants were informed that they were under no obligation to answer questions that they did not wish to and that they were able to take breaks, reschedule or withdraw from the study should they wish. Following the interview participants were debriefed, including an opportunity to discuss their experience of the interview and ask any questions. They were also provided with written information including sources for further support (Appendix M).

Given the proximity of the topic I also recognised that there was a possibility that I may experience some distress in the process of completing the research. It was agreed that, should this occur, relevant supervisors would be contacted.

2.6.5 Ethical Approval

Ethical approval was sought and granted from the University of East London ethics committee (Appendix N).

CHAPTER 3: RESULTS

This chapter presents the themes developed following analysis of each participant's account. Superordinate and subordinate themes will be outlined and discussed, including areas of convergence and divergence. These will be illustrated through the inclusion of quotes, which support the presentation of a rich account of participants' experiences and the meanings attached to these. I acknowledge that my interpretation is one of many possible constructions of participants' experiences. In order to aid transparency and convey my own contribution to the analytic process, personal reflections are interwoven throughout.

A summary of superordinate and subordinate themes can be seen in Table 3.

Table 3

Superordinate and subordinate themes

Superordinate themes	Subordinate themes
Everyday battles	Everyday work of disability
	Psycho-emotional experience
	The burden of responsibility
	Soldiering on: The need to manage
Identity	Navigating disability identity
	The personal, public and professional
	Being disabled enough
	Benefits of an insider identity
Silence and speaking	Silence around disability
	Navigating disclosure
	Becoming a problem
	Safe spaces

The reoccurrence of themes across participants can be found in Appendix K.

3.1 Everyday Battles

This superordinate theme aims to capture the everyday additional work involved in being a disabled trainee. This ranged from practical to emotional and incorporated the responsibility that trainees felt in regards to a number of disability issues. Alongside this was a need to adopt a position of resilience in order to endure the challenges encountered.

3.1.1 Everyday Work of Disability

Present in this theme is the effortful work involved in training with a disability. Trainees' use of language when discussing these issues was particularly striking, including the use of metaphors of war in order to convey experiences:

…for me it's a daily battle of… doing the job (Holly, 211-212)

… had I been fighting through all of this for nothing? (Sophie, 2696-2697)

This seems to indicate the intensity of the hardship of trainees' experiences in addition to reflecting metaphors commonly used around disability and illness in relation to fighting and survival. The suggestion that disabled trainees are at war also led me to question who their battle is against. At various points throughout participants' accounts this seemed to include their own health conditions, clinical psychology training and society itself, alluding to the multi-levelled complexity of their experiences.

The differences between healthy and unhealthy bodies also became apparent. Charlotte emphasised the differences between herself and others, focusing on the additional effort involved in explaining this:

…relatively easy to get to for a healthy person isn't the same as relatively easy to get to for myself… saying things like I can't walk for more than say 10 minutes, having to then explain this is my 10 minutes not your 10 minutes… So having to remember that that's not the same as someone else's 10 minutes but also having to really sort of spell out if I have to walk for more than this length of time I might not collapse but I'm gonna be exhausted and you're not gonna get a good days work from me. (Charlotte, 457-487)

Here, Charlotte explains the subsequent impact of using her limited energy resource on travelling to work. Leanne also made a distinction between herself and "normal" or "healthy" people, suggesting both she and Charlotte experience a strong sense of difference between themselves and others – something which was perhaps exacerbated by the training experience:

I feel much more disabled now than I ever have before… I have been through similar periods in the past… and it's never impacted me the same way as it has now so I don't know if that's because I'm on the course but I certainly feel, it might just be that

I'm getting older as well ((laughter)) feeling more disabled now than I ever have before (Charlotte, 2243-2265)

…it's made it more of a focus… made it a bit of a bigger circle the disability circle (Leanne, 1713-1715)

Thus for both Leanne and Charlotte, it appeared that training itself has had a disabling impact. Whilst Sophie and Kate did not make direct reference to this they vividly described the additional challenges they have faced throughout training:

…one of the things I struggle with when I'm either very tired or in a lot of pain is concentration and also motivation… the medication that I'm on also can make you a bit drowsy and one of them has sort of like cognitive effects so you can be a bit forgetful or a bit woozy (Sophie, 717-737)

I need to not get to a point where I'm so tired I'm gonna have a seizure… I think the challenge is balancing the course but then having to spend lots of time doing yoga and loads of sleep, eating well, exercise, all the extra crap you have to do that actually you could probably get away with not doing for three years but I can't (Kate, 2870-2891)

Therefore for Sophie the work is managing her "symptoms" alongside course demands, whereas for Kate the work is preventative yet vital, and highly time consuming.

For Holly, the interaction between her disability and her trainee role leads to additional complications and challenges:

…as a trainee it's just more complex, I don't know the code on the bloody wall or I haven't got a pass to get in so I've gotta wait for people to let me in, I've gotta ask someone to get me in. When you've got IBS and you need the toilet you need to go straight away. It's little things like that that create stress and just make every day really difficult (Holly, 2218-2244)

Holly therefore perceives the transient nature of training as leading to additional challenges in the management of disability. She suggests it places her in a position of dependency on others which, as she explains, does not fit the needs of a person living with IBS. This incorporates just one of the "little things" contributing to her "daily battle".

3.1.2 Psycho-emotional Experience of Being a Disabled Trainee

Further to the extra physical and practical labour, a second strain of work was required in relation to trainees' psychological and emotional experiences as disabled trainees. A number of participants described how aspects of the programme had affected them on a deeply emotional level, including experiences of teaching itself:

Oh rough, really rough again particularly to begin with I got very emotional and left the room ((sighs)) I went home I think actually in one of them. I struggled… it was thinking about how these things can affect people and when I really strongly identified that was really hard? Especially the things around self-identity, self-esteem and I was just like yeah I feel really crap. So it was hard and I left (Sophie, 804-820)

We see the strength of the emotional impact through Sophie's repeated use of the word "really". The discussion of issues around the self caused most distress, providing an insight into her own struggles with this. Importantly, several participants reported that training programmes neglected to acknowledge within disability-related lectures that trainees may be affected by the content. This may reflect assumptions that trainees do not have disabilities and also replicates wider silence around disability. Within these extracts we therefore see an overlap with the superordinate themes of both "Speaking and Silence" and "Identity", where some of these issues will be further discussed.

Leanne's journey as a disabled trainee also had an emotional impact. Like many participants, it was the approaches adopted by programmes that led to distress:

…it was like a massive massive thing that made you feel, well made me feel a bit shit. I was like this is what I've been told I need as a disability, need under that

framework, and then you're telling me "well we don't really like it" ... I have to tell each lecturer, I have to share my personal information to each lecturer and then they have the choice whether to say yes or no (Leanne, 138-148)

Leanne perceived the programme's approach to her requests around adjustments to be disproportionate, as indicated by her repetition of the word "massive". This perhaps in turn amplified the significance of her condition itself, contributing to the difficult emotions evoked by these experiences.

Charlotte also found herself affected by her course's approach. She spoke of the circumstances around her attempts to return to university part-time following a period of sickness:

I think one of the things I found hard is I never knew if the course really wanted me while I was fighting for it. I didn't feel like I was being supported and I thought that meant that maybe they didn't want me on the course and I now understand... that they were fighting for me but they couldn't do that openly and they didn't want to put stress onto me so they weren't telling me what they were doing, which ironically was very stressful (Charlotte, 3100-3114)

Charlotte described the uncertainty she experienced and the impact of this in terms of "stress"; the programme's lack of transparency resulted in her conclusion that she is unwanted. I found this incredibly emotive and wondered if the feelings raised in me were a small echo of what Charlotte herself had experienced. It therefore seems that approaches taken with the intention of protecting can, conversely, have the opposite effect.

For Daniel, the psycho-emotional impact came in the form of self-doubt:

...it feeds into all those ideas about imposter syndrome as well of am I a bad psychologist because I don't want to reflect on issues of disability? Am I a bad trainee because I don't want to go there? (Daniel, 1232-1235)

Ambivalence regarding reflecting on disability, in conjunction with a professional culture that assumes he should connect with these issues, contributed to Daniel feeling like an "imposter". Interestingly, he appeared to make a distinction between good and "bad" psychologists. I wondered where Daniel would perceive having a disability to be placed within this dichotomy and whether this might also contribute to feelings of being an "imposter"?

Holly also connected with the interaction between having a disability and being a good trainee. Here, she reflects on her experiences of self-doubt, describing changes over time:

In first year you…haven't got a clue what you're doing, you've got this health condition, you just feel like a burden and a failure and you basically feel not good enough and now 'cause I've grown in confidence and I know what I'm doing more and I'm learning that I feel a little bit like I accept my health condition a little bit more? I'm a bit like oh so what I'm on the loo for an hour and I've missed a meeting… I'm good, I'm good at my job (Holly, 1993-2009)

Holly presented training as a journey that induced and later diminished self-doubt. Her initial feelings of being "a burden" and "a failure" were replaced by a new-found confidence and acceptance of her position as a disabled trainee, with the acquisition of skills through training forming a key contributing factor.

3.1.3 The Burden of Responsibility

The theme of carrying responsibility was present across all accounts with variation within this, perhaps indicating the different responsibilities felt most heavily by each participant. Both Daniel and Kate raised how the onus is on them to raise issues relating to disability:

… no supervisor has ever prompted me to think through a disability lens about this or wonder what my reflections are as a disabled person and I wonder whether they feel a bit scared of doing so, understandably perhaps (Daniel, 1647-1654)

…unless you're not doing well or you're really struggling with your health I don't think it's asked about really, people just forget and they assume you're doing fine unless you bring up… (Kate, 1194-1196)

Daniel and Kate describe the different ways in which responsibility is placed on them. For Daniel, it was fear and discomfort that prevented others from raising issues of disability. Kate, however, felt that disability is forgotten. I found this particularly poignant, most notably when she told me that she would not express any difficulties unless specifically asked:

… sometimes you need someone to ask you whether you're not OK for you to be able to say you're not OK (Kate, 2986-2999)

It therefore seems that training programmes mistakenly assume that trainees will themselves raise difficulties in relation to disability. The onus on trainees to do so can result in these remaining unspoken and trainees feeling their experience has not been considered.

Sophie also reflected on the responsibility for navigating processes around support such as accessing occupational health:

…when one thing you struggle with is your energy levels and your ability to take on multiple tasks and that kind of thing, to then have to coordinate all of that…it's tiring and it uses up resources (Sophie, 2465-2475)

Her description of using up limited resources is reminiscent of Charlotte's earlier references to this idea. However, for Sophie it is the work involved in getting her needs met that uses these resources, subsequently impacting her ability to complete academic and clinical work.

Leanne also appeared frustrated in relation to the placement of responsibility, although her feelings were directed towards her programme:

…why can't you put me in a placement and tell them this is the needs of this person? Put me in a placement that supports those needs. There are plenty of places that would love you to do that, there are loads that it doesn't work for but find one that, I think that's your role, the course tells the placements what you need (Leanne, 1488-1603)

She described how her programme did not take responsibility for ensuring a placement was found that met her needs. Instead the responsibility fell to her to request this after beginning the placement. This shifting of responsibility from programmes to trainees is particularly important given power differentials between programme staff and trainees and the differences in weight that might subsequently be given to requests from each party.

3.1.4 Soldiering on: The Need to Manage

All participants spoke of the difficult nature of their training journeys and the need to manage this, with Daniel referring to the "need to get through" (Daniel, 1238-9) and the strategies he employs to do so as "survival" (Daniel, 1940). For me, this evoked an image of a lone person far out at sea, battling the waves as they struggle to stay afloat. This sense of struggle was present across participants' accounts.

Whilst all participants referred to a need to manage, this was experienced in various ways. For Sophie, the pressure to manage manifested itself through feeling that she must "hide" (862) her struggles due to dual concerns. Firstly, she questioned:

…if I spoke about it not being OK then what did that say about me as a person and you know, that sense of not being a good enough trainee (Sophie, 980-982)

For Sophie, not managing was intertwined with self-doubt, particularly around being "good enough". However, she was also concerned by the perceptions of others:

I think people do make an assumption about you if the first time you meet them and you talk to them you're sitting there crying, they think you're a bit of a weirdo (Sophie, 423-425)

The need to manage therefore seemed to arise both from the meanings that Sophie attaches to not managing and the meanings that she fears others may ascribe to this.

Holly explicitly described the pressure to manage as coming from her training programme:

I feel like the course just teach you to soldier on, they do kind of encourage you to make sacrifices or "it's OK to be struggling" and yeah I get that it is OK but there's a point as well and I think they just, again they just want to see you go through and pass (Holly, 1622-1629)

For Holly, the wellbeing of trainees comes second to the course's primary priority: for trainees to graduate. Her use of the word "soldier" extends metaphors of war previously discussed and reflects all that she feels she is up against, whilst "sacrifices" gives a sense of the losses she has encountered. She later repeated this, pairing it with the concept of resilience:

…we basically just put up with it and been really resilient and made loads of sacrifices (Holly, 2456-459)

Holly's "we" refers to disabled trainees as a collective, indicating that she feels that the need for "resilience" and "sacrifice" is a shared experience. She therefore indicates that TwD are compelled into adopting a resilient position, as opposed to the structural changes being made that might enable them to release this role and make fewer "sacrifices".

Finally, Kate drew more generally upon wider societal attitudes towards sickness:

I think feeling like a slacker comes into it a bit… I think it's almost socially constructed to be honest in terms of loads of people don't even take sick days which I find ridiculous, I don't know how they do it and I think we are in a culture of "well you've just got to work hard, you've just got to plug on" and I don't know whether

that's a British thing or just, I don't know just life. But I do feel like we are told a message of "well you should be cracking on"…I don't know whether it's something about if you're ill you're weak (Kate, 449-491)

Kate identified dominant narratives of sickness as "weak" and being a "slacker", creating barriers to taking the necessary time from work to manage her health needs. Similarly, Charlotte discussed societal attitudes towards disability and described the pressure to live up to the desires of others by fulfilling the image of "the happy brave person". She reflected:

… it seems like you've either got to be "this is terrible I can't do anything isn't my life tragic everyone feel a little bit sorry for me" or you've got to be… "I still have worth in society, I can still do things for society, maybe not in the same way as everyone else but" and you have to sell it, 'cause I think for a lot of people they don't understand a sort of a middle point… (Charlotte, 236-261)

For Charlotte, the dichotomy of dominant narratives around disability forces her into choosing between two roles; either she has a "tragic" life, in which she is unable to "do anything", or she has "worth". In having selected the latter, she is compelled to remain within that role and to manage at all costs in order to avoid falling into the alternative.

Leanne described how the position of being a trainee itself leads to an obligation to manage without needs being met:

I don't feel you can as a trainee say I need a desk or I need a space to put my stuff because you're a trainee… almost in terms of power even though I'm in the lesser position it's like even more so, you're in the lesser position, like you shouldn't have this thing (Leanne, 1752-1815)

Leanne referred to the power imbalances inherent within trainee relationships with others. Being in the "lesser position" means she feels unable to request required adjustments and is thus forced to manage without. Trainees are therefore placed in a marginalised position within placements and there is a significant intersection

between the way in which people marginalise disability and the reduced power inherent in the trainee position.

3.2 Identity

Many trainees expressed a conflict whereby, although they recognised themselves to have a disability, they did not necessarily identify in this way. This perhaps highlights the complexity of what it means to identify as disabled. This tension is captured within Kate's statement, which is representative of a number of participants:

I don't identify with having a disability as such although I know I do have one (Kate, 142-143)

The second superordinate theme described the intricate and often painful work that went into navigating identity during training. This occurred on multiple levels including disability identity itself, interactions between the personal, public and professional and the concept of being "disabled enough". A number of trainees also described how having a disability afforded them an insider identity, which carried multiple benefits.

3.2.1 Navigating a Disability Identity

All trainees discussed their relationship with disability identity, with a number of participants experiencing ongoing conflict within this. Holly viewed IBS as a strong aspect of her identity which she cannot separate from her role as a trainee. However, this appeared to carry negative consequences:

…I see IBS definitely as part of my identity, that's something I struggle with I struggle to differentiate myself from my IBS though the negative connotations that come with IBS I take on for myself… it's a big thing for me so because it's a big thing for me it's a big thing for me as a trainee (Holly, 1747-1769)

IBS seems to be intertwined with Holly's sense of self, with the significance of this represented through her repetition of the phrase "big thing for me". However,

dominant associations of IBS within society also appear to have been incorporated within this and I wondered if this indicated internalised oppression. Furthermore, for Holly there is no separation between herself as an individual and herself as a trainee. As such, IBS has been an important aspect of her training experience.

Daniel also spoke to me about his disability identity and his concerns around this:

…not wanting to be defined as having a disability, not wanting it to take over my experience as a trainee and not wanting it taking over my experience as a person (Daniel, 1696-1698)

Daniel described his fears of being "defined" and of disability "taking over". He also outlined his own conceptualisation of identity:

…I suppose you can add things like identity as a man, as a disabled person, as a straight person, all of these different things they all intersect and I think my identity on every single different one of those different things might, all the GGRRAAACCEEESSS might vary at different times… I think that's been one of the big bits of learning, that it's OK to have different identities as a psychologist and as a person and as a disabled person and anything else. I suppose the tension to the course… is that I feel like there's a pressure to develop a consistent identity and not have this fragmented and flexible system that I would like to have and I think has worked for me (Daniel, 1301-1323)

Daniel's understanding of identity drew on Burnham's (1992) Social GGRRAAACCEEESSS and he argues for flexibility within this. I wondered if this might serve a protective function against the fear of disability becoming his dominant identity. However, he experienced a threat to this view during training, feeling a pressure to unite his "flexible system". The following extract conveys how training compelled him to begin reframing his perspective on his identity:

…it's an interesting question about identifying as someone with a disability as well because it's something I've always kind of pushed away and only in the last, well

since the course really, I've started thinking more about disability identity (Daniel, 9-17)

It seems that Daniel previously avoided exploring his disability identity and his journey toward this was triggered by beginning training. I wondered whether confronting disability was a welcome prospect, or something he felt had been imposed?

For other trainees, navigating a disability identity appeared to be an ongoing process that involved changes and development throughout their training:

I have taken a few years to then say "look I do get colds a fair amount and I don't just soldier on anymore, I have learnt to just look after myself and I know that when I need to go home I need to go home". So that's how I say it now but that's definitely changed over time, 'cause I did used to just soldier on in the first year (Kate, 637-647)

The change in Kate's approach to her health needs might indicate an increased acceptance and ownership of her health as training progressed. On the other hand, it also suggested to me that the heavy demands of training meant she was no longer able to "soldier on", signifying that the challenging nature of training can trigger a reorganisation of disability identity.

For Sophie, the process of training had a dual impact both in terms of accepting and questioning her difficulties and her disability identity:

…in one way it's made me think, well actually you have these difficulties but you can still do things with them and that things fluctuate and there'll be [days] where I have to sleep all day, but then there'll also be days where I can hammer out a lot of work and feel really good about it. ((sniffs)) But then I also think that there are times when you feel am I disabled enough? So I think sometimes belonging to like online groups can be a really great support but also ((sniffs)) there seems to be this kind of peacocking of who has it worse? And that maybe your disability isn't valid because you can still go to work (Sophie, 2064-2087)

For Sophie, achieving during training despite the fluctuations in her health contributed to an increased acceptance of her disability. Conversely, the act of working evoked a comparison with others and conflicted with dominant disability narratives. This led her to question whether her disability is "valid", overlapping with the later subordinate theme of being disabled enough.

3.2.2 The Personal, Public and Professional

Many trainees discussed the challenge of navigating their personal, public and professional identities in relation to disability. Daniel described a set of professional norms associated with being a clinical psychologist:

…in psychology there's a pressure to own your own position and wear that on your sleeve and show it outwardly (Daniel, 1177-11799

Daniel portrayed training as promoting a single acceptable way to be a clinical psychologist, including ownership and outward expression of one's position. Conversely, many trainees viewed disability as socially constructed as part of a private self:

…we just don't talk about it and I kind of feel like there is this kind of taboo about it, or at least maybe not taboo but it's very private for some reason… I think because it's about your physical make up (Kate, 497-505)

Kate related the personal nature of disability to its connection with "physical make up". She later described a fear of being reprimanded for disclosing her disability to clients, suggesting that bringing disability into the professional space crossed perceived boundaries. Her use of the word "taboo" is particularly telling, and this sentiment was echoed by others:

… there's definitely stigma around it (Holly, 2849-2851)

Trainees therefore experienced a conflict between dominant views of disability as personal and a professional culture that demands outward ownership of one's position. This requires them to navigate pressure to be open within a context in which part of the self is stigmatised and constructed as "private".

For both Kate and Holly the interaction between the personal, the public and the professional resulted in feelings of embarrassment. Kate shared her feelings regarding an upcoming lecture:

… everyone will know that I have epilepsy because I will say, because I feel like I need to say my views will probably be very biased in that lecture because I have got my own experiences, but also the fact that that will come up is so f- … you know it's such a horrible experience that as well feeling like people would know that I looked like that? And that being kind of embarrassing and really eugh (Kate, 2253-2283)

Kate discussed feeling compelled to disclose her epilepsy in order to own her position and views, echoing Daniel's earlier sentiments. As her trainee peers develop an increased understanding of the realities of epilepsy, she will undergo a process of exposure in which the previously personal will become public. Her use of expletives and "eugh" indicate the strength of embarrassment created by this.

Holly explicitly described her struggle of navigating professional norms and culture whilst living in a body that frequently exposes her disability and results in her being regarded as unprofessional:

… I don't come across very well because I'm either burping in the office or I've got gas or I need to run to the office 'cause I'm gonna poo myself, and I let people know that so I come across actually quite informal. And that's something that's actually been brought up by a few placement supervisors… definitely some trainees in the cohort and some qualified psychologists put on a different mask for work or take on a different role and I don't really do that… sometimes related to my health I feel like I could be seen as more unprofessional (Holly, 1783-1791)

Holly's reference to a "mask" distinguishes between a psychologist's personal interior and the professional exterior they might convey. Both the nature of Holly's disability and her open approach to managing her needs contradicts this distinction. Thus for Holly, disability is incongruent with the professional culture of clinical psychology. Negative responses from others in relation to this can then be internalised:

I work really hard to give a good impression and to be professional and then… that made me angry at my health condition (Holly, 1942-1945)

Here, the comments of a senior member of staff resulted in Holly experiencing anger towards her IBS. I found Holly's account of the challenges she faced particularly emotive, perhaps as it resonated with my own experience of difficulties associated with my condition being conflated with professional competence.

Sophie also reported negative perceptions of disabled trainees:

…it's nice to be seen as somebody in your own right and who maybe just finds some things difficult rather than being someone who isn't capable or someone who is a pain in the bum to work with, someone who's a bit of a nightmare where you're like "oh God I've got that trainee, y'know the one who needs this that and the other" (Sophie, 1386-1396)

Supervisors can therefore view TwD as both incapable and inconvenient. Charlotte portrayed a similar view:

…it felt like they were waiting for me to go "this is too hard I'm going to quit"… you don't want to input money to someone who might not finish the course (Charlotte, 1025-1032)

In this respect, the training system exists as designed for healthy bodies and Charlotte perceived there to be an expectation of failure from disabled trainees, who experience themselves as undesirable to supervisors and to training programmes.

3.2.3 Being Disabled Enough

All participants referenced the concept of being disabled enough, which interacted with navigating their identities and with specific aspects of training itself:

…it's not like I've had to have my legs taken off or y'know, I don't have a terminal illness and sort of thinking am I impaired enough? Am I disabled enough to warrant feeling this way? Or to feel that I need extra support? (Sophie, 1946-1957)

Not feeling "disabled enough" compelled Sophie to question the validity of her experiences, posing a barrier to accessing support. This resonated strongly with my own experiences of describing my health as "not that bad" and questioning whether additional support or the emotions I experienced were justified. Like many participants, Sophie understood this through dominant narratives and concepts of visibility:

…comes perhaps from this idea of disability being somebody in a wheelchair? Or ((sniffs)) y'know, a veteran who's lost a limb is how people see disability, or disability that you can see very visually. So for example I have a friend…she had a very visible hump in her back ((sniffs)) and so I think maybe that's where those ideas come from is the idea that disability isn't valid unless it's visible (Sophie, 1972-1989)

Conversely, Holly strongly perceives herself as having a disability but feels others do not share this view:

…I do see it as a disability a hundred percent but I've never called it a disa- I've never called it a disability, I think just the way IBS is framed is more of a long term health condition. Like I don't think it's under the disability act…I've tried to apply for different disability stuff and it just doesn't get acknowledged at all. So IBS in terms of society doesn't see it as a dis- er as a disability, so I think a reflection of that I don't use the disability, you know that word (Holly, 17-54)

Holly explained that she does not feel IBS is taken as "seriously" (2752) as other health conditions or that it is seen as a disability, and she consequently struggles to access support. The views of others also affect how she herself describes her condition. She repeatedly tripped over the word "disability", possibly indicating her lack of familiarity or comfort with this term.

Not being "disabled enough" or having valid needs was also reflected in the language used by participants to discuss their wellbeing:

…epilepsy can be really really awful for some people and they have seizures like three times a day every day and I don't…and because it's not very bad in comparison to other people's I kind of feel like that's probably why I don't consider myself to have a disability, I don't really feel like it's bad enough…so I do feel like I'm playing the card (Kate, 1845-1860)

Kate understood requests for adjustments as "playing the epilepsy card" as a result of comparing herself to others, echoing Sophie's questioning of whether her disability is "bad enough". Daniel similarly made reference to the "use" of disability, including in order to gain exam adjustments. He later reflected:

… I'd have written a lot less than other people so actually it was really helpful, I think it was needed and justified in hindsight but I'd also not wanted to 'cause I didn't want to identify as disabled back then (Daniel, 2018-2022)

Daniel therefore experienced a shift in his thinking during training, from an unjustified "use" of disability to an acceptance that his need is valid and that he is, perhaps, disabled enough.

3.2.4 Benefits of an Insider Identity
Despite the numerous challenges, trainees frequently spoke of the benefits and strengths associated with their disability identity. These ideas emerged across all accounts, often organically. It could be argued that this occurred as they were highly salient to participants. Alternatively, or additionally, participants might have been

motivated to avoid presenting problem-saturated narratives of TwD that could reinforce negative connotations.

Whilst many trainees experienced an ongoing struggle in navigating their disability identity, Kate spoke of a shared identity with clients:

…there's like an affinity between me and the people that we talk about in some ways, because I mean no-one's perfect obviously but I have a very explicit thing that is wrong with my brain so it's much easier in some ways to identify with people who also not necessarily have things wrong with their brain but are disadvantaged (Kate, 2134-2148)

The benefits associated with this shared identity were wide ranging, including reducing the power differential inherent in therapist-client relationships:

I have shared it with clients before I think to kind of bring us down to a (…) maybe to kind of unsettle the power imbalance in terms of trying to say I have an experience as well (Kate, 1479-1481)

Daniel explicitly drew on his insider identity to become a role model for young people, and reflected on the powerful impact of this on everyone involved:

I acted as a co-participant and I think that was quite powerful for them and for me as well. So I was essentially disclosing something to them, showing that I am actually someone working in this medical team at this time… so that's an example of somewhere where I think it was really good for me too (Daniel, 1474-1487)

For many trainees, holding an insider identity carried benefits even without explicit disclosure:

…people can see that I have a disability, they can see that I've had a struggle or difficulty and so that I think does open people up to talk about it and talk about their problems (Charlotte, 2276-2288)

Thus for Charlotte, the visibility of her condition and the "struggle" and "suffering" associated with this helps the formation of connections with clients, facilitating openness.

Trainees also described the specific skills that they had developed as a result of their personal experiences:

…I've had to learn to adapt so I'm quite good at thinking about like how can this happen (Leanne, 1934-1935)

I'm often the one in meetings or when thinking about client groups like actually is there access to this service, are we having breaks, because just because we can plough through doesn't mean everybody can or wants to or should…That's probably me as a person with a disability that's probably why that happens (Leanne, 1909-1921).

Leanne's experiences of disability therefore led to the development of an alternative perspective, in which she is a skilled problem solver. Furthermore, as a result of her experiences she considers the needs of others in a way others may neglect.

For many trainees, having an insider identity was a strong motivator in their decision to embark on clinical training. This showed itself in a variety of ways. Holly explained:

…if I didn't have IBS I wouldn't be on the course because the reason, when I had IBS I sought, I got depressed and I sought therapy and that's how I got interested in being a psychologist… if I didn't have IBS I might not have been where I am now (Holly, 2103-2122)

For Holly, it was not the direct experience of IBS that led her to clinical psychology, but the impact of this on her emotional wellbeing and her subsequent experiences of therapy. This affords her a dual insider identity as having experienced difficulties with both physical and mental health, and she attributed her current position as a trainee to these.

Charlotte discussed a number of additional ways in which her insider identity influenced her career choice:

I became a psychologist ultimately because I want to be worth something to society, having grown up with a disability you feel like you have to prove your worth and I in some way want to pay back the NHS for keeping me alive for all this time (Charlotte, 1400-1410)

Thus for Charlotte, becoming a clinical psychologist was a coping strategy through which she can prove her "worth". She did not state to whom this needed to be proved; I wondered if this was to society or perhaps to herself, having internalised negative connotations of disability. Notably, she also shared the need to repay a debt to the NHS, perhaps reflecting narratives of disabled people as a drain on resources. Participants were therefore motivated by their previous experiences and insider identities in a number of ways.

3.3 Silence and Speaking

The final superordinate theme reflected trainees' awareness of a culture of silence around disability, which required them to undertake the complex work of navigating disclosure and managing consequences of breaking the silence. Perhaps as a result, finding safe spaces became crucial.

3.3.1 Silence around Disability

A sense of a silence around disability within training was present within many trainees' accounts:

…literally think it's been mentioned like once, it's not something that the course really has promoted (Kate, 1132-1136)

…our year have set up sort of like support spaces or thinking spaces…none of us even raised or thought about disability space. I'm not sure if that's because we feel

it's not needed or because we've not raised it or there's not space (Leanne, 2367-2374)

Kate's description of a single mention of disability and her use of the word "promoted" suggests discussion of disability is not encouraged by course teams. In Leanne's extract, we see an onus on trainees to develop spaces for support. Importantly, it suggests that the silence around disability is perpetuated not only by programmes but by trainees themselves, perhaps indicating that they assume a culture of silence early in training.

Almost all participants were asked about contact with disabled qualified psychologists, with Daniel being the only participant to report this. Charlotte attempted to understand the apparent absence of disabled psychologists:

… I'm sort of assuming there just aren't a lot of psychologists that have disabilities. I know there are some because I've googled, looked it up I know there are some but I think part of my assumption is they're not there or they're not talking about it, and if they're not talking about it then you start wondering why they're not talking about it and whether I should be talking about it or whether I'm shooting myself in the foot (Charlotte, 2886-2905)

Charlotte made sense of this invisibility by understanding disabled psychologists as either rare or choosing to pass, which in turn led her to question her own openness. Thus the silence of others created concerns regarding the consequences of talking and a potential silencing of herself. It is also notable that Charlotte "googled" disabled psychologists, suggesting a desire to identify and perhaps connect with others. This perhaps indicates a sense of isolation and I wondered about the messages conveyed by the lack of visible role models.

Trainees also demonstrated an awareness that silence during training replicates a wider social context. Kate told me:

…it's been really interesting reflecting on how crap the course is but society in general in talking about disabilities… how little we talk about stuff like this both in society and more specifically the course (Kate, 3074-3108)

Trainees attempted to make sense of this silence in several ways. Daniel raised a number of factors, the first of which was a lack of understanding of the lived experience of disability:

…it almost felt like the message of the lecture was "It's OK guys, got the social model, this is what's happening in society now it's ok" and that is just not the case and that might be where the thinking's at but that's not been my experience (Daniel, 454-459)

For Daniel, the discrepancy between his experience and the messages conveyed during teaching generated frustration. His repetition of "it's OK" suggests he experienced this lecture as denying ongoing issues relating to disability, raising possibilities regarding the silencing of future discussion. He later discussed notions of permission:

… it comes back to what I was saying earlier about different types of diversity being favoured and you're allowed to talk about this and not this (Daniel, 733-736)

I feel that supervisors don't feel they have permission to talk about it (Daniel, 1629-1630)

I was struck by Daniel's description of preferred types of diversity and wondered how and why disability became less "favoured". His suggestion that neither trainees nor supervisors feel they have "permission" to break the silence led me to question where this idea originated and whose permission would be needed for conversations to occur.

Finally, both Daniel and Charlotte raised the discomfort of others, particularly supervisors, as barriers to discussion:

… no supervisor has ever prompted me to think through a disability lens about this or wonder what my reflections are as a disabled person and I wonder whether they feel a bit scared of doing so (Daniel, 1647-1650)

… it's uncomfortable for people to talk about it. I think people worry about it and they're scared of thinking about it because it's not a pleasant discussion and because I think it is very ingrained in society that being disabled is a terrible thing and we must all be miserable and no-one wants to worry about that because that's an uncomfortable thing to think about (Charlotte, 805-825)

Daniel also described supervisors as "shell-shocked" when he has disclosed, indicating their surprise and suggesting assumptions that trainees are able-bodied. In addition, both Daniel and Charlotte experience others as "scared" of discussing disability, which Charlotte understood in the context of dominant disability narratives. From this perspective, others avoid discussions of disability in order to evade the associated discomfort.

3.3.2 Navigating Disclosure

A striking amount of work went into navigating disclosure. Trainees with invisible disabilities were constantly required to decide whether to disclose or pass as able-bodied. These decisions could carry many meanings. For Daniel, disclosure was intertwined with issues of identity:

I'm never going to ask someone to swap chairs, it's just not something I would do… I don't want to have to continually disclose "oh yeah I need that chair 'cause I've got a disability"…it would just feel very embarrassing and uncomfortable for me and it would mean having a conversation about disability that maybe I don't want at that time…'Cause it's one aspect it's definitely not everything but it can become overriding (Daniel, 875-897)

Here, Daniel's ongoing concerns of disability dominating, and the emotional discomfort associated with this, prevent him from disclosing despite his subsequent experiences of physical discomfort and pain.

Sophie also described disclosure as interwoven with her sense of self:

…part of it was not wanting to admit it had got worse? ((sniffs)) I think some of it was feeling embarrassed about it and that if I admitted it then I had to do something about it, and that would mean I wasn't good enough and all of those kind of things (Sophie, 231-235)

For Sophie, disclosure to others would require acknowledgement to herself of the worsening of her condition and the meanings attached to this, including feelings of inadequacy. Disclosure could therefore carry additional implications of transforming the hypothetical into a painful reality, adding an additional layer of complexity. Notably, both Daniel and Sophie referred to feelings of embarrassment, suggesting a sense of shame which may relate to the stigmatised nature of disability.

Sophie highlighted an additional barrier to disclosure in relation to fears regarding repercussions:

…I tried to hide it, I think because of that experience I'd had and also being worried that they'd, I dunno not kick me off the course but that ((sniff) it just wouldn't go very well I suppose (Sophie, 173-176)

"That experience" was a job offer which was ultimately withdrawn following Sophie's disclosure of disability. This highlights both the discrimination that trainees may encounter during their journey on to clinical training and the ways these experiences may continue to influence them.

Other trainees viewed disclosure as necessary in order to manage their health needs. In order to accomplish this, many developed a language around disclosure which they attended to closely. Charlotte described how this changed throughout training:

…if I continue to try and just sell the benefits and not talk about the difficulties then I'm not gonna finish the course (Charlotte, 220-222)

…it's a difficult balance showing the full impact while also remaining what they see as a good hard-working psychologist… you just try and think a little bit before you speak and you try and watch how people are reacting to how you talk about things (Charlotte, 1472-1498)

Charlotte began training by focusing on the strengths arising from disability. However she later learned that, in order to be supported, she needed to "talk about the difficulties" and she attempts to strike a balance within this. This requires a great amount of work in relation to monitoring the responses of others and she adapts accordingly to ensure that she is still perceived as a "good hard-working psychologist".

Conversely, decisions around disclosure were sometimes beyond trainees' control. Leanne described a conversation that took place with a member of course staff in a public corridor:

… I knew exactly what he was talking about and in my head I was like "this is OK 'cause they don't, they'd have to enquire to know that was a disability person" and then he went "oh because of your disability" so I was like "that's really not OK, you've just told everybody" (Leanne, 840-851)

In this instance, it was Leanne who had elected to stay silent by choosing to pass and someone in a position of power, namely course staff, who did the speaking by breaking confidentiality and "outing" her.

3.3.3 Becoming a Problem
A number of trainees shared the consequences of speaking about disability, including finding themselves framed as the problem. This often arose in relation to trainees' needs conflicting with an inflexible training system. The experience of being problematised occurred in varying ways, for example:

I think my experience has been that I've been labelled as difficult with a disability, so my exam arrangements I was specifically told "oh we've never had someone like this before, this is really difficult" (Leanne, 187-190)

Leanne experienced herself as "labelled as difficult" by her course and, from later comments, it seemed as though she may have internalised these ideas. For example, she described how requesting facilities to meet her needs "felt like I was causing a fuss" (315-316). Furthermore, she expressed concern about potential ramifications should she attempt to get her needs met whilst on placement:

… they're helping you as well with your training and they're assessing you and there's a level of inconvenience you don't wanna, or me personally don't want to cross so you can't ask them (Leanne, 1767-1771)

Supervisors' dual roles as supporters and assessors, and the power imbalance inherent within supervisor-trainee relationships, poses a barrier to Leanne seeking support. Perhaps in light of this, Leanne developed a particular approach:

…there's a way they do for most people and then if you need something different then it is, I mean it would be inconvenient for me like legit like that's ok, so I tried to ask for as little as I needed (Leanne, 891-894)

Leanne therefore perceives training as consisting of structures that are aimed at "most people", with anything outside this norm becoming "inconvenient". It seems likely that Leanne's designation "most people" represents those in healthy bodies. To manage this, Leanne requests as little as possible in order to pose less of a problem to others.

Holly and Sophie also described problematic situations arising from speaking up. For Holly, this occurred after attempting to discuss the challenge of meeting the numerous demands of training whilst living with a disability:

…she's like I just think you find things busy because I don't know, because my own threshold of busyness perhaps or something like that whereas I don't think she gets

that it actually feels really busy because of my health and that impact…then spoken about well that must be because, I don't know I'm not competent in some other area or that's just not one of my strengths, but actually it might just be because of my health condition (Holly, 948-1003)

Rather than considering the impact of an inflexible and demanding system, Holly's tutor attributes busyness as an internal struggle. As such, the problem stops with Holly, as the tutor queries her competence instead of considering the role of a rigid training system aimed at healthy bodies.

Sophie was also blamed for problems within the training system occurring during her transition to part-time work, in which she was given incorrect information. Despite the error being made by her course, Sophie herself was blamed for a lack of "thought around the wider process" (2337-338). She later elaborated:

…that feels like an unfair position to be put in when it's something beyond your control…nobody asks to have health problems, nobody wants to be in pain, nobody wants to struggle with these things so it felt unfair and it felt like if I'd made a decision to go off on maternity leave that's better received and better managed because it's a more typical experience? Than you know, managing a trainee who needs to take an extended amount of time to finish (Sophie, 2395-2417)

For Sophie, training is unequal for TwD as indicated by her repetition of "unfair". This also overlaps with Leanne's earlier comments through the notion of there being a "typical experience", which is "better received and better managed" than the comparative unfamiliarity of supporting a disabled trainee.

Conversely, Charlotte reflected on her lack of negative experiences:

… I think because I've been disabled my whole life and because I have what is a very obvious visible disability but also probably because I'm generally quite a cheerful sort of stubborn person that gets on with it I think people are nicer to me…

if I'm feeling very cynical then I say that I am a nice white middle class slim person who gives the impression of trying very hard to manage a disease and therefore is a good disabled person (Charlotte, 366-414)

Charlotte attributed her lack of negative experiences to being a "good disabled person"; for her, this incorporates a visible impairment and a positive attitude. She also drew on intersectionality in relation to her position as "a nice, white, middle-class, slim person". Whilst this may have enabled her to avoid being problematised, she nevertheless appeared affected by the risk of this and described how highlighting instances where needs are not being met feels "like you're moaning, you feel like you're overplaying the bad day" (Charlotte, 614-615).

Overall, extracts within this theme suggest that programmes are organised along a single trajectory aimed at those with healthy bodies. Worryingly, when faced with the need to respond to trainees who speak up or challenge, the response can be to problematise trainees themselves. Thus in naming a problem, trainees can quickly find themselves becoming the problem. This may discourage them from speaking out, perpetuating silence around disability.

3.3.4 Safe Spaces

All participants emphasised the importance of safe spaces and connections, the nature of which varied. For some, relationships with their cohort provided a space that was accepting and supportive. Daniel described how much of this value came from shared experiences:

…the cohort they're a far better source of support than anything the course has to offer or any of the structures around it…Particularly other people on the course who identify as having a disability they get it, they get the experience of what it's like to go through these bureaucratic hoops and I feel that going to the course staff would feel just like a bureaucratic hoop to jump through when actually maybe all I want is to whinge and moan for a bit, just get it out and for someone to say "yeah that reminds me of this" and that makes a huge difference and that's all that's needed (Daniel, 2074-2102)

Daniel made a clear distinction between the bureaucratic support offered by his course and the acknowledgement and understanding stemming from connections with other TwD. This connection also carried other benefits:

I think what's really helped me is talking with other trainees who identify as having a disability…If I was the only person with a disability on this course then I probably would never have talked about any of this stuff and I probably wouldn't even have thought about reflecting on it in a different way, and it was only through that that I have faced these things (Daniel, 2187-2196)

For Daniel, connecting with other TwD thus facilitated an exploration of his own disability. This may have been particularly important given the silence experienced elsewhere during training.

Conversely, a number of trainees prioritised external support and Kate described being unlikely to approach her course about difficult experiences:

…I wonder whether if they were more inclusive and talked about disability more that I would feel like instead of going to the toilet and having a cry I'd go talk to someone on the course. I just don't feel like we're connected enough to the staff really, I'd go have a chat with my friend or I'd go speak to my boyfriend or [unintelligible] or something but I don't feel like as a cohort or as a staffing [this course] is not particularly connected in an emotional way to their trainees and therefore I probably wouldn't (Kate, 2423-2446)

Kate highlighted the importance of the quality of relationships and described how the lack of connection and meaningful relationships between staff and trainees, combined with her course's overall silence around disability, led her to seek safety externally. In addition to those with whom she shared a personal relationship, this also included therapy:

Getting therapy actually, that is my number one thing because I really didn't realise how much shit I was carrying around with me…I realised through therapy how

widespread it is across how I am in my work, how I am in my personal life especially and that was invaluable to work that out 'cause I really did not appreciate the extent that that had had an massive effect on me. (Kate, 3038-3062)

For Kate, therapy provided an important space to explore her relationship with epilepsy. She strongly advocated this to other TwD and many other participants similarly discussed its value. This highlights the desire for a space for conversation, particularly when faced with a culture of silence elsewhere.

In addition to accessing safe spaces, a number of participants discussed providing these for other TwD, for example:

…people don't share it and I do and that's definitely encouraged other people to share it, one of my friends also has a disability and she's actually said to me "Holly you've really helped me come out of my shell a bit more and explain to people and be more confident about my disability (Holly, 765-773)

Holly therefore adopted a supportive role towards other TwD by becoming a role model and a mentor. Similarly to Daniel, shared experiences thus facilitate support. Fortunately, Holly described gaining value from these roles. However, I wondered what was missing from courses that resulted in her adopting these responsibilities in addition to the labour she was already undertaking as a disabled trainee.

CHAPTER 4: DISCUSSION

This chapter discusses the study's findings in relation to the research questions and situates these within relevant literature. This is followed by a critical appraisal of the study and implications for practice and research.

4.1 Discussion of Findings

The research findings suggest that TwD face numerous challenges during training resulting in a burden of labour further to the already demanding nature of the role. Many of these arose from a training system aimed at those in healthy bodies, with trainees subsequently facing practical and attitudinal barriers. Participants perceived training itself as a time of identity development, which was both facilitated and complicated by the professional culture. Their perspectives converged with those of trainees from other minority groups at times, highlighting common themes associated with marginalisation, in addition to raising distinct disability issues. Participants frequently understood their experiences through dominant disability narratives and situated their experiences within sociocultural contexts.

4.1.1 How are the Academic and Clinical Components of Training Experienced by TwD?

Trainees encountered numerous structural inequalities throughout training. Pope (2005) suggested that barriers to accessing psychology can be understood in terms of communication, physical, cognitive and affective barriers. Whilst participants did not refer to the former, the latter were present throughout their accounts. Physical barriers included inaccessible placements and limited access to required equipment, reflecting Olkin and Bourg's (2001) findings that many services are inaccessible to TwD. Regarding the final category, trainees were acutely aware of the attitudes of others, describing disability as stigmatised; previous research suggests that services may be reluctant to offer placements to TwD (Hauser et al., 2000) whilst supervisors and programmes may hold concerns around competence (Atherton & Dent, 2003; Dent & Atherton, 2004). Within this study trainees experienced themselves as undesired by supervisors and programmes, understanding this in relation to the "inconvenience" of their needs and programmes not wishing to invest in those who may not graduate. Ironically, it seems it is the structural inequalities within programmes that might decrease the probability of this, supporting Lund's (2018)

claim that higher attrition rates of TwD compared to able-bodied trainees is a result of systematic discrimination which ultimately forces TwD from the profession.

Similarly to previous accounts, trainees experienced a silence around disability including a lack of disabled role models (e.g. Andrews et al., 2013) and disability discussion (e.g. Ingham, 2018). Disability was perceived as an unprioritised aspect of diversity, replicating previous findings (Green et al., 2009; Hertzsprung & Dobson, 2000). Participants consequently questioned their positions as disabled trainees and whether this was something they could discuss. As such, the stigmatised nature of disability and the silence of others led to a silencing of themselves. As in Andrews and colleagues (2013), trainees described others' discomfort when confronted with disability. This could be hypothesised to exist for a number of reasons including feelings of pity evoked by disability narratives. From a psychodynamic perspective, discomfort may arise from fears of mortality (Livneh, 1982; Hirschberger et al., 2005) or rejection (Siller, 1970). Consequently, trainees invested energy in attending to the responses of others and developed approaches to manage this. This reflects previous suggestions that PwD are skilled at putting those around them at ease, for instance using humour whilst simultaneously suppressing their own frustration (Gill, 2001). This affect regulation has been proposed as a common feature of belonging to a minority group. For PwD, prescribed affect includes cheerfulness, gratitude and prohibiting anger (Olkin, 2002) as demonstrated by participants in this study. It is notable that, on the few occasions when disability was discussed in lectures, strong emotions were evoked which could result in trainees leaving the session or university. For others, it induced frustration and increased marginalisation due to incongruence between the lectures' perceived messages and trainees' lived experience. This echoes issues raised in previous research relating to disabled (Olkin, 1999) and BME trainees (Rajan & Shaw, 2008).

Consistent with Hauser and colleagues (2000), trainees described the extensive labour involved in training with a disability. Further to work relating to impairments, such as pain management, trainees also emphasised a responsibility for managing their needs including seeking support and completing associated processes. This reflects findings by Lund and colleagues (2016) in which trainees outlined the importance of self-advocacy and taking responsibility for getting needs met.

Participants went further than previous research by also describing the psycho-emotional labour of being a disabled trainee, including coping with frequent experiences of embarrassment, self-doubt and stress. Hochschild (1979) coined the term "emotion management": the work of inhibiting emotions to suit the "feeling rules" of a situation. For TwD this included minimising distress due to concerns regarding how this might be perceived and, at times, removing themselves from training spaces. Particularly noticeable was a pressure to "soldier on", which was understood as a message from programmes and a consequence of polarised disability narratives, previously identified as victim/slacker or courageous inspiration (Gill, 2001). This dichotomy forces those with disabilities to choose between roles and many engage in efforts to avoid the former (Gaskin, 2015). This was reflected in trainees' experiences and they were subsequently compelled into positions of resilience. Internalised oppression (Reeve, 2006) was therefore evident throughout participants' accounts and trainees frequently internalised the negative attitudes encountered in others. Consequently, they experienced their needs as inconvenient and there was a sense of being "lesser" than able-bodied trainees. This was also expressed through self-doubt and anger which was often directed internally.

Overall, trainees described a system aimed at healthy bodies with anything outside this norm perceived as inconvenient and troublesome. Particularly striking was the responses encountered should they raise concerns; participants often found that, rather than considering the role of a system based on structural inequalities, staff located problems within trainees. Difficulties raised could therefore be viewed as pertaining to individual competence issues. From a social psychology perspective this can be understood as a result of the fundamental attribution error: the tendency to ascribe the difficulties and errors of others to individual, internal characteristics, whilst one's own errors are understood as a result of situational factors (Jones, 1976; Ross, 1977). Locating responsibility in individuals is also an extension of the popular rhetoric of "overcoming disability", in which those with impairments are viewed as responsible for overcoming these through compensation. This narrative neglects the role of disabling contexts, allowing issues of inequality to persist and removing the need for affirmative social action (Linton, 2006), in addition to enabling others to escape the discomfort associated with inequality and privilege. The issue of being problematised reflects experiences of BME trainees, who described fears of being

marginalised should they speak out (Rajan & Shaw, 2008). It is also reminiscent of issues encountered by feminists, who can attract labels including "feminazi" (Ahmed, 2017). Trainees subsequently adopted strategies to manage this including adapting to the environment rather than requesting adjustments.

4.1.2 How do Trainees Experience the Dual Identities of "Living with a Disability" and "Trainee Clinical Psychologist"?

4.1.2.1 Disability identity: Despite volunteering for the study, many trainees reported not fully identifying as disabled. This reflects earlier findings that many living with impairments which could be considered disabilities do not identify them as such (Chalk, 2016) . Previous authors have acknowledged the challenges of claiming a disability identity (Mona et al., 2017) due to numerous disincentives and an absence of advantages, in addition to a "lack of ways to understand or talk about disability that are not oppressive" (Garland-Thompson, 2006, p.268). Two of the strongest predictors of disability identification are stigma and severity of impairment (Bogart, Rottenstein, Lund, & Bouchard, 2017). In line with this many participants, particularly those with invisible disabilities, questioned whether the severity of their impairments justified support. Participants understood this in relation to stereotypes, particularly what disability "looks" like, reflecting themes raised by those with hidden disabilities (Valeras, 2010).

Many trainees described training as triggering a reorganisation of disability identity, supporting Olkin's (2009) suggestion that, further to undergoing the same developmental tasks as able-bodied trainees, TwD face the additional work of navigating disability identity. This occurred for numerous reasons including professional requirements for personal and professional development. Moreover, trainees encountered numerous structural inequalities and barriers and experienced a need to own disability to obtain adjustments. Context therefore played a significant role in the extent to which impairments were experienced as disabling, in line with social (Oliver, 1990) and critical models of disability (Hosking, 2008). Conversely, successes during training could increase acceptance of disability. That external influences can stimulate a reorganisation of disability identity reflects previous suggestions that increased realisation of difference can influence sense of self (Kelly

& Millward, 2004), and challenges stage models of identity formation which present this as a task of adolescence (e.g. Erikson, 1963).

4.1.2.2 Identity as a disabled trainee: Ahmed (2017) coined the term "diversity work" (p 91): the labour involved when one does not meet the given norms of an institution. In line with Tan & Campion (2007) participants referred to a professional culture within psychology which contains numerous "unwritten rules" (p.14) including pertaining to self-presentation. For trainees, this culture neither valued nor accepted disability. Consequently, they experienced implicit and explicit pressure to minimise aspects of this to meet professional norms. The suggestion that trainees in minority groups may be forced to exclude subjugated identities in the process of developing a TCP identity has previously been highlighted in relation to BME (Adetimole et al., 2005) and lesbian and gay trainees (Butler, 2004). Regarding disability, it is reminiscent of research where one participant suggested that, to be viewed as a competent psychologist, one must prevent disability from becoming their identity (Lund et al., 2016). Perhaps as a combination of this, disability stigma and personal conflicts, participants often elected to pass, either through not disclosing (Linton, 2006) or minimising needs and managing without adjustments (Devlin & Pothier, 2006).

Participants elaborated on a further challenge raised in previous research, namely intersectionality between dual marginalised identities. The power imbalances inherent within trainee roles carried numerous implications for participants' experiences including a reluctance to "inconvenience" supervisors, whose roles included assessment. Whilst possibilities regarding the impact of supervisors' assumptions about disability have been discussed (Andrews et al., 2013) this is the first time trainees have raised fears of repercussions within evaluations should they request support. Concerns of how adjustments could be perceived by colleagues holding more power were also discussed. Interestingly, whilst Andrews and colleagues raised possibilities of resentment from one's cohort, co-workers' reactions were not considered.

Similarly to research with BME trainees (Shah et al., 2012), participants highlighted advantages associated with their insider identities including motivations and skills.

Several trainees described bringing themselves into their clinical work and relationships with clients. This could occur with or without disclosure and consequences included improved rapport, increased empathy and minimising power imbalances. The use of self as a resource has previously been advocated (Rober, 1999). However, it is noteworthy that some trainees expressed concerns regarding how disclosure might be perceived by supervisors, suggesting that bringing disability into this space crossed a professional boundary.

Overall, participants attempted to navigate their dual identities as disabled trainees within a context of contradictory messages; they should reflect on and own their positions, yet disability was stigmatised. They should be open about their needs in order to manage these, yet revealing the reality of living with a disability could be construed as "unprofessional" and carried repercussions including being problematised.

4.1.3 What Systems of Support are Available to and Desired by Disabled Trainees?

4.1.3.1 Available and desired support: As in previous research (Lund et al., 2016) trainees described a responsibility for getting their needs met. This was demonstrated in several ways. Firstly, staff held erroneous expectations that trainees would spontaneously raise any difficulties. Secondly, the structures in place to support TwD, such as occupational health processes, were often experienced as bureaucratic tick-box exercises which frequently fell to trainees, resulting in additional labour. Meaningful programme support was thus perceived as lacking, which one participant related to limited genuine connection between staff and trainees.

In contrast to suggestions that disabled trainees may experience difficulties in peer relationships (Andrews et al., 2013; Levinson & Parritt, 2006) many participants described their cohort as a significant support. Particularly valued were relationships formed with other TwD. These provided validation, encouragement and safe spaces for discussion, prompting reflection and novel perspectives. These relationships were perhaps especially important given that, unlike those belonging to some other minority groups, disabled trainees may not have had previous opportunities to

connect with others with disabilities (Olkin, 2002). Previous authors have discussed the value of mentorship from disabled psychologists (Andrews et al., 2013; Lund et al., 2016) and several participants noted that this would have been beneficial. However, similar to previous research (Lund et al., 2014), no participants received this and only one had had contact with a disabled psychologist, perhaps making peer relationships increasingly crucial.

Participants also emphasised external support including friends and family. Keeping with recommendations previously made by disabled psychologists and trainees (Lund et al., 2016), personal therapy was highly valued. This provided a space for exploration of relationships with disability and interactions with work. It could be argued that the need for this space reveals the lack of support structures within programmes themselves. Furthermore, attending therapy is time and energy consuming which may be particularly relevant to TwD due to access issues and symptoms including fatigue. It is also noteworthy that funding for therapy is not typically available to trainees (BPS, 2019). Access is therefore reliant on expendable income, posing an additional burden (Kumari, 2011).

4.1.3.2 Barriers to support: The structure of training, with its frequent changes, posed a particular challenge to disclosure, echoing barriers raised by psychologists with minority sexual orientations (Daiches & Anderson, 2012). This further influenced the support available to trainees. Moreover, participants described that staff incorrectly assumed they would raise any difficulties or concerns. In reality, they faced a number of obstacles: Firstly, trainees' concerns about how they might be perceived by others; Secondly, requesting support involved the painful work of acknowledging their reality; Thirdly, as previously noted, the intersection of being a disabled trainee led to significant power imbalances particularly within relationships with supervisors, who held dual roles as supporters and assessors. Worries about potential repercussions became a barrier to requesting support and, as mentioned above, many trainees found it led to becoming problematised. Responses of others could therefore prevent trainees from attempting to get their needs met and many requested as little as possible.

Dominant narratives also prevented trainees from accessing support. Disability and illness are frequently spoken of through metaphors of war (Sontag, 1977). This was present throughout participants' accounts, including descriptions of pressure to "soldier on". High levels of stress have been identified as a norm amongst psychology trainees (Pakenham & Stafford-Brown, 2012) with greater demands than PhD students and those completing psychiatric nursing training (Galvin, 2005). Meanwhile for people with disabilities "inspiration porn", the ideological presentation of disability as something to be overcome through individual efforts, creates an impossible standard (Grue, 2016). The dual result for TwD is a context of high demands alongside narratives of coping and overcoming. This narrative also serves an additional purpose; reminiscent of the "strong black woman" (Beauboeuf-Lafontant, 2007) it results in social expectations that make it difficult for those with disabilities to raise concerns or even take their own experiences seriously. Conversely, and as previously discussed, stereotypes of disability including visibility and severity led many trainees to question whether they were "disabled enough" to warrant support, creating another barrier.

4.2 Critical Evaluation

The research was guided by Yardley's (2000) principles for evaluating qualitative research. These have been considered in relation to IPA (Smith et al., 2009) and are outlined below.

4.2.1 Sensitivity to Context

Sensitivity to context can be demonstrated in several ways. Firstly, I immersed myself in relevant literature, which identified a paucity of research and informed my research question. Secondly, I considered my own and participants' contexts and how these might influence our experiences, attending to this through supervision and a reflective diary (Appendix L).

Sensitivity to context can also be demonstrated through interactions with participants. I attempted to conduct interviews sensitively and shaped the interview schedule accordingly, including introductory questions in line with Braun & Clarke

(2013). I also considered power; post-structuralist psychology promotes enabling participants to have increased control within the research process in order to reduce the researcher-participant power imbalance (Rappaport & Steward, 1997). Honouring participants' preferences for Skype interviews was one measure taken toward this. Furthermore, I hoped my own disclosure of a long-term health condition would aid rapport and further reduce power imbalances (Dickson-Swift et al., 2007; Liamputtong & Ezzy, 2005; Oakley, 1981; Mercer, 2007). Participants' openness within interviews suggests this was impactful and a number of trainees cited speaking to someone who "understood" as influencing participation. Nevertheless, I remained aware that power imbalances would persist.

4.2.2 Commitment and Rigour

Commitment and rigour incorporate engagement with the topic, the development of necessary research skills and immersing oneself in the data (Yardley, 2000). My initial interest in the topic stemmed from personal experience whilst the potential for change sustained my engagement. In relation to research skills, I was mindful of my novice position to qualitative approaches. Whilst this was anxiety-provoking, I was transparent about this and received supervision from experienced IPA researchers.

Data collection consisted of in-depth interviews lasting up to 90 minutes. This, in conjunction with completing individual level analysis before proceeding to the group level, demonstrates a commitment to a full exploration of participants' experiences. Each resulting theme was supported by most if not all participants, and quotes are included to illustrate this. Allocated research days were particularly beneficial to full immersion in the data, although this also felt overwhelming at times.

4.2.3 Transparency and Coherence

Transparency refers to how clearly the process of conducting the research is described (Smith et al., 2009) whilst coherence refers to the research making sense as a whole. I outlined each stage of the analysis and examples of the coding and theme development processes can be seen in appendix H. Themes were also reviewed by my supervisor to check the fit between data and my analysis. Nevertheless, I maintained an awareness that my analysis is one possible

interpretation and including extracts facilitates transparency, providing opportunities for the reader to review my analysis and potentially draw their own meanings (Elliott, Fischer & Rennie, 1999).

Reflexivity is an important aspect of qualitative research and I endeavoured to be open about my own position, including use of the first person and sharing reflective journal extracts. These elements allowed me to own my perspective including the experiences influencing my interpretative framework.

4.2.4 Impact and Importance

Qualitative research does not aim to make generalisable claims beyond the participants involved (Willig, 2008) and it is important to note that the participants in this study do not form a homogenous group speaking on behalf of all TwD. Nevertheless, the results provide novel insights into an under-researched area. I hope that this contributes to an increased understanding of the experiences of disabled trainees and highlights how ableism operates within the profession. Some of the themes raised are also likely to be relevant to qualified disabled psychologists. Multiple recommendations for clinical psychology training have been developed based on the findings, in addition to suggestions for future research. I anticipate that the study will be disseminated through publication in a journal article, whilst the thesis will become a public document.

4.2.5 Limitations

As previously discussed, critical approaches position disability as a construct arising from interactions between context, power dynamics, individual responses and impairment (Hosking, 2008). Imposing a narrow definition of disability would contradict this, my values and the study's epistemological position, in addition to creating difficulty recruiting a large enough sample. However, the openness of the inclusion criteria led to a heterogeneous group of participants including variation in visibility and longevity of impairments, which influenced participants' experiences. Despite this diversity there was also much overlap across participants' accounts and it was possible to draw themes from these areas of convergence and divergence. Unfortunately participant validation of the analysis did not take place due to

anticipated time limitations in addition to not wishing to further contribute to trainees' burden of labour. However, I plan to share an analysis summary with participants.

The sample comprised of self-selecting participants and it was not possible to explore why others may have chosen not to participate. Given the nature of the topic, concerns around confidentiality and implications of participating may have been one factor; during the recruitment process, some participants expressed apprehension regarding this. However, it is also possible that those who chose not to participate simply felt they had less to say, perhaps due to not having experienced the challenges reported by those who volunteered.

Counter to initial plans, the majority of interviews took place over Skype at the request of participants. I carefully considered merits and drawbacks of Skype. Lo Iacono, Symonds, and Brown (2016) discuss issues of rapport and conclude that while some have argued that developing rapport can be more difficult through Skype than in face-to-face interviews, others have found the converse effect. The latter was in line with my experience and rapport was readily established. It has also been suggested that Skype allows participants to complete interviews from a safe and private space (Hanna, 2012) which may have improved participants' comfort, increasing openness. Skype also facilitates overcoming practical barriers, including time and location (Janghorban, Roudsari, & Taghipour, 2014). This was particularly pertinent given the nature of the research and issues of accessibility and exclusion.

4.3 Implications for Clinical Psychology Training

4.3.1 Structural Change

Overall, the participants within this study provided a sense that clinical psychology training is aimed at healthy bodies, with this forming the prevailing assumption. This creates the possibility for anything outside this norm to be perceived by staff and trainees as inconvenient or burdensome. Several changes are proposed to address this:

- Course staff and supervisors should avoid assumptions that trainees live in healthy bodies.

- Programmes should move away from the rigid training system and offer increased flexibility, for example developing structures for part-time completion.

- Programmes should streamline processes for accessing adjustments, reducing the bureaucratic labour falling on TwD.

- Programmes and supervisors should remove responsibility for requesting support from trainees; for example supervisors should ask all trainees about possible adjustments. This has previously been recommended as best practice as it removes the work of requesting adjustments from trainees and opens space for disclosure (Olkin, 2009).

- Prior to placement allocation staff should liaise with trainees regarding their experience of disability and specific needs.

- Programmes should increase transparency, holding open conversations with TwD to reduce stress and anxiety.

- Programmes should be mindful of power dynamics inherent within relationships with trainees and how these might impact their ability to raise concerns, including that trainees may not feel safe requesting adjustments from those who assess them.

4.3.2 Staff Training

Training regarding disability in the context of clinical training may be beneficial for programme staff and supervisors. This should address several areas including legal rights and wider aspects of disability culture, including identity development. This is in line with previous recommendations (Andrews et al., 2013; Dunn & Andrews, 2015) and reflects the significant work participants described regarding navigating their identities. Training should also consider how this interacts with developing a professional identity, as well as the lived experience of being a disabled trainee including how previous experiences might impact disclosure and help seeking.

Encouraging systemic thinking might be particularly beneficial, including encouraging consideration of the layers of context surrounding PwD through Bronfenbrenner's

(1979) Ecological Systems Model. This may highlight both experiences trainees may have had within the microsystem (their immediate environment) and wider sociocultural beliefs and attitudes operating within exo- and macro- systems, making transparent issues of power and ableism. Systemic approaches also shift the focus from problems to the resources and strengths that individuals bring (Fredman, 2010). This might work to counter dominant negative narratives around disability and move to considering TwD as valuable colleagues as opposed to potential liabilities, in line with previous recommendations (Andrews et al., 2013). Systemic approaches also encourage acknowledgement of our own position including personal and professional values and assumptions (Fredman, 2010), potentially encouraging staff to reflect on their attitudes in relation to disability. More specifically, "talking about talking" (Fredman, 1997) might provide a space for staff to explore their ideas regarding talking about disability, possibly increasing these conversations and reducing the silence around disability.

4.3.3 Spaces for Support

Many trainees highlighted the benefits of connecting with other TwD, indicating the value of initiatives enabling this such as reflective groups. However, some expressed concern regarding artificial as opposed to organic support spaces. Care must therefore be taken to ensure these are meaningful and wanted spaces. Programmes should also consider alternative options for facilitating connections including peer mentorship programmes and signposting to the BPS Minorities in Clinical Psychology Group.

Trainees also described a desire for mentorship from qualified disabled psychologists and previous findings suggest this is valuable (Andrews et al., 2013; Lund et al., 2016). Programmes should therefore develop initiatives to support and promote awareness of these. It is worth noting that trainees may find different types of support beneficial throughout their training journey as their identities develop. As such, information regarding such schemes should be regularly redistributed.

Many participants described personal therapy as an important source of support. As previously noted, funding for this is not typically provided by programmes (BPS, 2019). It is important to acknowledge the wider political and economic contexts that

influence the income and resources of universities (Universities UK, 2019). Nevertheless, programmes should consider ways of supporting trainees to access therapy should this be desired, for example signposting to reduced cost services.

4.3.4 Attitudinal Change

Previous authors have called for disability affirmative training environments (Lund, 2018), and the removal of barriers is not in itself sufficient to change cultural attitudes towards disability (Oliver, 2004). Additional steps are therefore needed to address the stigma experienced by TwD. Firstly, training programmes should explicitly outline their commitment to supporting disabled trainees. Two formats for this would be via the Clearing House website and by committing to the "Disability Confident" scheme. Programme staff and supervisors should also attend to language, utilising inclusive terms (e.g. "we" as opposed to "them") to avoid a dichotomy which marginalises and isolates disabled trainees. Furthermore, programmes should greaten the visibility of disability within the profession. Previous authors have suggested that increasing the presence of disabled staff and supervisors might foster an environment in which trainees feel able to be open about disability (Lund et al., 2014). This also reflects the comments of a participant in this study, who questioned "…if they're not talking about it then you start wondering why they're not talking about it and whether I should be talking about it". However, this forms a slight impasse; increased visibility might lead to cultural shift, yet it is this shift that might be necessary for psychologists to feel safe enough to disclose. Initial steps may therefore include promoting role models of disabled psychologists, such as those who have published about their own experiences (e.g. Pimm, 1993; Stannett, 2002, 2006; Supple, 2005).

Programmes should also consider disability within the curriculum. Bartolo (2010) argues that in addition to training students in supporting individuals, programmes must also train them to understand social contexts and work towards change. He suggested that programmes can do this in two ways. Firstly, they should model inclusivity and respect within their structures. The recommendations above predominantly pertain to this. However, Bartolo also states that programmes should increase trainees' awareness of discrimination. Whilst programmes commonly consider issues of diversity, previous research (Green et al., 2009; Hertzsprung &

Dobson, 2000) and the current study indicate that disability is often neglected within this. Therefore when considering personal and professional development and issues of difference, disability needs to be meaningfully included. This could improve trainees' ability to work sensitively with disabled clients and to supervise disabled trainees. Furthermore, it would break the silence around disability and open spaces for TwD to engage in self-reflection.

A number of these recommendations, such as inclusive language, welcoming statements and promoting role models reflect previous BPS (2006) suggestions. However, the perspectives of the trainees within this study suggest that there has thus far been little movement in regards to implementation

4.4 Areas for Further Research

IPA necessitates a homogeneous sample and its ideographical influence means it seeks to locate generalisations within the particular, as opposed to the broader generalisations often associated with psychology (Smith et al., 2009). Within this study I was aware of the absence of male and BME participants. It is important to acknowledge these missing voices which raise areas for future research, particularly given issues of intersectionality. Indeed, one participant specifically questioned whether her position as a white, middle class person had influenced her experience of being a disabled trainee. Furthermore, a number of researchers (e.g. Adetimole et al., 2005; Daiches & Anderson, 2012; Rajan & Shaw, 2008; Shah et al., 2012) have raised specific issues relating to being a trainee from a minority group which overlap with themes in this study, suggesting this intersection may be important to consider. Finally, it has been argued that the way black women experience depression is both gendered and raced (Beauboeuf-Lafontant, 2007), leading me to speculate that the same may be true for black female trainee's experiences of disability; perhaps the need to manage is even more profound. Future studies could therefore explore the experiences of BME disabled trainees.

I also wondered about the experiences of male TwD, for whom dominant narratives surrounding masculinity might pose barriers to seeking support. Hegemonic

masculinity refers to the idealised constructions of masculinity within a given society and time. In today's Western culture this includes an appearance of strength and the denial of pain or vulnerability (Courtenay, 2000). Consequently male TwD may be drawn to passing. Indeed, (Flurey et al., 2018) found that men with chronic illness were required to renegotiate masculine identities, including pushing though pain. It is notable that the only male in this study made multiple references to passing, including when this caused pain. It is therefore important to specifically explore the experiences of male TwD.

In line with its aims, this study provided an in-depth analysis of the experiences of a small number of trainees. It may be useful to replicate findings on a wider scale, for example using online surveys. It would also be interesting to observe whether this raised variances in experiences across location, such as rural versus urban environments.

Previous authors have reviewed the literature pertaining to supervising TwD and discussed issues including legal and ethical concerns, disability culture and physical and attitudinal barriers (Andrews et al., 2013; Olkin, 2010). They also identified a lack of research and no studies have investigated supervisors' experiences of supporting disabled trainees. Exploring the training that supervisors have received, challenges experienced and what supervisors would find helpful might increase our understanding of how best to support supervisors, subsequently improving the experiences of TwD and retention rates.

4.5 Final Reflections

Ahmed (2017) describes noticing racism and sexism as political labour. I would argue that the same is true of ableism. Throughout this thesis I became increasingly aware of historic and current ableism, creating an additional strain of work further to training and managing my health. My position as an insider researcher also carried an emotional impact and hearing stories that resonated with my own was emotionally triggering at times. In contrast, hearing participants' accounts was also incredibly validating. These experiences echo those previously raised in relation to insider

research (Ross, 2017). Given the dearth of related literature I experienced a sense of responsibility to complete the study and utilise it to instigate change, whilst simultaneously feeling inadequate as a novice researcher navigating my own identity and questioning my position as an insider researcher. Interestingly, submitting chapter drafts also evoked anxiety given that it entailed highlighting issues within training, tempting me to minimise the concerns raised. This reflects issues raised within the research itself regarding apprehension around voicing problems and being drawn into silence.

Whilst completing interviews I recognised that this was several participants' first opportunity to reflect on their experiences as TwD; indeed, many reported this as influencing their participation. Therefore for some, the interview process involved sharing previously untold stories resulting in a new awareness and the emergence of novel meanings. This has been referred to as opening "Pandora's box" (Ramos, 1989) and "the tin opener effect" (Etherington, 1996). This evoked varying emotions for participants including sadness and anger and I felt incredibly moved by the experience. At times I experienced a paralleling of participants' emotions, which has been previously reported by those researching sensitive topics (Alexander et al., 1989). I also felt guilt at having provoked these emotions which increased my sense of responsibility to accurately reflect participants' experiences and use these to promote change. This was somewhat alleviated given that several participants spoke positively of the opportunity to reflect on their experiences. I also found it helpful to consider Freire's (1970) concept of concientization, in which the development of a critical consciousness of issues of oppression enables social action and possibilities for change. From this perspective, the growing of awareness could be viewed as a benefit of participating. Nevertheless, I found it especially difficult when faced with reflecting participants' experiences within the word limit available. I experienced omitting aspects of their accounts as doing an injustice and felt as though participants were once again being silenced.

It is notable that between completing my analysis and finishing writing this thesis I went on extended sick leave. As such, whilst completing the research I simultaneously enacted it. I was acutely aware of the new experiences I gathered as a result of this; whilst some of these converged with those of participants', others

contrasted significantly. This left me wondering how my analysis might differ should I have repeated the process upon returning from leave, highlighting the active role that the researcher takes in shaping the analysis and that the analysis presented here is one of many possibilities.

4.6 Conclusions

This thesis presented the experiences of disabled trainees using IPA. Whilst some of these converged with trainees from other marginalised groups, including the challenge of negotiating dual identities (e.g. Adetimole et al., 2005), others were unique such as the labour of symptom management and challenges associated with requiring adjustments.

This thesis has referred to the professional culture of psychology, which many might argue include values of equality and social justice. However, reflecting on the profession itself can be uncomfortable. Disabled psychologists continue to be underrepresented and, whilst the participants of this study do not speak for all TwD, their perspectives provide a rich insight into what it is like to attempt to enter the profession with a disability. This is a call for those within the profession to examine their own privilege and biases in relation to disability. It is a call to break the silence and to address the structural inequalities within the field. Ultimately, it is a call for change.

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APPENDICES

Appendix A: Model of social and psychosocial disability development

Acceptance status: Individuals are born with or become disabled and they, friends and family are accepting of this.This may involve moving through traditional stages associated with grief.	Relationship status: Individuals yearn for and seek others like themselves and learn more about the norms of the group.	Adoption status: individuals become increasingly aware of legislation and "unwritten rules" of disability, test out the values of disability culture and decide which to integrate into their identity.	Engagement status: individuals embrace their disability, immerse themselves in disability culture and give back to the disabled community.

(Forber-Pratt and Zape, 2017)

Appendix B: Recruitment email to programme directors

Dear (Course director),

My name is Nicola Coop and I am a third year trainee clinical psychologist at the University of East London. I'm emailing to ask if you would consider sharing the attached information regarding my doctoral research project with your current clinical psychology trainees.

My study aims to explore the experiences of trainee clinical psychologists in the UK who identify as living with a disability. The perspectives and needs of trainees living with a disability have been largely overlooked within the existing literature, with the little research that does exist suggesting that living with a disability may impact the training experience in a number of ways. It is hoped that this research will help training providers and supervisors to better understand these issues and inform both future guidance and the support systems available for trainees living with disabilities.

I am aiming to recruit 10-12 participants who will be invited to take part in a semi-structured interview. I would be grateful if you would consider circulating the attached information sheet, which includes details outlining how I can be contacted by any trainees who might be interested in participating.

Please do contact me at u1524900@uel.ac.uk if you have any questions or concerns.

Thank you very much for your time.

Kind regards,

Nicola

Appendix C: Participant information sheet

School of Psychology
University of East London
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
Nicola Coop, Trainee Clinical Psychologist
Email:

"Exploring the experiences of trainee clinical psychologists who identify as living with a disability: A qualitative study"

My name is Nicola Coop and I am a Trainee Clinical Psychologist at the University of East London. I also have experience of living with a long-term health condition. As part of my Professional Doctorate in Clinical Psychology degree, I am conducting research to explore the experiences of trainee clinical psychologists who identify as living with a disability. This letter is to give you more information about the research so that you can decide whether or not you would like to take part.

Accessible information
If you would like to receive this information in any other format, please contact me using the details at the top of this document.

Project Description
What is the research about?
This research aims to begin to develop an understanding of how living with a disability affects the experience of clinical psychology training. The experiences, perspectives and needs of trainees living with a disability have been largely overlooked within the existing literature, with the little research that does exist suggesting that living with a disability may impact the training experience in a number of ways. It is hoped that the research will help training providers and supervisors to better understand these issues. It is hoped that this in turn may influence future support available for trainees and guidance for clinical psychology training courses and supervisors.

What does the research involve?
If you decide to participate, you will be asked to come to an interview with myself lasting approximately 60 minutes (although this may vary). This would involve talking about your experience of being a trainee clinical psychologist who identifies as living with a disability, for example in relation to the academic and clinical aspects of training.

The research isn't designed to cause you any harm and there are no dangers associated with taking part, although it is recognised that discussing your experiences could feel difficult

at times. You wouldn't have to answer any questions that you did not want to and would be given information about sources of support after the interview.

<u>Who can take part?</u>
It is recognised that the term 'disability' is very broad. For this research, any trainee who self identifies as living with a disability due to a physical and/or learning difficulty (e.g. dyslexia) is welcome to take part. Unfortunately if your disability relates to mental health, you will not be able to take part in this research (unless this is in addition to a physical and/or learning difficulty). This is because mental health is a broad area in its own right with its own associated experiences and research literature.

What happens to the information I give?
Any information you give will be confidential. The interview will be recorded and only I will listen to the recordings, which I will then type into transcripts. In the transcript, I will change any names and other identifiable information. The transcript might be read by my supervisors at the University of East London and anonymised extracts may be read by the examiners who test me when I hand in the research to be assessed. Both the audio file and transcript will be kept on a password-protected computer. After the examination, I will delete the audio recordings. The written transcript will be kept as a computer file for three years.

Quotes and extracts from the interview may be used in the final write-up or in an article to be published in an academic journal. These will be carefully selected to ensure that other people cannot identify you.

If you were to say anything that led me to be concerned about your safety I may signpost you towards options for further support and discuss this with my supervisor. I would keep you informed throughout this process.

Location
Interviews are likely to take place at the University of East London, but we can consider alternative locations if you would prefer. We can also discuss use of video calling (e.g. Skype) if necessary.

Do I have to take part?
Please remember that you are not obliged to take part in this study and should not feel coerced. If you do decide to take part, you are free to withdraw at any time without giving a reason. However, should you decide to withdraw after the 1st March I may still need to use your anonymised data in the write-up of the study, for example in relation to themes that have arisen. I will however remove your data from any subsequent publications.

What happens next?
If you have any questions, please feel free to contact me to discuss these. If would like to participate in the study, please contact me and we can arrange an interview. You will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

Thank you very much for taking the time to read this information!

Yours sincerely,

Nicola Coop

If you have any questions or concerns about how the study has been conducted, please contact:

The study's supervisor: Ava Kanyeredzi, School of Psychology, University of East London, Water Lane, London E15 4LZ

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Appendix D: Social media (Facebook) recruitment advert

*** Seeking trainee clinical psychologists in London ****

Hi, my name is Nicola Coop and I am a Trainee Clinical Psychologist at the University of East London; I also have personal experience of living with a long-term health condition. As part of my Professional Doctorate in Clinical Psychology degree, I am conducting research to explore the experiences of trainee clinical psychologists who identify as living with a disability.

I'm currently looking for trainee clinical psychologists attending courses in London or the surrounding area who identify as living with a disability and might be interested in completing a one-off interview to talk about their experiences of being a trainee with a disability. For this study this includes people with physical or learning difficulties but not mental health difficulties (unless this is in addition to the above).

If you would like more information (with no obligation to take part) please email me at

I'd also be really grateful if you would consider passing this information to anyone you know who may be interested.

Thanks very much!
Nicola

Appendix E: Interview schedule

Introductions and engagement
- Introduce self
- Go through information sheet and consent form
- Re-iterate confidentiality and right to withdraw, reschedule etc
- Collect demographic data

1. Before we start, how do you prefer to refer to the reason that you identify as having a disability?
- E.g. "Disability"? "Impairment"? Specific term?

2. How did you hear about the study?
- Reasons for participating, thoughts about the research area

3. Can you tell me a bit about your approach to disclosing your [preferred term] whilst on training?
- When? How talk about? How make these decisions?
- Disclosing to course, cohort, supervisors, clients?
- Positive/negative specific examples?

4. Can you tell me about some of your experiences during teaching in relation to being a trainee living with [preferred term]?
- Barriers encountered in teaching and assessment?
- Is disability spoken about? In what way?
- Any specific disability teaching? What like?
- Experiences with cohort?
- Experiences of direct/indirect discrimination?
- How manage any challenges/difficulties that arise?

5. Can you tell me a bit about some of your experiences on placement in relation to being a trainee living with [preferred term]?
- Experiences with supervisors, teams, clients?
- Specific examples (positive and negative)?
- Experiences of direct/indirect discrimination?
- How manage any challenges/difficulties that arise?

6. Could you tell me about the relationship between your identity as a person living with [preferred term] and your identity as a trainee clinical psychologist?
- Has this changed during the course of your training? In what way?

- How has training affected your identity as someone with [preferred term]?
- How has living with [preferred term] affected your identity as a trainee?
- Intersectionality?

7. Are there any specific strengths that come with being a trainee living with [preferred term]?
- Specific example?

8. Are there any limitations or dilemmas that come with being a trainee living with [preferred term]?
- Specific example?
- How manage this?

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

10. What advice would you give to other trainee clinical psychologists living with a disability?

11. What advice would you like to give to training programmes in relation to trainees living with a disability?

12. Is there anything I haven't asked about that you would like to tell me?

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

Appendix F: Consent form

Consent to participate in a research study

"Exploring the experiences of trainee clinical psychologists who identify as living with a disability: A qualitative study"

I have the read the information sheet about this research study and have been given a copy to keep. The researcher has explained to me why the study is being done and what it will involve. I have had a chance to talk about it and ask questions. I understand what is going to happen and what I will be asked to do.

I understand that my involvement in this study, and the things I say, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I am happy to take part in the study which has been fully explained to me. I understand that I can pull out of the study at any time without having to say why, and that this won't disadvantage me in any way. I also understand that, should I withdraw after the analysis of data has begun, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………….

Participant's Signature

…………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………..

Researcher's Signature

…………………………………………………………………………………..

Date: …………………..……

Appendix G: Transcription coding key

All identifying information was removed from transcripts. In order to aid readability, minor changes were made according to the key below:

…	-	Part of text omitted
((laughter))	-	Laughter
((sighs))	-	Sigh
(…) – long pause	-	Pause
[unintelligible]	-	Transcription not possible as speech inaudible/unintelligible
[?]	-	Speech unclear, word presented is the best guess
[text]	-	Explanation provided to the reader, or identifying information replaced with anonymised text

Levels of coding:

- Descriptive comments (pink text) stayed close to the participant's explicit meaning and focused on the context of what the participant had said
- *Linguistic comments* (purple text) focused on the specific use of language, for example pauses, repetition or metaphors
- Conceptual comments (blue text) were focused at an interpretive and interrogative level, for example further questions

Appendix H: Initial coding and formation of themes (individual level)

Extract from Holly's transcript:

Emergent themes	Line number	Transcript	Exploratory comments
	67	N: But if I say anything that feels funny just let me know	
	68		
	69	H: No that's alright yeah	
	70		
	71	N: So so you heard about the study through I think a thing that a	
	72	friend of mine shared actually erm but I was just wondering what	
	73	your kind of thoughts about the research area were and what made	
	74	you decide to take part?	
	75		But meeting inclusion criteria doesn't mean had to volunteer
I don't fit in / divided	76	H: Well just because like obviously the recruitment or the	"fitted the bill" - but (i.e. does identify as disabled)
	77	advertisement it just I fitted the bill	
	78		
	79		
	80	N: Mm	
	81		
	82	H: Erm ((laughter))	
	83		
	84	N: ((laughter))	
Being in the minority	85		Invisibility of disabled trainees?
	86	H: Erm you know I'm there's not many trainee psychologists and erm	A sense of isolation?
	87	I don't think there's there's many trainee psychologists with a	
	88	disability	
	89		
	90	N: Mm	
	91		
	92	H: or long term health condition so because erm I fitted those	Feels the topic is important
A curious lack of knowledge + understanding	93	descriptions I was like well I'm perfect for it and I also would you	Appearance of lack of research currently - there is a lack of understanding, wants something to be different
	94	know I'm really glad that you're doing this research 'cause as you	
	95	said there's limited there's hardly nothing out there erm I would want	
	96	courses erm er and people to know about you know the implications	
	97		
	98	N: Mm	
The desire to change	99		There are a number of implications - those aren't currently understood by others
	100	H: Of having a condition or disability on the course	
	101		

Emergent themes	Line number	Transcript	Exploratory comments
The significance (see impact on the trainees experience)	102 103 104 105 106	N: Mm H: I think it's really important and it's something that has probably impacted on my experience quite a lot	Disability has had big effect on training experience
	107 108	N: Mm	
Lack of discussion	109 110	H: And I've never spoken about it either	Silence around the issue - why? Shame? Discomfort?
	111 112	N: Mm	Lack of opportunity? Knows the impact.
Desire to discuss and reflect	113 114 115	H: So it was a good opportunity you know to talk about that aswell and think about it for myself I guess	Wanting an opportunity to discuss and reflect for self
	116 117	N: Mm	
Desire for change	118 119 120	H: too aswell as helping you and you know hopefully you'll publish this I know not all ((laughing)) third year trainees want to but	The hope their finding might reach a wider audience
	121 122 123 124 125	N: But no that yeah that is that is my hope for it to actually be done something with as opposed to be be useful so that is the hope. But thinking about that I'm just interested you said that you kind of it's not something you've really spoken about while while	
	126 127	H: No	
	128 129 130	N: You've been on training is that kind of with sort of course people or sort of (...) does it go more kind of wider than that aswell?	
	131 132	H: I talk I talk about my IBS a lot	Open about IBS. Comfortable discussing? Comfort with identity?
Openness as a coping strategy	133 134	N: Mm	Openness. Has this always been the case?
	135 136	H: I'm really open with it and erm yeah I yeah I'm very open with it and I let everyone know	Confrontational with it?

Emergent themes	Line number	Transcript	Exploratory comments
Openness as a (coping shared)	137	N: Mm	
	138		
...around situation with care	139		Openness as a management...
My commitment	140	H: That's a bit of my coping strategy aswell but no-one's really asked	// strategy? Other people don't ask? Need to be asked to discuss? It doesn't seem to ask the true interest?
	141	me in terms of the course	
	142	N: Mm	
	143		
	144		breath - a big issue/idea? Difficult to phrase?
	145	H: Or my supervisors in placement or course or uni ((big breath))	Concern + worry re: IBS from others
Concern of others	146	they've they def: they know about my IBS and they're concerned	
Attempts to support	147	about that and they try and support me but they've never actually	Supervisors attempt to support
	148	asked what it's like they've never asked my experience	but not looking at actual experience
	149		
	150	N: Mm	
Lack of interest is actual experience	151		Is there an exception/management approach as opposed to trying to understand/support
	152	H: Or what's impacted it at all that's never yeah it's something I've	
	153	never (...) been asked about.	
	154		
	155	N: Mm. So almost like a kind of concern about it but without properly	Concern not perceived as genuine
	156	sort of looking into what that experience is like for you have I got that	
	157	right?	
Feeling used for tick box & genuine concern and care	158	H: The concern about it from uni in particular is just more erm it	Concern not perceived as genuine. Protecting selves as opposed to supporting. Tick box approach - why? The anxiety around health + disability from others? (bureaucracy)
	159	doesn't feel genuine for me it's feels they've got to cover their back	
	160		
	161	N: OK	
	162		
	163	H: And they've got to do the paperwork for the	
Tick box approaches	164		
	165	N: Mm	
	166		
	167	H: HR for example	
	168		
	169	N: Mm	
	170		
	171		

Commented [NC]: How manage - being open

Following the individual level analysis for each participant, a summary paragraph was written in order to attempt to capture their account and ensure I fully attended to each participants' individual experience. The summary for Holly can be seen below:

Holly's experience of training is strongly influenced by her IBS on a day to day basis, which she experiences as a struggle in terms of the embodied experiences of pain and fatigue, and in relation to others. In particular, despite her debilitating symptoms she feels that her condition is not taken seriously by others which affects their responses and the subsequent support she experiences and is able to access.

Holly experiences a strong sense of stigma both around disability and particularly her specific condition of IBS. She internalises many of the dominant ideas around this, for example in her fears of being a burden to others. She is strongly concerned about the perceptions of others throughout her training journey, in particular in relation to her professionalism which is at times questioned by others on the basis of her IBS and coping strategies around this (both practical e.g. hot water bottle and in relation to discourse e.g. use of humour). She continuously lives, and struggles, with the embarrassment that she feels in relation to her condition. She experiences a strong lack of understanding from others in relation to the difficulties of being a trainee with IBS and appeared to feel uncared for by the course, with a lack of flexibility and strong messages of the need to manage and to soldier on. Worryingly, attempts at raising her concerns resulting in her being problematised herself with internal attributions being made regarding her own competence. Overall, these experiences have resulted in her having made numerous sacrifices throughout training including the worsening of her health.

Holly's narrative of her experience of training gives a sense of a journey which has taken place. Whilst her approaches to managing and disclosing her disability have remained constant, her relationship with this and sense of self have developed. In particular, through increasing her skills as a clinician and gaining confidence she also gains an increased acceptance of her IBS, herself as a trainee and as a future psychologist living with IBS. This journey has taken place not with the support of the course, but with the aid of personal therapy and the support of her cohort and external relationships.

Appendix I: Initial and Final Superordinate Theme Arrangement (Group Level)

The below diagram shows my initial theme arrangement including potential theme titles

Following supervision and further reflection, amendments were made to highlighted themes: "Needing to manage as a trainee" and "Needing to manage as a disabled person" were converged into one subordinate theme of "Needing to manage". "Intersection with

professional identity" was renamed "The public, personal and professional" and "Meanings of disability" was renamed "Being disabled enough". Finally, the superordinate theme of "Training is aimed at healthy bodies" was removed, and was instead seen as running throughout the three remaining superordinate themes.

The final theme arrangement can be seen below:
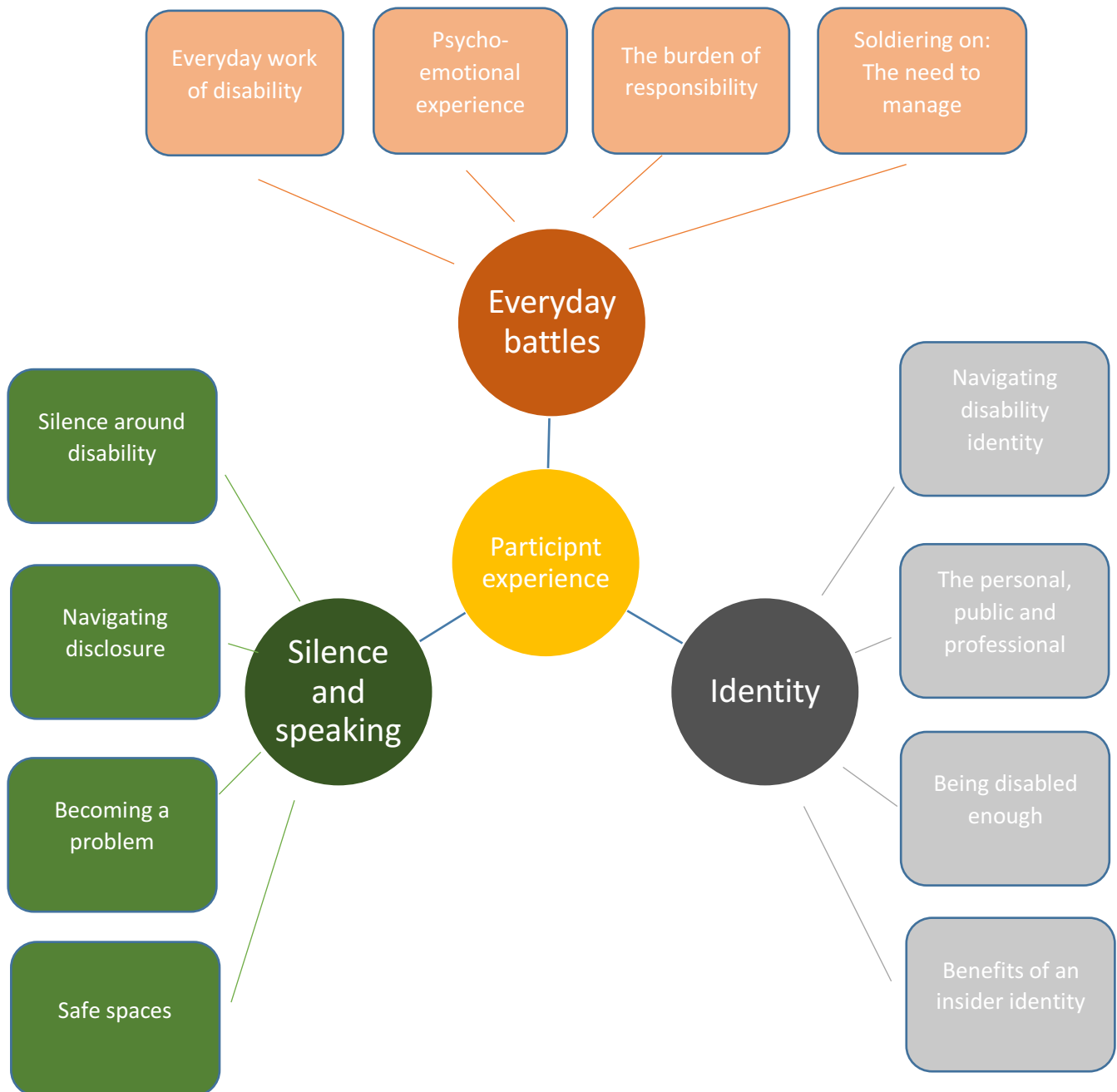
Appendix J: Table of Overall Group Themes and Corresponding Individual Themes

Group level super-ordinate theme	Group level sub-ordinate theme	Participant	Corresponding individual level themes
Everyday battles	Everyday work of disability	Daniel	Pain
			Numerous battles to be fought
		Leanne	Drawing on limited resources
			Needing to consider additional things
		Kate	Work of managing health
		Charlotte	Differences between healthy and unhealthy bodies
		Holly	Added complexity of being a trainee
			A daily battle
			Everyday effortfulness of being a disabled trainee
		Sophie	Managing the everyday experience of disability:
	Psycho-emotional experience	Daniel	Self-doubt
		Leanne	Emotional impact of course's approach
		Kate	Psycho-emotional impact of disability
			[Coping with] the emotional impact of teaching
		Charlotte	Uncertainty
			Guilt
			Failed expectations
		Holly	Psycho-emotional impact on self
			Inducing guilt
			Self-esteem
		Sophie	Mourning and loss
			Self-doubt
			When teaching material resonates
	The burden of responsibility	Daniel	Onus on self to raise disability
			Onus on self to manage needs
		Leanne	Programme doesn't protect its trainees/take responsibility
			Burden on self to manage needs
		Kate	Holding responsibility to raise difficulties
		Charlotte	Work of managing external systems
		Holly	Focus on bureaucracy
		Sophie	Managing needs and systems
			When others take the initiative
		Daniel	The challenging nature of the course
		Leanne	The need to manage

	Soldiering on: The need to manage		Trainees as a marginalised group
		Kate	Managing as a personal coping style
			The need to manage as a trainee
			Being in an anti-sickness culture
		Charlotte	Needing to be a brave soldier
		Holly	Soldiering on
			The difficulty of saying no
			Programme priority is graduating
		Sophie	Hiding the impact
			Developing permission to look after self

Group level super-ordinate theme	Group level sub-ordinate theme	Participant	Corresponding individual level themes
Identity	Navigating a disability identity	Daniel	Developing own model of identity
		Leanne	Struggle to accept disability identity
			Disability as one aspect of the self
		Kate	Rejecting the disability identity
			Developing a different relationship with health
		Charlotte	Acceptance of disability
		Holly	Relationship with disability identity
		Sophie	Navigating the self
	Navigating the personal, the public and the professional	Daniel	Professional pressure to be open
			Pressure to conform to a professional culture
		Leanne	x
		Kate	Disability as personal/part of the private self
			The personal becoming public (embarrassment)
		Charlotte	Lifelong versus acquired disabilities (Shame)
			Attitudes towards disabled trainees
			Perceptions of disabled trainees
		Holly	Professionalism
			Stigma
		Sophie	Stigma
	Being disabled enough	Daniel	Using disability
			Acceptance of need
		Leanne	Using disability to draw boundaries
		Kate	(Not) being disabled enough
		Charlotte	Being disabled enough
		Holly	Attitudes towards diagnosis
		Sophie	Influence on identity: Being disabled enough
			Struggles need to be visible to be valid
	Benefits of an insider identity	Daniel	Taking a strengths position
			Drawing on previous experiences
			Being a role model
		Leanne	Advantages in clinical work
			Being a more considerate clinician
		Kate	Benefits of an insider identity
			Holding hope
			Reducing power imbalances
		Charlotte	Experiences drove career choice
			Repaying a debt
		Holly	Experiences as motivators
		Sophie	Empathy for clients

Group level super-ordinate theme	Group level sub-ordinate theme	Participant	Corresponding individual level themes
Silence and speaking	Silence around disability	Daniel	Permission to talk
			Discomfort of others leads to silence
			The denial of issues of disability
			Disability not a priority
		Leanne	Silence around disability
			Discomfort of others
		Kate	Silence around disability
		Charlotte	Invisibility of disabled psychologists
			Discomfort of others
			Failed expectations
			Lack of understanding
		Holly	Disability isn't a priority
			Normality of silence
			Lack of discussion
			Priorities of course: Disability isn't a priority
		Sophie	Disability isn't avoided
	Navigating disclosure	Daniel	Passing
			The fear of disability dominating
			Developing a language to talk about disability
		Leanne	Breaking confidentiality
			Dilemmas around disclosure
		Kate	Disclosure to manage needs
		Charlotte	Role of visibility
			Developing a flexible language
		Holly	Dilemmas around disclosure
			Invisible disabilities require disclosure
		Sophie	Meanings of disclosure
			Fear of repercussions
	Becoming a problem	Daniel	x
		Leanne	Being problematized
			Fear of repercussions
			Developing strategies
			Programme culture around disability
		Kate	x
		Charlotte	Being a "good" disabled person
		Holly	Making internal attributions
			Being a burden
		Sophie	Problems placed in self not system
			Penalised for disability
	Safe spaces	Daniel	Value of shared experience

		Leanne	Support of cohort
		Kate	External versus internal support
			Value of personal therapy
		Charlotte	Importance of support
		Holly	Supporting others
		Sophie	Using expertise to help others
			Importance of the interpersonal
			Value of a space to explore

Extract of table demonstrating supporting quotes for individual level themes and how these correspond to group level themes:

Group super-ordinate theme	Group sub-ordinate theme	Participant	Individual level theme	Supporting quotes and line numbers
Identity	Navigating a disability identity	Kate	Rejecting the disability identity	I don't identify with having a disability as such although I know I do have one (142-143)
			Developing a different relationship with health	I didn't do this at the beginning of the course I've done this over time I've I've very much do it now but I have taken a few years to do to then say "look I do get colds a fair amount and I don't just soldier on anymore erm I have learnt to just look after myself and I know that when I need to go home I need to go home so that's that's kind of how I say it now but that's definitely changed over time 'cause I did used to just soldier on in the first year whereas over time I've learnt this is stupid just go home ((laughter)) (632-648)
				In making me kind of be a bit more have more healthy views about myself afterwards 'cause I just realised how ridiculous it was that epilepsy had been the reason that I had these quite negative views about myself and like once I was like well that's stupid I wouldn't think anyone else should think that (2100-2108)
		Charlotte	Acceptance of disability	in my family we have a lot of disability of one sort of another erm and so it was you know they always said "if you want to be registered disabled if you want to get a blue badge you go ahead and do that" and it took me fourteen years to feel comfortable saying OK yeah I am sick enough if you want to use that word but I am disabled and so since then I think I've been embracing it a bit more and being like this is who I and I'm happy with that (1992-2012)
				C: ((laughter)) Erm on a day to day basis I'm not really going around thinking oh yes I am a disabled person but if asked to describe myself I would say the disability is a huge part of who I am because it's guided what I've done throughout my life from the the types of experiences I've had to the type of job that I'm now erm and I don't know what kind of person I would be without the disability erm and so for me I have a very strong belief that I like who I am now erm and I don't know who I would be without the disability so I'm gonna be go with the kind of I'm happy to have a disability because it's led me here and I like here erm so it's a big part of my identity in terms of liking where I am now and sort of perhaps nonsical belief that it's led me here (1809-1849)
		Holly	Relationship with disability identity	it's a big thing for me erm so it does, because it's a big thing for me it's a big thing for me as a trainee (1768-1769)
				In terms of general terms I see IBS definitely as part of my identity, that's something I struggle with I I struggle to erm differentiate myself from my IBS (1747-1770)

Appendix K: Recurrence of Themes Across Participants

Super-ordinate theme	Subordinate theme	Daniel	Leanne	Kate	Charlotte	Holly	Sophie
Everyday battles	Everyday work of disability	x	x	x	x	x	x
	Psycho-emotional experience	x	x	x	x	x	X
	The burden of responsibility	x	x	x	x	x	x
	Soldiering on	x	x	x	x	x	x
Identity	Navigating disability identity	x	x	x	x	x	x
	The personal, public and professional	x		x	x	x	x
	Being disabled enough	x	x	x	x	x	x
	Benefits of an insider identity	x	x	x	x	x	x
Silence and speaking	Silence around disability	x	x	x	x	x	X
	Navigating disclosure	x	x	x	x	x	x
	Becoming a problem		x		x	x	x
	Safe spaces	x	x	x	x	x	x

Appendix L: Reflexive Journal Extracts

November 2017 – Prior to interviewing "Daniel"

I'm feeling quite excited about doing my first interview today, I think particularly as it has felt like such a long time coming because of my first thesis falling through. I'm feeling slightly apprehensive about the actual running of it though. I haven't done research interviews before and think I might find it hard to not do too much reflecting back and end up making leading statements because of it. I'm also worried about being too empathic – it feels like in clinical work empathy is valued, but because research is supposed to be "scientific" this has less of a place?

I think I am also starting to worry about being exposed as a bit of a fraud in a way, that participants might feel as though "you don't have a real disability, why are you doing this research" or something like that.

I've just re-read some interview advice/guidance in the Braun and Braun book and at several times there are mentions of acting as the researcher, not as yourself. While I understand this and it makes sense and I agree to an extent, I think it's what I will struggle with the most particularly as the interview topic is so personal to me. I think it reminds me of the idea of a personal/professional divide etc in clinical work, which is something I also don't think really exists. How can we realistically separate off parts of ourselves? And I suppose that's partly what I'm curious about in my research in relation to identities of TCPs and identity as disabled.

November 2017 – After interviewing "Daniel"

I think the first interview went fairly OK for the first time! I perhaps fumbled at times and fluffed up the opening where I ask about how describe the disability, but I think it got better from there. The conversation seemed to jump around a lot and I went with that, but I think we covered everything in the interview schedule. I was also concerned about occasionally summarising and that becoming a leading question.

There were times where I was starting to lose track whether the conversation was interested to me because it was relevant to the research topic, or interesting to me as a person, which was difficult. It is difficult to separate Nicola the researcher from Nicola the person, and while I think this is a good thing in many ways I wonder whether in this instance it meant I was less directive in bringing the Daniel back to topics that were directly relevant. Or perhaps they are relevant – I'm not sure yet! Also being more directive wouldn't have fitted with the overall style of the interview or my approach. I was aware of becoming very tired towards the end of the interview, I think we both were and the conversation then felt much more question and answer, so this is something to keep an eye on in future interviews. It also reinforces that I need to make sure I don't arrange more than one interview on the same day.

Daniel spoke about some of his early experiences in the medical system which didn't surprise me and I had perhaps assumed that we might have some of these shared experiences (so I need to keep an eye on my assumptions as not everyone will necessarily have these experiences). There were also similarities in relation to these experiences being a drive to go into clinical psychology in order to work in a more person-centred way, and the disappointment and frustration experienced when on placement and realising that things haven't moved on. It felt very validating my own experiences,

but also immensely frustrating that these are so common and, by the sound of the Daniel's account, still are.

December 2017 – After attending a conference: "Disability in the NHS"

Went to a "Disability in the NHS" conference yesterday, which I would never have done previously. It felt good to connect with other people. Some of the main things that stood out for me were:

- Presentation by someone about perspectives of staff with disabilities, who himself identified as disabled but spoke about historically hiding this. Resonated strongly!
- ESR data suggests 3% of NHS staff are disabled, whereas the study they discussed found 17%! So a huge issue around people not wanting to disclose.
- The idea that good practice can be reliant on individuals– reflecting the variability in placement experiences
- Conversation around whether someone is "disabled" or not, which came up in relation to HR and use of schemes. Led to some conversation around identity and how personal this is – seems like the issue of whether someone identifies as disabled or not is a really difficult one, and lots of people seemed to be saying that they don't identify that way. I wonder if this is an issue with my recruitment – do people read "self identify as living with a disability" and assume the study isn't for them? I'm not sure if I read that I would think I was eligible.

I'm also thinking more and more about language. I started the project using "trainees living with disabilities". I think I wanted to put as many words as possible between trainee and disability, as well as using "person first" language. Then I became more aware of the arguments for the phrase "disabled trainee" around people being disabled due to the environment not something within them, links with the social model etc. But I've wondered whether people not familiar with critical disability approaches would make that link and worry they would see it in the more labelling way that I historically have. I think I also really struggled with the idea of identifying myself or describing myself as a "disabled trainee" as opposed to someone living with something, which is probably strongly related to all the dominant discourses surrounding disability. But now the more I think about it the more "trainee with" makes me cringe slightly; it seems as though it's very clearly locating the "problem" within the trainee. Not sure what to do about this debate!

December 2017: After interviewing "Kate"

I just finished my interview with the participant with epilepsy and I feel quite strange, but can't really put my finger on what it is. I think the interview itself went OK and there were definite differences between us (her epilepsy is well controlled, generalised seizures, has been able to prioritise looking after herself on placement and has had generally positive experiences with being able to do this). But there were also massive similarities (triggers, the panic from others following disclosure, the "jolt" when teaching mentions epilepsy and feeling exposed, the lack of acknowledgement that people may be affected by issues raised, the relationship with identity, looking through slides in advance when it might mention epilepsy…).

I'm hoping I managed to do OK at not getting too side-tracked by what I personally might have wanted to ask directly about and I'm really glad that I didn't name epilepsy on my recruitment materials as I think that would have made us identify with each other even more had she known that

we had that shared experience. Writing down notes during the interview of when I was particularly identifying also helped as I think it enabled me to separate this off slightly/ to acknowledge the similarity but then also "shelf" it. I think I might have stuck to the interview schedule more rigidly than perhaps in other interviews – I think to try and help me stay as "Nicola the researcher", although I also think that to an extent this was associated with her having a different style of answering questions than some other participants. I think the times when I maybe got more swept up is when I found myself feeling quite protective e.g. when she discussed the upcoming teaching on epilepsy I asked about this a lot and also enquired about managing this. Even though this is relevant to the research I think I also felt quite concerned and very moved by the idea of her going to the toilets to have a cry part way through, and also actually quite angry about someone being in that position.

In terms of using Skype, I think this meant that I rushed through the consent and introductions a little, which could have affected rapport but based on her answers I don't think was an issue. In a way doing the interview via Skype made it feel a little more relaxed – we were both in our own homes and we'd had more emails back and forwards beforehand as well so this felt less formal and might have helped with rapport. On the other hand, there was glitchy internet occasionally which interrupted the flow and I had a lot of anxiety about recording and felt slightly more preoccupied about this. However, hopefully now that I've had a successful experience of recording via Skype I won't feel as anxious about this next time.

January 2018 – General reflections

I'm finding that I'm struggling with the research a bit at the moment. I'm not sure if it's the aftermath of transcribing the interview with Kate, or because of my personal life in relation to placement difficulties and my own health (probably a combination), but it feels very difficult to concentrate on what I'm reading in the literature as I find myself constantly reflecting on my own experiences automatically. Which actually becomes a bit tiring and exhausting – I don't want to reflect on my experiences and my "stuff", I just want to get on with my research!

I know I was warned about doing a topic so close to home and I don't know whether at the time I was just in a better place (having just had positive experiences on placement and around my epilepsy within the professional arena), but I genuinely didn't think it would be an issue. However at the moment it is feeling quite difficult, draining and difficult to focus. I think previously when reading literature or thinking about my research I felt angry at times but in a way that was passionate and useful. Whereas currently I feel quite deflated, hopeless and disillusioned and have been questioning my own place within clinical psychology and whether I would be accepted as myself with epilepsy being a part of that. I've also been feeling quite angry with the field for being what I see as very hypocritical, e.g. promoting self-care but then expecting the opposite if you need to do something slightly different to others. This idea did come up in the interview with Kate and resonated strongly.

February 2018 – Prior to interviewing "Sophie"

I am doing my final interview today. It's the last one so I feel like I want to make it a "good" one, although I feel as though I'm still not sure what that would look like!

I am very tired today though, I had surgery at the weekend so I'm glad we arranged to do the interview via Skype as opposed to face to face, but I'm worried I won't be able to give it my best.

However I feel like I really need to get this final interview done – it feels difficult enough to take time off placement, but also so hard to sit at home and "rest" when there is so much academic work to do, you feel behind and there are upcoming deadlines. So this in itself is an interesting example of doing clinical training while living with a health condition!

Appendix M: Debriefing Sheet

Thank you so much for taking the time to talk to me.

What happens next?

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

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

If you think of any questions, please don't hesitate to contact me at

Where can I get information and support?

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

Below are a number of external organisations which can provide information or support. You can also contact your GP for further support.

1. Equality and Human Rights Commission
www.equalityhumanrights.com
Information and advice in relation to equality, rights and discrimination.

2. Scope
www.scope.org.uk
Information and support about living with a disability, including a free confidential helpline: 0808 800 3333

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

Thank you again for taking part!

UNIVERSITY OF EAST LONDON
School of Psychology

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APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

</div>

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a <u>Professional Doctorate in Occupational & Organisational Psychology and PhD candidates</u> should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to:
http://www.uel.ac.uk/gradschool/ethics/

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.
Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.
Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website
http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015)
http://www.uel.ac.uk/gradschool/ethics/

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would

like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will <u>not</u> have to apply for another in order to conduct research with vulnerable populations.

<u>Your details</u>

1. **Your name**: Nicola Coop

2. **Your supervisor's name**: Ava Kanyeredzi

3. **Title of your programme**: Professional Doctorate in Clinical Psychology (ClinPsyD)

4. **Title of your proposed research**: Exploring the experiences of trainee clinical psychologists who identify as living with a disability: A qualitative study.

5. **Submission date for your BSc/MSc/MA research:** May 2018

6. **Please tick if your application includes a copy of a DBS certificate**

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (<u>m.j.spiller@uel.ac.uk</u>)**

8. **Please tick to confirm that you have read and understood the <u>British Psychological Society's Code of Human Research Ethics (2014)</u> and the <u>UEL Code of Practice for Research Ethics</u>** (See links on page 1) x

<u>2. About the research</u>

9. **The aim(s) of your research:**

The proposed study aims to explore the experiences of trainee clinical psychologists who self-identify as living with a disability. Despite its focus on human experience, clinical psychology training has historically neglected disability as an aspect of diversity (Andrews, Kuemmel, Williams, Pilarski, Dunn & Lund, 2013). Whilst one study has explored the factors leading to a consideration of a career in clinical psychology in undergraduates and graduates living with a disability (Twena, 2008), the literature regarding experiences of trainees during training remains limited and much of what does exist is based on surveys conducted within the context of clinical psychology in America. This research has identified issues such as reluctance and concerns regarding disclosure of disability (Lund, Andrews and Holt, 2016) and experiences of discrimination and a lack of support (Lund, Andrews and

Holt, 2014). Researchers have also discussed concerns in relation to how disability is addressed within psychology teaching and the way in which this may marginalise and alienate students living with disabilities (Olkin, 2002).

The individual training experiences of those living with disabilities has yet to be explored in-depth and has not been researched in the context of the UK. It is hoped that the proposed research will draw attention to the thus far neglected area of the experiences and needs of trainee clinical psychologists living with disabilities and might influence future support for trainees and guidance for both clinical psychology training programmes and supervisors.

10. Likely duration of the data collection from intended starting to finishing date:

1st November 2017 – 30th May 2018

Methods

11. A) Design of the research:

A qualitative approach will be used. Semi-structured interviews will be conducted with trainee clinical psychologists, which will allow a more open exploration of the topic. Questions will be asked relating to the research questions. Interviews will last approximately 60 minutes. Data will be analysed using Thematic Analysis. This approach has been selected as its theoretical openness lends itself to the exploratory nature of this study, whilst its flexibility in relation to epistemological stance allows for the use of a critical-realist approach (Braun & Clarke, 2006) which is in keeping with the epistemological position of the research.

B) The researcher's position:

The researcher has personal experience of living with a long-term health condition, which has had implications for her journey into clinical psychology training and her clinical training experience. This position will be attended to during the course of completing the research through reflexivity, the use of reflective diaries and use of supervision.

12. The sample/participants:

The study will include 12 participants who will be trainee clinical psychologists undertaking clinical training in the UK who self-identify as living with a disability. For the purpose of this research, this will include physical and learning difficulties, but not mental health difficulties (unless this is in addition to a physical and/or learning difficulty). This is because it is recognised that mental health is an area in its own right with its own unique set of experiences.

The sample may include participants of different ages, gender and ethnicities. Participants will be recruited though a number of methods. Course directors of clinical psychology training courses will be contacted regarding the research and asked to share this with trainees. Personal contacts, word-of-mouth and social media will also be used to publicise the research and a snowballing technique will be used to recruit additional participants.

Due to the location of the researcher, recruitment will initially be limited to participants completing training at the four courses in London (University of East London, University College London, Royal Holloway University of London and Kings College London). Should it prove difficult to recruit the required number of people, this will be broadened to the surrounding area (University of Surrey, University of Hertfordshire and Salomons). Should it still not be possible to recruit enough participants, this will be widened further.

13. Measures, materials or equipment:

A semi-structured interview schedule will be used to guide each interview. Interviews will be recorded on audio-recording equipment and transcripts will be saved on a password-protected computer.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

Not applicable

15. Outline the data collection procedure involved in your research:
(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

1. A) Course directors of Professional Doctorate in Clinical Psychology programmes will be contacted with information about the research and asked to share the information sheet with trainees. This will ask interested trainees to contact the researcher.
   B) Simultaneously, information will be shared about the study on social media and via personal contacts and word of mouth. Interested trainees will be asked to contact the researcher for further information if they are interested in participating.
2. Trainee clinical psychologists who contact the researcher will be sent additional information about the study and given the opportunity to contact the researcher to ask any questions. They will be asked to contact the researcher if they still wish to participate.
3. Those who wish to participate in the study will be contacted by the researcher to arrange a time and date for the interview.
4. Interviews are likely to take place in a quiet room at the University of East London. However, if participants would feel more comfortable completing the interview elsewhere then this will be discussed and an alternative location sought if possible. Face-to-face interviews will be preferred, but video calling (e.g. Skype) and telephone calls will also be considered if necessary.
5. Prior to commencing interviews, participants will be given another opportunity to ask any questions, then asked to sign the consent forms.
6. Interviews will last approximately 60 minutes and will be audio-recorded.
7. After interviews end, participants will be given the opportunity to ask any questions. They will also be asked about how they found the interview process and given the opportunity to give any feedback. They will be given a debrief sheet which will include details of organisations that may be able to provide information or support.
8. Audio recordings will be transcribed by the researcher within three months of the

interview taking place.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary):

Fully informed consent will be obtained by asking participants to read an information sheet (Appendix 1). Participants will be given the opportunity to ask any questions before interviews are arranged. Participants who attend interviews will be given the opportunity to discuss the study and ask any questions before the researcher seeks consent (Appendix 2).

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

After reading information sheets and having the opportunity to ask questions, participants will be asked to read and sign a consent form (Appendix 2).

18. Engaging in deception, if relevant:

The proposed study does not involve deception. Participants will be fully informed about the aim and nature of the research.

19. Right of withdrawal:

Participants will be informed that they are able to withdraw from the research at any time without giving a reason, and that this will not disadvantage them in any way. Participants will be informed that should they withdraw from the study before the analysis has begun they can request for their data to be destroyed, but that if analysis has already begun their anonymised data may still be used.

20. Anonymity & confidentiality:

20.1. Will the data be gathered anonymously?

NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?
(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

The names and contact details of participants will be saved in a password-protected word file on a password-protected computer and will be deleted after examination. In order to protect

anonymity, names and other identifying information will be changed within transcripts, the thesis and any subsequent publications. Participants will be given the option to select their own pseudonym. Quotes will be carefully selected to minimise the possibility that contributions will be identifiable by readers at the universities which trainees attend. Audio recordings and transcripts will be stored on a password-protected computer. Audio recordings will only be accessed by the researcher and will be deleted after examination. Transcripts will only be accessed by the researcher, supervisor and examiners and will be deleted three years after the study.

Should any concerns arise in relation to the safety of participants or others, the researcher will seek support from the supervisor and keep the participant informed throughout this process.

22. Protection of participants:

(Are there any potential hazards to participants or any risk of accident of injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)

N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

As participants may discuss difficult experiences, it is possible that they may become distressed during the interview. Participants will be informed prior to the interview that they are able to withdraw at any time, take breaks or reschedule should they wish. During the interview the researcher will be attentive to any signs of distress. Should a participant become distressed, the researcher will ask the participant what they would like to do, offering options of taking a break or continuing the interview on another day. Participants will also be reminded that they are able to withdraw from the study if they wish. As part of the debrief all participants will be signposted to support should they wish to access this (Appendix 3).

23. Protection of the researcher:

Interviews will take place at the University of East London. Where participants are unable or do not wish to travel to the University of East London, alternative locations will be considered. The supervisor will be aware of the time and location of all interviews and will be contacted by the researcher after each interview to confirm completion. Should the researcher experience any distress in relation to contact with participants or the process of completing the research, relevant supervisors will be contacted.

24. Debriefing participants:

(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

No deception will have been involved in the study. At the end of the interview, participants will be given the opportunity to ask any questions. Participants will be asked how they found the interview process. They will be reminded about what will happen to their data and asked if they are still happy to have their data used in this way. Participants will be given details for organisations that are able to offer further support (Appendix 3).

25. Will participants be paid?   NO

Participants will not be paid for participating. However, funding for the reimbursement of travel costs to attend interviews will be explored.

26. Other:
(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

                                                                        NO

If your project involves children at a school(s) or participants who are accessed through a charity or another organisation, you must obtain, and attach, the written permission of that institution or charity or organisation. Should you wish to observe people at their place of work, you will need to seek the permission of their employer. If you wish to have colleagues at your place of employment as participants you must also obtain, and attach, permission from the employer.

If YES please give the name and address of the institution/organisation:

Please attach a copy of the permission. A copy of an email from the institution/organisation is acceptable.

In some cases you may be required to have formal ethical clearance from another institution or organisation.

28. Is ethical clearance required from any other ethics committee?
                                                                        NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet?   NA

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable.

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*

                                                                          NO

    If YES have you obtained and attached a DBS certificate?   NA

    If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

                                                                             NO

    If NO please give reasons. (<u>Note that parental consent is always required for participants who are 16 years of age and younger</u>)

* <u>You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2)</u> 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

30. Will you be collecting data overseas?   NO
    This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

<u>Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas</u>.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

<u>IN MANY CASES WHERE STUDENTS ARE WANTING TO COLLECT DATA OTHER THAN IN THE UK (EVEN IF LIVING ABROAD), USING ONLINE SURVEYS AND DOING INTERVIEWS VIA SKYPE, FOR EXAMPLE, WOULD COUNTER THE NEED TO HAVE PERMISSION TO TRAVEL</u>

5. References

Andrews, E., Kuemmel, A., Williams, J., Pilarski, C., Dunn, M. & Lund, E. (2013). Providing culturally competent supervision to trainees with disabilities in rehabilitation settings. Rehabilitation Psychology, 58(3), 233-244.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.

Lund, E., Andrews, E. & Holt, J. (2014). How we treat our own: The experiences and characteristics of psychology trainees with disabilities. Rehabilitation Psychology, 59(4), 367-375.

Lund, E., Andrews, E. & Holt, J. (2016). A qualitative analysis of advice from and for trainees with disabilities in professional psychology. Training and Education in Professional Psychology, 10(4), 206-213.

Olkin, R. (2002). Could you hold the door for me? Including disability in diversity. Cultural Diversity and Ethnic Minority Psychology, 8(2), 130-137.

Twena, S. (2008). Factors in the consideration of a career in clinical psychology by undergraduates and graduates with disabilities: A Q methodology study. (Unpublished doctoral dissertation). University of East London, London. Retrieved from http://hdl.handle.net/10552/3779

6.Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Nicola Coop

Student's number: u1524900   Date: 28/10/2017

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Dr Ava Kanyeredzi   Date: 30/10/2017A

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Max Eames

SUPERVISOR: **Ava Kanyeredzi**

STUDENT: Nicol Coop

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Exploring the experiences of trainee clinical psychologists who identify as living with a disability: A qualitative study.

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Approved.

Minor amendments required *(for reviewer)*:

Consideration might be made of the comment made about clarifying cut-off at the stage of data-analysis, but this is not a required amendment; only a suggestion to safeguard the position of the researcher.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the <u>researcher</u> to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any). N/A

Reviewer *(Typed name to act as signature)*:   MAX ALEXANDRE EAMES

Date: 14 NOVEMBER 2017

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

<u>**RESEARCHER PLEASE NOTE:**</u>

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard