AN EXPLORATION OF EMERGING IDENTITIES IN MENTAL HEALTH, EDUCATION AND RESEARCH

"These are powerful forces and we're feeling the effects now, it's going to be good to be part of that… seeing how those forces shape it."
~ Expert by Qualification

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy.

VEENU GUPTA

June 2023

ABSTRACT

There is an exponential growth in lived experience work in the field of mental health, education, and research. Those in lived experience roles are people with personal experience of services and disabilities that use their experiences to help inform service provision that better meets the needs of other service users. The lead researcher has engaged in this type of work herself and noted that it made a profound impact on her identity. However, the current theoretical framework on identity including social identities and role identities, do not account for identities that span service user and service provider, as they are typically considered binary and oppositional. Therefore, this thesis aimed to explore and give greater clarity to the identities within this sector, how they can work together more effectively, and to better support the process of lived experience work.

To explore this, Study 1, a systematic review of the literature was conducted to understand the identities of lived experience researchers and providers. The EMERGES framework was developed, encompassing, Empowerment, Motivation, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots, factors influencing identity. The findings suggested that identity in the field of clinical psychology was under researched, providing the rationale to study the collective identity of clinical psychology training and its subgroups of Experts by Experience, Expert Carers, Trainee Clinical Psychologists and Experts by Qualification in separate focus groups in Study 2, to observe how their identities were socially constructed. It was hypothesized that the process of identification between trainees and their trainers would be influenced by individual differences in mental health and professional identities and personality differences which was tested in Study 3, a pilot study. Quantitative methods were used to understand how trainee clinical psychologists identified with these trainers. An in-group identification measure for trainee clinical psychologists was tested for reliability and validity. The study found three factors of cognitive, affective, and evaluative identification. Study 4, a preliminary study, gathered findings from across the thesis to understand lived experience researchers' needs from supervision using Q methodology. Three types of lived experience researchers were found, the first focused on developing their skills, identity, growth, and empowerment, the second focused on understanding their relational and emotional link to the research, and the third focused on support to navigate personal and professional identities in practical and emotional ways. Together these studies provide insight into the identities in mental health, education, and research and ways to forward lived experience work.

TABLE OF CONTENTS

CHAPTER 4. UNDERSTANDING THE IDENTITY OF LIVED EXPERIENCE RESEARCHERS AND PROVIDERS. A SYSTEMATIC NARRATIVE REVIEW ………………………………………………………………………………31

CHAPTER 6. DEVELOPING AN IN-GROUP IDENTIFICATION MEASURE IN CLINICAL PSYCHOLOGY TRAINING………………………………………………108

ACKNOWLEDGEMENTS

I have many people to thank that supported me in my journey to completing this PhD and helped me navigate personal and professional storms.

Firstly, thank you to each of my supervisors, Dr Peter Fisher, Dr Catrin Eames, Dr Laura Golding, Dr Beth Greenhill, Alison Bryant, and Dr Jennie Day. I really appreciated exploring and developing the research together and how you enabled me to take control and go on the route I envisioned. Thank you for reading multiple drafts and for your guidance throughout the PhD. Each of you have stepped in at different times to help complete the journey. Thank you also to my independent reviewers, Professor Rhiannon Corcoran, Professor Ross White, and Dr Emilia Trapasso. Thank you also to examiners Dr Gayle Brewer and Dr Gerald Jordan.

Thank you, most importantly to my family for supporting me when I was at my lowest and particularly to my Mum, and Sister, Nitika, who each provided unwavering support to me. I know my experiences overwhelmed us sometimes and became your experiences too. Conversations with you shaped the research for the better. Thank you also to my Dad who generally takes a back seat, but I know is proud of me. You all reminded me of the importance of my work and were my constants throughout this time. You calmed the storm along the way, and I couldn’t have got through this without you. I wish I could bottle the support you gave and keep it with me.

I want to also thank the Service User Reference Group (SURG) on the Clinical Psychology training course at University of Leicester, the Liverpool Experts by Experience group (LExE) on the Clinical Psychology training course at University of Liverpool and the National Clinical Audit of Psychosis team. Experiences with these groups helped me learn a lot about lived experience work and allowed the roots for the PhD to form. Thank you also to my PhD friends who I shared and went on parallel journeys with. Thank you also to friends who supported me along the way and took an interest in my research.

Finally, I want to thank all the Experts by Experience, Expert Carers, Trainee Clinical Psychologists, Experts by Qualification and Lived Experience Researchers that took part in the research, shared their experiences with me and to others who I connected with through lived experience work. It is this collective insight that shaped this PhD and will help forward the field of lived experience work in mental health, education, and research settings.

DECLARATION

I declare this thesis is being submitted in partial fulfilment of the requirements for the degree of PhD. This thesis is the result of my own independent research. This work has not been submitted by me for any other higher degree or award at this or any other university or place of learning. Although data I have collected in this research have been used in secondary analyses for Undergraduate dissertations for Brooke Sharples and Rachel Verity at University of Liverpool, whom I co-supervised. Sources of knowledge are acknowledged by explicit references. I hereby give consent for my thesis, if accepted, to be available on the university database, and to outside organisations and other universities.

Signed:

Veenu Gupta (Candidate)

January 2023

THESIS OVERVIEW

This PhD explores the identities in, mental health, education, and research with the aim to use this knowledge to connect groups in the sector, reduce ‘Them and Us’ divisions, support effective teamworking and promote better meaningful lived experience work. The groups within clinical psychology training are explored, including Experts by Experience (Service users and Carers), Trainee Clinical Psychologists and Experts by Qualification (Research Psychologists and Clinical Psychologists) and Lived experience researchers. Identity constructions are understood through how identity is spoken about within these settings by these groups. The dynamics in this thesis represent the mechanisms, contexts and directions that influence the positions of identity. The PhD researcher is an Expert by Experience herself and also an Expert by Qualification and generated the concept for the thesis based on this personal experience, with a personal subjective observation that these roles have had a profound impact on her identity. There is a shift within the thesis moving from a subjective account to the observed, with the PhD researcher aiming to move from introspection towards measuring the experience of others through the data. The PhD researcher revisits her own identity towards the end of the thesis, recognising how the cumulative wealth of knowledge from the research has influenced her own expertise in the lived experience field and how it has utility and can be applied in her further work and the work of others in the field.

Chapter 1 identifies the motivation behind the research through anecdotal reflections. It begins by exploring how the research is an extension of the self, following on to discuss the importance of acknowledging objectivity and subjectivity and the use of supervision to negotiate relations to the research. A brief history of service user involvement is presented in Chapter 2. The theoretical basis of identity in Chapter 3 discusses social identity theory, identity theory, intersectionality, and liminality in the field. Although, it is argued that these theories are not sufficient in explaining the complex nature of lived experience roles. The thesis aims to give greater clarity to identities in mental health, education, and research.

Chapter 4 (study 1) is a systematic review and narrative synthesis of the literature into understanding how the identity of lived experience researchers and providers are conceptualised in mental health, education, and research settings. A conceptual framework to understand identity construction and formation was developed in the form of the EMERGES framework. An acronym for themes that influence identity encompassing, Empowerment and enablers, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots. This is tested within this chapter followed by reflections from a service user advisor of the research. Reflections from the PhD student and coproduced recommendations for the utility of the framework can be found at the end of the thesis.

Chapter 5 (study 2) is an empirical qualitative study into understanding how groups in clinical psychology construct their identities (Service users, Carers, Trainees and Experts by Qualification). This study used focus groups to recreate social identities that these groups work within. The study was based on the first part of social identity theory, that of self-categorisation where individuals were first asked to self-define themselves into a particular group. This study details four focus groups and uses a thematic analysis with social constructionist approach to understand how identity is constructed across these groups and there is an exploration of whether similar or novel conceptions to the review are found. The empirical study uses a critical realist approach and roots the findings in contextual factors and deductively interprets the data through the EMERGES framework.

Chapter 6 (study 3) is a pilot study that adopts and adapts an in-group identification measure and assesses its factor structure, reliability, and validity, to measure how trainee clinical psychologists, identify with their trainers. This is based on the second part to social identity theory, social identification, to understand how individuals come to belong to a group and their motivations behind this. Personality measures are used as predictors of cognitive and affective identification and these identification measures are used as predictors towards mental health and professional identities. The study creates a reliable and valid in-group identification measure for use with trainee clinical psychologists.

Chapter 7, (study 4) a preliminary study brings together learning from empirical studies and the systematic review and reflective chapters and develops a Q methodology study identifying the priorities for supervision of lived experience researchers that identifies factors of lived experience researchers that can support in personalising supervision for lived experience researchers.

Chapter 8 is a reflective chapter including entries by the PhD researcher and service user advisor to the thesis of their relation to the findings and is a way to support immersion in the research, offering additional insights into their own expertise as lived experience researchers.

Chapter 9 is the discussion and concluding chapter that brings together the learning from each chapter and synthesises this in relation to the findings of the systematic review and identifies recommendations from across the thesis. This chapter attempts to address the importance of identity consciousness and exploration.

LIST OF ABBREVIATIONS

A

ACP-UK, Association of Clinical Psychologists – UK

AIC, Akaike Information Criterion

AR^2, Adjusted Variance Squared

B

B, Regression Coefficient

BPS, British Psychological Society

C

CAT, Cognitive Analytic Therapy

CBT, Cognitive Behavioural Therapy

CFA, Confirmatory Factor Analysis

CFI, Comparative Fit Index

CHIME-D, Connectedness, Hope, Identity, Meaning, Empowerment and Difficulties.

CQC, Care Quality Commission

D

DBT, Dialectical Behavioural Therapy

DCP, Division of Clinical Psychology

Df, Degrees of Freedom

DoH, Department of Health

E

EBE, Expert by Experience

EBQ, Expert by Qualification

EMERGES, Empowerment and Enablers, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots.

F

F, ANOVA

G

GTiCP, Group of Trainers in Clinical Psychology Training

H

HCPC, Healthcare Professional Council

I

ID, identification

IP addresses, Internet protocol address

J

JBI, Joanna Briggs Institute

K

K1, Kaiser method

KMO, Kaiser Meyer Olkin

L

LExE, Liverpool Experts by Experience group

LGBT, Lesbian, Gay, Bisexual, Transgender

LXP, Lived Experience Practitioner

M

N

NHS, National Health Service

NIHR, National Institute of Health Research

NSUN, National Survivor User Network

NVIVO, Software for qualitative analysis

O

OCD, Obsessive Compulsive Disorder

OSF, Open Science Framework

P

P, Sig, Significance

PCA, Principal Components Analysis

PRISMA, Preferred Reporting Items for Systematic reviews and Meta Analysis

PROSPER, Personal identity and strength, Receiving support, Opportunities and possibilities, Strategies for coping, Perspective shift, Emotional experience, and Relationships

PSWs, Peers support workers

PTSD, Post Traumatic Stress Disorder

Q

R

RCPsych, Royal College of Psychiatrists

RMSEA, Root Mean Square Error of Approximation

r, correlation coefficient

R^2, Variance squared

S

SOL, Shaping Our Lives Network

SPIDER tool, Sample, Phenomenon of Interest, Design, Evaluation, Research type

SRN, Survivor Researcher Network

SCIE, Social Care Institute for Excellence

SLEF, Sharing Lived Experience Framework

SPSS, Statistical analysis software

T

TLI, Tucker Lewis Index

T, T statistic

U

V

W

X

X^2, Chi Square

Y

Z

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

DISSEMINATION

CHAPTER 4

This Systematic narrative review has been submitted and accepted in a modified format as:

Gupta, V., Eames, C., Golding, L. *et al.* Understanding the identity of lived experience researchers and providers: a conceptual framework and systematic narrative review. *Res Involv Engagem* **9**, 26 (2023) https://doi.org/10.1186/s40900-023-00439-0

A summary of the systematic review has also been submitted in part for a blog:

Gupta, V, 2022, Understanding the Identity of the Lived Experience Researchers and Providers, National Survivor User Network. https://www.nsun.org.uk/understanding-the-identity-of-lived-experience-researchers-and-providers/

Presented in part for a conference: Gupta, V (2021) A Systematic review and Narrative synthesis of the conceptualisation of identity of service user providers in mental health, education and research, Presentation, PsyPag2021 conference (Online) Psychology Postgraduate Affairs Group

CHAPTER 5

Presented in part at conferences as: Jones, N., Lee, Y., Gupta, V (2021) Supporting meaningful lived experience involvement in Early Intervention in Psychosis research, Early Intervention in Mental Health, (IEPA) virtual online conference, 11th November 2021

Gupta, V (2021) How the groups involved in Clinical Psychology Construct their identities, Presentation, PsyPag2021 conference (Online) Psychology Postgraduate Affairs Group

Gupta, V (2019) Reflections of the many faces in Clinical Psychology. Symposium: Coproduction: Impact and Identity. Group trainers in Clinical Psychology conference. Liverpool. https://www.kc-jones.co.uk/files/uploads/1572965488.pdf

CHAPTER 6

Presented in part at a conference as: Gupta, V (2019) A PhD research proposal: Identity as a connecting factor between them & us. Group of Trainers in Clinical Psychology conference. Liverpool.

Presented in part as a poster presentation as: Gupta, V (2022) How do trainee clinical psychologists identify with their trainers (Experts by Experience, Carers & Clinical psychologists) and how does this impact their clinical skills and learning? Poster Presentation. International Conference on Social Identity and Health (ICSIH)

CHAPTER 7

A summary of the Q sort study has been submitted in part for a blog at McPin Foundation Gupta, V (2023) The 3 types of lived experience researcher and how to support them. McPin Foundation Blog. https://mcpin.org/3-types-of-lived-experience-researcher/

CHAPTER ONE

WHO AM I?

UNDERSTANDING THE IDENTITY OF THE RESEARCHER

“*The best way to find yourself is to lose yourself in the service of others.*”

~ Mahatma Gandhi

1.1. How the research is a reflection and extension of the self

As the author of this PhD research, I am a lived experience researcher with Psychosis and I also work as an Expert by Experience, using and applying lived experiences and professional experiences to my work, which I observed shaped my identity. This research aims to apply the observation that lived experience roles are formative to identity and as the researcher, I am hoping to observe this in the real world. Throughout the thesis I will draw on personal reflections to underpin the research questions and which will be understood through the theoretical evidence base of Identity to contextualise these experiences. Social Identity theory (Tajfel & Turner, 1979), Identity theory (Stryker, 1980), Liminality (Turner & Abrahams, 1969) and Intersectionality (Crenshaw, 1989) will be used to understand the identity of lived experience researchers and providers and consider whether these are cohesive in capturing this population, or whether additions to the theoretical evidence base is required to adequately explain these identities.

As the researcher, I have significant experience of being a member of a service user group of two clinical psychology programmes. Through this experience, I developed a strong group membership and a personal identity as someone with a lived experience of mental illness. The group's membership encouraged and fostered such an identity and enabled my voice to grow stronger and more powerful in communicating this identity to others within and outside of the clinical field, to raise awareness of mental health and challenge stigma. I also became a mental health activist as a result. Within my role as a service user representative, I taught a teaching session to clinical psychology trainees, regarding my lived experiences and identity, on the course where I shared my personal story and experience of psychosis and psychological and psychiatric treatment. The teaching that I delivered about my personal experiences, allowed me to make sense of my experiences and gain control of them through the way I spoke of and the narrative I understood them through. Through the process of being involved in service user involvement work I noted the impact and changes to my identity. It was important to me to understand this further and to see if other people's identities are impacted through this work and context.

The role of belonging to a service user group enabled a strong service user identity, but also encouraged a connection with other service users. However, at the same time influenced a barrier towards connecting with service providers and healthcare professionals with no direct experience of mental distress. For example, I was at a conference where a speaker, who was a clinical psychologist, was talking about Psychosis, but it left me doubting their expertise, due to the lack of personal experience of mental distress. Although, when the speaker said their family member had experience of psychosis, the story and experience began to resonate and connect more. This was attributed to the notion that it came from a place of direct experience and personal expertise. This experience inspired the idea that lived experience and professional attributes may differ in their emotive qualities and may resonate differently with trainee clinical psychologists, depending on their own mental health and professional identities and who they subjectively perceive as experts, those with experience or those with qualifications. It also made me aware that individuals can hold multiple identities that are triggered to manifest dependent on and specific to context.

In my experience, the very nature of service user reference groups encourages identification with the lived experience identity and influences an acceptance of and strength of this identity. It is also evident through my experiences that belonging to a group and the centrality and saliency of this identity is strengthened when in a minority where I feel a need to use my voice to represent my in-group minority in which I belong, such as representing and advocating for ethnic minorities. This suggests that in-group status may also influence the acceptance of stigmatised identities through belonging and feeling a part of a group.

I also work as a Service user Advisor for the National Clinical Audit of Psychosis to ensure the service user voice is represented and embedded within the design and outcomes of the research, working with key stakeholders such as the National Health Service (NHS) England and The Royal College of Psychiatrists. Therefore, I am aware how roles and occupation can result in the development of a professionalised service user identity. This professionalised identity may be perceived differently to the raw and emotive content of a service user speaking from personal experience. However, these distinct roles may have different purposes, and as the researcher, I have experience of both roles.

As a former mental health nurse, I identified with service users due to the dominance of my own lived experience identity. However, the culture of the occupational role of being a mental health nurse encouraged a professional identity as a practitioner. This consequently encouraged a rejection of my lived experience identity within training as it was thought to act as a barrier between understanding other patients’ unique experiences and separating them from my own experiences. These experiences suggested the idea that professional personas and sharing of lived experiences may be more useful in certain contexts.

I therefore have multiple identities such as a service user identity, a professional identity and an activist researcher identity. These different identities are triggered and manifest themselves differently depending on the context. This research triggers a combination of these different identities to emerge that can be used to guide and inform the research. However, it is also clear to me that some aspects of my identity are more salient and central to my self-concept than others and this may also unintentionally affect and inform the research conducted in this PhD thesis.

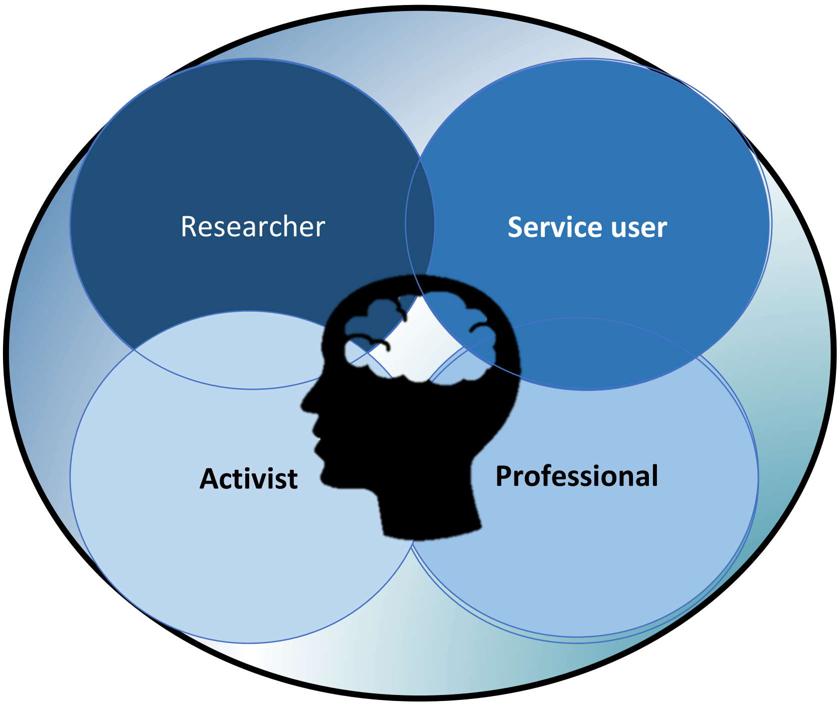


Figure 1.1. A visual representation of the researcher's multiple identities

Figure 1.1 visualises the different identities the researcher holds as a PhD researcher. The different identities become more salient dependent on triggers in personal or professional contexts. The identities can exist independently, simultaneously and in different combinations.

Therefore, the idea for this PhD research stems from a collection of these observations regarding my own identity, group membership and relation to others outside of that. These personal observations of the self in relation to others will help inform the research. However, I am aware that these personal identities may bias the work and therefore, where possible, theory and research will underpin and guide the research. The research is therefore a reflection of and an extension of my own personal experiences and I seek to validate and generalise these experiences to others and observe them in the real world.

1.2. Separating the self from the research – the supervisory process

The supervisory process was about supporting me as the researcher to contemplate the research and to support me to see my research from other perspectives as well as my own. The fundamental learning from this process has been to step outside of the research and allow it to emerge and be observed from an unbiased viewpoint and to be able to perceive and interpret the emergence of data in a way that reflects reality. This has been a challenge for me as the subject matter of the thesis is an extension of my own experiences and tied strongly to my own identity. Therefore, learning how to separate the self from the research has been a challenge. However, there are advantages in having direct expertise related to the subject matter that may give insight into novel research ideas. Though, there are setbacks to allowing personal experience to guide and inform the research, as it can unintentionally create more bias in creation and interpretation of it.

Associating the research as a part of my own identity has made it more challenging for me to accept critique and feedback regarding the research, as all feedback has felt like a direct criticism of me as the researcher. Therefore, there were key advantages to learning to separate the self from the research and to become more of an objective researcher. Being able to observe the research from the outside is essential in being able to interpret data from a bottom-up perspective, rather than a top-down perspective, and this allows for the research to be more sensitive, reliable and valid in interpreting the data. It also inhibits me, as the researcher, from interpreting the findings through my own personally held schemas.

Being an objective researcher is key in interpreting data to accurately represent findings that occur in the real world. However, it could be said that when interpreting data all researchers bring something of themselves and their experiences into it, suggesting all research is subjective. Therefore, it could be said that all research is biased in some respect, but there is value in identifying those biases and acknowledging their existence when conducting and interpreting data.

Being involved as a service user in research consultations of trainees' research in my previous experience provided me with knowledge of what is expected of service users who are involved in research. However, it did not offer me insight into what it is like to be the researcher working with the service user. To some extent, whilst working with supervisors it felt as though as the researcher, I was back in my role as a service user involved in research and that the supervisors were actually coproducing their research with me as a service user group member.

In reality, my supervisors were treating me like I had expertise in service user involvement. However, from my perspective, they wanted to foster a researcher identity as opposed to a service user researcher identity. Being a researcher is a clear, and discrete role that encompasses an objective truth to emerge. However, being a service user researcher is more complex, as again, it brings personal experience into the mix, which may actually unintentionally act as a barrier to effectively conduct research.

The service user involvement within the research acted like a mirror that reflected the dynamics of the supervisory process. As a researcher I had to act as the academic researcher, and act like my supervisors and coproduce with other service users. I had to now fit into the researcher identity whilst working with service users and carers that informed the research and supported its coproduction. This was difficult to do, as working from a service user led perspective requires relinquishing power and allowing others to direct and inform the research. However, I felt this was more difficult to do as a service user researcher where I felt the research should to some extent reflect my own experiences of the field too. The service user researcher identity is still a valid and important perspective to hold, but within the research, it was important to find a balance between my different held identities, as the researcher who is also a service user, service user researcher and researcher. This conflict of knowing when to draw on these different identities was a great challenge. A method used to reduce the bias and encourage the researcher to be more objective has therefore been to make use of a service user advisor to offer a perspective on the design and analysis of the research.

1.3. Social positionality in relation to the research

Despite feeling connected to the target research groups, my positionality relating to the research is an interesting position to be in as it almost lies outside of the periphery and boundaries of each trainer in clinical psychology (Expert by Experience (EBEs), Trainee Clinical Psychologists and Experts by Qualification (EBQs) including Clinical Psychologists and Research Psychologists), which should theoretically support me in being objective. The research is regarding identities involved in clinical psychology training including EBEs, Carers, Trainees and EBQs. Having been a service user and involved as a trainer in clinical psychology my identity is therefore strongly tied to my research area and I feel like the research is an extension of the self and it is difficult to separate the self from the research.

My PhD identity is somewhat of an outsider in each group I am connected to, for example the Expert by Experience group I am linked to potentially do not regard me as an Expert by Experience as I largely speak about the PhD research to them. I therefore feel that maybe my identity as an Expert by Experience may not be as visible there and this makes me feel disconnected from the group and affects my sense of belonging and moves me further away from the service user identity, which feels incongruent towards my personal identity.

Another aspect of my research is about understanding the identities of Clinical Psychologists. Three of my supervisors are Clinical Psychologists and another supervisor is a

Research Psychologist, all of which teach on the Clinical Psychology doctorate. This is another dichotomy as they are linked to Clinical Psychology training, and again I do not feel connected to this as my role is as a PhD student in research psychology. This perspective may be influenced to some extent by the rhetoric and discourse from some Clinical Psychologists and their view of those with PhDs in psychology and their claim to be experts. It also to some extent undermines the PhD experience and challenges the expertise of the PhD regarding the domain of clinical psychology, as an expert that does not belong to the profession. Therefore, navigating the many identities involved in clinical psychology has been an interesting process, as well as negotiating, managing, and understanding where my own identity fits within this.

My research is therefore important in terms of finding the mechanisms that better connect different groups and identities, so individuals feel like they belong to a social identity. My research will therefore hopefully be the missing piece that will provide insight into the key mechanisms that allow people to relate and connect with one another and better learn from each other. Moving through the PhD I am hoping I will get a better understanding of my unique position and identity and how I fit into the role and the wider world of mental health, education, and research.

To understand my own social identities and the extent to which these apply to the research was important to measure in some way, so I created a social identity map of the different target groups I am researching and how I relate to these. Figure 1.2 shows the social identity mapping I performed, using a colour-graded system to represent high to low identification with these target groups. I find this exercise useful in allowing me to acknowledge my unique position within the research. As you can see, I identify more with EBEs and to some extent, Trainee Psychologists and EBQs, having trained and worked as a mental health professional previously. My connection or understanding of the identity of Carers is more limited and may therefore indicate this is an area I may require more guidance on. However, despite being better connected to EBEs, this may bias my perspective in some way, in that my experience may not generalise to all EBEs. The colour gradients may be an indicator of bias and subjectivity and/or objectivity.

What connects these different target groups is that they all work in clinical psychology and my experience of being both mental health nurse and EBE gives me insight into the idea that lived experience and mental health experiences are present in all these groups, but the extent to which they are expected, acknowledged, or stigmatised may differ dependent on the social identity you belong to and the requirements of the occupational role. Therefore, this is a focus of the research, in determining the extent to which these social identities are constructed of lived experience or professional identities. The graded shades of colour indicate levels of social identification with the target groups being researched and illustrates parallels between researcher and target group but also indicates areas of bias where further insight is necessary. Acknowledging your own insights and biases towards the research being conducted is essential in moving from subjectivity to objectivity.

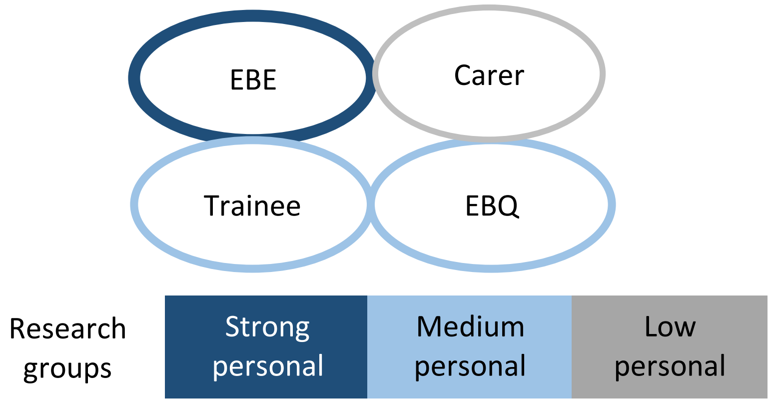


Figure 1.2: Identity mapping against research groups

Figure 1.2. shows the identification of the different identities I am researching and the dark to light colour gradients represent the extent to which I identify with the research populations.

Research suggests that it is essential for researchers to map their own identities in relation to the research they are conducting, however this has not been applied to service user researchers who are researching an area related to their own personal expertise. The social identity mapping tools also are quite complex, and this colour graded system is relatively simple and easy to grasp. The social identity mapping of the researcher's own identities against the research groups they are working with has also not been visualised using this system before. The types of social identity mapping tools available are also complex in nature and this system is more user friendly and easy to understand. The social identity mapping tools also have not used the stages of social identity theory to inform the visual representation of the social identity map, and this is where this social identity mapping differs and is unique. Understanding relation to the research and support strategies for service user researchers to perform their roles is another focus of the research, as bringing lived experience to a professional context is likely to leave the service user researcher vulnerable and thereby require tailored support.

CHAPTER TWO

A BRIEF HISTORY
OF
SERVICE USER INVOLVEMENT

> “...*from being dangerous and irrational to being considered equal partners with health professionals, creates an unresolved tension that has existed through the ages*.”
>
> ~ Rush, 2004

2.1. Background

Historically, healthcare service providers have been seen as healing professionals that ameliorate the illnesses of their patients. However, these service providers also have the potential to cause harm (Boisvert & Faust, 2002). Service users and survivors of the mental health care system have historically suffered iatrogenic harm such as coercion, and abuse at the hands of healthcare providers, which arguably continues to this date. Patients and service users have, in the past, been seen as morally degenerate (Rush, 1812). This meant society thought service users suffered with mental illness due to their lack of faith in God and their questionable morality, and potential possession by the devil. The morally degenerate were thought as needing to be controlled and treated, with no space for their involvement in decision making regarding their treatment. These individuals were incapacitated in Bedlam in the UK, now known as Bethlam Hospital, and locked and chained up, being viewed by the public in freak shows (Rush, 1812).

Later, with the advent of the Enlightenment period, the perspective shifted towards the mentally ill being perceived as having a moral weakness. This occurred in light of progress of psychiatry as a profession, in parallel to the growth of the medical field in general, due to the emergence of diagnostic labels and medical interventions (Pinel, 1818). This moral weakness was attributed to more medical aetiologies (Verplaetse, 2009) and medical professionals sought to understand the experience of suffering through rationality and psychopathology (Thomas & Bracken, 2004). Psychiatry received more prominence at this time and arguably solidified the idea of mental illness, through diagnostic categories, and the distinct roles of the mental health patient and that of the mental health professional. At this time, there were more humane ways of treating patients and they went from needing to be shackled in madhouses, to being treated in asylums with the purpose to protect themselves and be segregated from society in the late 18th century. Although this was still perceived by some, as a form of control and power over the patient (Foucault, 1967) even if this treatment was more compassionate than being locked up in Bedlam hospital. Despite a shift in the way patients with mental illness were perceived, they still had little control over their care because they themselves were perceived as being out of control of their own minds (Rush, 2004).

The biomedical model was a prevalent ideology, in the UK mental health system, whereby the medical professional was seen as the one with greater knowledge and power, and the patient as someone needing their help. This meant that there were clear power imbalances and role identities being constructed of the patient and professional relationship (Bleakley et al., 2011). Sick role theory argued that patients could adopt the sick role and therefore society bought into the idea that these individuals were not responsible for taking care of their illnesses, but instead the healthcare provider should perform this role. This had implications for who had power regarding the care of these patients and the decision-making process and consequently reduced the amount of control patients had over their own healthcare (Parsons, 1951), which can be seen to have longer term consequences to the patient and provider roles in the mental health system.

The medical model continues to permeate the UK mental health system through continued undercurrents of power imbalances between patients and providers. The strength of this positionality, however, began to change in later years. The recovery movement arose from the survivor movement in America around the 1970s and permeated Western individualistic countries. This was premised on anecdotal evidence from service users and survivors, and medical evidence that suggested that those with mental illnesses could recover, and/or that they could live fulfilling lives despite having symptoms (Davidson, 2016). It meant that patients could be seen as moving beyond being understood through their symptoms and the diagnostic constructs they may be understood through (Jacob, 2015). The movement supported those with healthcare disabilities to advocate for greater control over their care by service providers. The recovery movement enabled medical professionals to better listen to those who had lived with mental illness from a position of recovery and use these experiences to inform their care (Davidson, 2016). The history of service user involvement dates back to the early 1960s within Europe, Canada and USA, that emerged in direct conflict and reactionary opposition to psychiatry and the biomedical model (Chamberlain., 1990). The idea of de-institutionalization and the influence of philosophical and political movements at the time were responsible for a shift towards greater service user involvement (Pilgrim & Waldron, 1998). The consumerist approach and the democratic approaches that dominated at the time were both, in part, responsible for the development of the service user involvement movement (Noorani, 2013). The stakeholder model, otherwise known as the consumerist model, is based on market led approaches, where the idea is that a service should be informed through the consumers' needs (Croft & Beresford, 1988). The process of service user involvement was seen as a form of quality improvement for services. In the context of mental health institutions this meant gaining feedback from service users in response to care provision. Services could then re-evaluate their methods of care and treatment based on this feedback. There was a changing attitude towards service users, who could be people to learn from, who held expertise on their health conditions or disabilities and who could help inform their care, services and policy. Minogue et al., (2009) identified how supporters of service user involvement felt that service users brought a different expertise to other professionals. Service users started being seen as experts by experience, which is the grounding and roots of service user involvement. The concept of service user involvement in the literature is associated with greater person-centred care (empathy, congruence and non-judgemental attitudes), increased control over decision making, advocacy, a rejection of the medical model and better partnership working between the service user and professional and motivations to learn from the service user through feedback (Millar et al., 2016).

Over the past two decades, service user involvement in healthcare has been made a requirement in government policy making. The department of health declared that there should be service user involvement in every aspect of a patients' care and decision making (DOH, 1999, 2000, 2001). The paper 'No decision About Me, Without Me' (Coulter & Collins, 2011), was also central to supporting the rights of patients and involving them in their health care. Recently, service user involvement was made a mandatory requirement in all healthcare professions training in the UK regulated by the Health & Care Professioans Council (HCPC), in domains such as social work and clinical psychology training (HCPC, 2018) with the aim that this would support healthcare trainee professionals to be more attune to the needs of service users and how to support them in a person-centred way. Examples of service user involvement comes through the Group of Trainers in Clinical Psychology Involvement group, which are service user and carer representatives from across each clinical psychology training course in the UK. Similarly patient and carer representatives within the Royal College of Psychiatrists contribute to the training of psychiatrists and other medical professionals. Although creating and having these exclusive roles of service user and carers within these organisations as representatives of their experiences reinforces the idea the service user and the healthcare provider are two distinct exclusive roles, and are considered as dichotomous identities, that has further implications regarding where lived experience and professional knowledge comes from.

In contrast to the consumerist approach, the democratic approach is rooted in the idea that everyone should have equal rights and there should be a redistribution of power between all involved in healthcare services (Beresford, 2002). The service user and survivor movement occurred in opposition to the anti-psychiatry movement, briefly outlined by (Wallcraft & Bryant, 2003). The movement was challenging towards inequalities of service users and survivors and was associated with their empowerment within the mental health system. There was a motivation to strive for greater rights and control over their mental health care and decisions. Although, survivors of the mental health system within grassroots organisations were motivated to move beyond this and achieve further control over their care and service provision, through emancipation. This required moving away from the limits that involvement within professions such as Psychiatry and Psychology confined and imposed on them and through the anti-psychiatry movement, move towards citizen control and more user led initiatives (Felton & Stickley, 2004). Today, this can be seen through the grassroots sector with organisations such as Mad Covid, Hearing Voices Network, National Survivor User Network and McPin Foundation that support user led work, independent of the psychiatric or psychological institutions and promote and advocate for their own rights and the rights of other service users and survivors.

Through the contexts in which service users or survivors perform their lived experience roles, in combination with their historical experience of mental health treatment, are likely to inform the way they conceptualise and come to understand their own mental health experiences. For example, those who are survivors are more likely to be anti-psychiatry and prefer more humanistic approaches to care, having had to survive the mental health system (Adame, 2011; Richards et al., 2016). There is also great variation and nuance within and between service users and survivors in terms of their approaches to service user involvement and the conceptual models that drive their work (Wallcraft et al., 2009). Some believe in the social disability model, some in the chemical imbalance theory, some in the recovery model, and some believe in trauma-informed care. Others focus on the impact of the social inequalities responsible for mental illness. These perspectives may inform and have a bearing on whether service users and carers choose to work for psychiatry, psychology or independent user led initiatives and grass roots organisations. However, organisations such as Hearing Voices Network do not ascribe to a particular ideology and are more inclusive in nature and diversity of thought.

Currently, there is no real common shared language for what is meant by service user involvement, with reference to terms such as coproduction, engagement, participation, and involvement that are commonly used (Faulkner & Thompson, 2021). Today, reference to service user involvement may refer to several types of integration of lived experience at any one time, with no real consensus on what each term means. This may account for the large variation in approaches to integrating lived experience. Such variation can be problematic for all involved as expectations of the service providers, the service users and researchers may not be met. Some models of patient and public engagement have been created to help explain and give clarity to the different types of involvement that occur, such as the International Association for Public Participation (IAP2, 2018) This model suggests service user involvement is conducted in the following ways: inform, consult, involve, collaborate and empower. Daya’s (2021) ladder of participation also identifies more nuance in the way lived experience is integrated and there are certain levels that begin with exclude, following on to coerce, educate, inform, consult, engage, co-design, coproduction, consumer-led and consumer owned. Arnstein’s, (1969) ladder of citizen participation moves between eight points on the ladder, beginning with manipulation and therapy which both count as non-participatory, through to informing, consulting, placation which are forms of participatory involvement which may be perceived to be more tokenistic. The top of the ladder is made up of working in partnership, delegation and citizen control. These models of integrating lived experience are hierarchical and linear in nature and suggest that the field of service user involvement work, and the way it is conducted, is still structured similarly to this day. The models suggest that integration of lived experience should aspire to achieve the greatest heights and the higher these models are ascended is perceived to be the most ideal way of integrating lived experience. Similarly descending the ladder of participation leads to less control by the service user and more power for the service provider. However, there is little knowledge of the impact of these varying degrees of lived experience integration on the individual in terms of their identity and satisfaction with these types of involvement and limited understanding of the positive or negative effect this has on the institution or organisation in which this occurs. The contexts in which this involvement occurs may also be limiting and disabling, depending on the agendas and motives of the institution or organisation and how much control is relinquished and power shared with service users. This variation in type of lived experience integrated into services may also be impacted by differences between consumerist and democratic ways of working.

Conceptually the service users who work for mental health institutions to support the learning and training of healthcare professionals are far removed from the service users and survivors of Bedlam. They have moved beyond the role of a service user and are empowered by healthcare professionals to use their expertise to make a difference to services. However, it is the healthcare professionals who are empowering service users through giving them the opportunity for involvement, and thereby inadvertently still exerting a form of control over them. This maintains the power of healthcare professionals and institutions, who control the agenda and responses to involvement. In contrast, service user and survivors within grass roots organisations work towards more emancipatory practices and are less confined by the agenda of service providers and work in a more user-led way with greater autonomy (Felton & Stickley, 2004).

Across democratic and consumerist organisations, service users and survivors are considered professionalised, competent and articulate and so their authenticity and representativeness of being a service user with healthcare needs can be doubted due to a movement away from the stereotype of what it historically meant to typify a patient. These Expert by Experience roles sit in conflict with the perceived attributes and typical characteristics of service users or patients (Andreassen et al., 2014). Therefore, there is sometimes resistance to learning from the service user, in an institution that is built on treating them or oppressing them. The service user involvement context sits in opposition to the historical notion of what it means to be a service user. The idea of service user and professional are often perceived as dichotomous, infused with the influence of their histories and the meanings and burden their roles as service users carry (Hodge, 2005).

Mental health professionals with lived experience have also influenced the service user movement as insiders in the system. Those with lived experience may be more motivated to perform roles that support others with lived experience (Newcomb et al., 2017). Healthcare professions integrating their own lived experiences into their training and clinical work has also become more commonplace. The British Psychological Society, (BPS, 2020) has published guidance on how trainee psychologists can integrate their lived experiences of mental illness into their work. Many mental health professionals now speak openly about their own lived experience alongside their professional roles (Adame, 2011; Fox, 2016; Richards et al., 2016). However, historically, the roots of service user involvement in research can be traced back to those with lived experience who were motivated to conduct research on topics related to their own experiences which was the beginning of lived experience research (Wallcraft & Nettle, 2009). This has implications for challenging the exclusivity of service user and professional domains, promoting an integration of lived experience into the professional spheres and identities that span across patient, provider and researcher roles.

The context of the research reported in this PhD relates to the identities that exist within the context of clinical psychology training and mental health, education, and research in the UK. Felton & Stickley, (2004) suggest that institutional contexts, that are consumerist in nature, may provide limits to the type and style of service user involvement that exists within them and may confine involvement based on their own agendas, which may negatively impact those who are involved. The research will therefore look at a snapshot of professional and service user identities within this context, that is limited to a a particular point on the ladder of participation, within which the context of mental health, education and research is situated.

Historically, the mental health system has caused harm to service users, but this may be reconciled and repaired through effective service user involvement. Through the integration of lived experience into the field may have implications for reducing power imbalances between patients and providers and consequently humanise the field. It can also go some way in helping reduce the barriers and exclusivity of these roles, providing insight into how to learn from the lived experience of patients and providers or those who are both. The recent movement to integrate lived experience may shift the identities that exist within mental health, education, and research. Understanding these identities and how they can work together more effectively in the training of healthcare professionals is a focus of this thesis.

The form of control and power that lay with healthcare providers historically, but also to this date, may be re-distributed and made more ethical through the service user involvement movement, with healthcare services becoming more person-centred. Service user involvement aims to ensure that the needs, rights, and wishes of the service user are embedded at every point within healthcare, training, research and policy making. This may ensure that the forms of control, oppression and harm done by mental health institutions to service users and survivors in the past are not recycled in the form of lived experience work in the field of clinical psychology training and mental health, education and research settings. A focus of this PhD research will be to understand how service user involvement in this context impacts the service user and the institution and how they can be further supported to reduce any further harm that the institution may cause. A key focus is to establish methods to understand current experiences and to reduce any harm and better connect those who work in these mental health institutions with greater humanity.

2.2. A personal reflection on the context of consumerist lived experience work

This PhD research seeks to explore and understand how lived experience researchers and provider identities are impacted by their roles. These are some personal reflections being a service user researcher. From the beginning I designed the research for the PhD alongside my supervisors but very much wanted it to be user led (i.e., informed by my own experience) to see if others were also impacted similarly or differently and observe this in the real world. It was difficult because the research is based in a consumerist model of service user involvement which is limited to the context of mental health training, at a particular point on the ladder of participation. The nature of this context and what it means to be a researcher and the expectations of performing the PhD role meant I needed to inform the work through other service users in order to effectively engage in service user involvement, rather than through a user led approach. This sat in direct conflict with my motivations, so I had to grapple with relinquishing some of my own experiences and being led by the experiences of others. The research therefore goes from a personal perspective to observing other identities. Although, along the way it has felt like I have been confined into such a role, where I seek a level of emancipation and further control. I have, in some respects kept moving between degrees of autonomy and control throughout the process.

I was pushing for more democratic rights as a user led researcher whilst confined by constraints of consumerist involvement and the push for me to separate my own lived experience and strengthen my researcher identity and allow the service user advisor to be in the service user role in this research. It has been difficult because I am not only a service user but a researcher and within this research striving to be both. There needs to be greater clarity to the identity of service user researchers so others know how to work with them and understand them better and their needs and wishes to integrate lived experiences and the extent to which this should occur. This may mean that existing methods of research may not be compatible with lived experience work. For example NIHR set out that all research should have a degree of lived experience involvement, but it does not clarify how this can also qualify and come through researchers leading with their own lived experience. Ideas of where certain knowledge comes from, such as the service user perspective, is perceived in traditional research settings as limited to those in lived experience roles, rather than being extended to researchers and professionals also with lived experience. Thereby, resulting in many conflicts in lived experience work when navigating the mental health research sphere as someone spanning both professional and lived experience identities.

I find that sometimes my closeness to the research means my objectivity in relation to the data and field of research is queried and that my lived experience adds bias and subjectivity to the research process. It can be difficult when your integrity as a researcher is questioned because you are a service user, working in a user led way and you are viewed through this lens. I think personally service user researchers bring a lot of value and expertise to the table through integrating both the personal and professional identities that they hold.

It is typically more satisfactory to have clarity in terms of roles and identities, as highlighted by Stryker (1980). It is complicated when you are both professional and service user; it is easier to be either/or. The process of negotiating identity of service user researchers requires more thought and reflections to make the process less painful. The process should not repeat or recycle the trauma researchers have experienced in care as service users, within the work they do in research or clinical work. Services have a habit of reverting back to the medical model even within service user involvement work. This thesis hopes to give greater clarity to lived experience researcher and provider roles and how their identities are impacted within the context of consumerist involvement work in mental health, education and research.

CHAPTER THREE

THE THEORETICAL BASIS
OF IDENTITY

"*What we know matters, but who we are matters more*."

~Brené Brown

3.1. Background

Identity is a socially constructed concept and historically has many definitions and explanations of what it constitutes of (Stryker, 1980; Tajfel & Turner, 1979; Turner & Abrahams, 1969). It can be constructed through the roles, groups or characteristics that uniquely identify us (Burke & Stets, 2009). The existence and definition of identity are contested, and this influences conceptual understanding, and consequently, its empirical measurement. Due to varying perspectives and theoretical positions of the concept adds to the variability in the methodology used to measure it and thereby impacts the variability in factor structures that explain the structure of identity (Postmes et al., 2013; Leach et al., 2008; Karasawa, 1991). It is therefore important to have a clear definition of identity and the positionality of this research.

It is important to understand how identity is already constructed and whether the thesis offers new or different insights into conceptualisations of identity. There are four main theoretical models of identity, which originate predominantly from Social Psychology: Social Identity theory (Tajfel & Turner, 1979), Identity theory (Stryker, 1980), Liminality (Turner & Abrahams, 1969) and Intersectionality (Crenshaw, 1989) which provide a cohesive basis from which to understand identity, considering both inter and intragroup relations and their effects on the formation of an identity.

Collectively these theories will be evaluated in their ability to explain identities within clinical psychology training and those engaged in lived experience work. An exploration of the identities of those within mental health, education and research has predominantly focussed on the formation of professional identities. However, roles that simultaneously require integration of lived experience in the professional domains are a recent development and therefore a relatively under-researched area. It is necessary to assess whether these theoretical frameworks cohesively explain the impact of lived experience and professional roles and the different social identities and role identities within clinical psychology, including service users, carers, trainee psychologists and research and clinical psychologists or whether a new and novel theoretical understanding is necessary. Clarity regarding identity is essential to support individuals to understand themselves, but also each other and therefore to support being able to effectively work together and learn from each other. Therefore, the focus of the thesis is to give greater clarity to the identities within mental health, education, and research and to use this knowledge to support those in the sector to work together more effectively.

3.1.1. Identity theory

Identity theory has its roots in and was developed and built on the symbolic interactionist theory (Stryker, 1980). Identity theory relies on a society that is structured in terms of roles that represent a structured society. Firstly, the individual classifies themselves in relation to their roles in society, such as Expert by Experience, Carer, Trainee Clinical Psychologist or Clinical Psychologist. This is termed identification in Identity theory (Turner et al., 1987). This leads to the formation of an identity. Individuals within society are understood through their roles and this carries attributions and meaning associated with them, impacting how they are perceived, but that also guides their own behaviours to fit with these expectations (Stryker, 1980). For example, roles such as Clinical Psychologist or Service user, carry certain meanings, and affect how these individuals think of each other and themselves and their perceived roles in society. Examples of this include how the Clinical Psychologist role is perceived to have more power, they are perceived to be helpers and are influenced to work within the boundaries of their professional role. The service user, in contrast, may have the perceived expectation of being the one who is receiving the help, their identities perceived as stigmatised, and how they hold less power. These labels and roles may affect and guide interactions and understanding of these groups and promote interactions to be based on these expectations. The interactions between people in different roles serve to accentuate differences between other roles, to preserve the meanings, clarity, and distinctiveness of their role (Thoits & Virshup, 1997). This may have implications for the polarity in how service users and mental health professionals are perceived. Clear distinct roles are likely to influence more certainty and more satisfaction with one’s own role, relating to contentment and a sense of belonging to that role. This suggests that roles that lack clarity are less satisfactory to those that perform them. This may have implications for those who are both patient and provider. Identity theory suggests very strongly that there are clear parameters and boundaries to role identities, but this does not adequately account for the unique constructions of identity formation of lived experience researchers and providers that hold less clarity, supporting the focus of this thesis in aiming to better define these identities.

Identity theory also posits that we can belong to multiple roles, for example, a service user can also be an Expert by Experience and/or Service provider, depending on the context, but can switch between roles based on whom they are interacting with. Although, the theory does not account for roles which are less clear and discrete in nature, where for example multiple identities are conveyed through one role, such as the Expert by Experience that occupies both the service user and professional role. To some extent, it is accounted for through the idea of a lack of clarity of the role that is dissatisfactory, but the theory does not seek to address the formation of the role or identity that is less clear and discrete in nature. Roles that span multiple roles and identities are more difficult to understand by others and so this justifies an exploration of roles such as lived experience researcher and provider roles to better understand and therefore begin to better define these unique roles and identities.

Through separating individuals into their unique roles within society, and by removing them from being able to interact with others from different roles may enhance our understanding of that specific role and enable its effective measurement. This may be useful in understanding the roles of service users, carers, trainee clinical psychologists and clinical psychologists as discrete identities. However, through removing the interactions with those from different groups may negatively impact the clarity or meanings associated with these roles which are reinforced through social interactions according to Identity theory and impact understanding of their roles that are guided by a structured society (Stryker, 1980). It would therefore be useful within this thesis to understand these role identities, that exist independent but also dependently of each other and whether we are able to observe and measure these role identities effectively. There have been limited empirical measurement of role identities through identity theory as it is difficult to quantify and observe directly. However, this may be captured more effectively through qualitative inquiry and the process of labelling individuals as performing certain roles and their identification with that role.

3.1.2. Liminality

Whilst it is clear identities are formed through self-defining or categorising the personal self as belonging to a social group or role, these identity theories are definite in their characteristics of identity formation. However, they do not account for “in between” states or where there is lack of clarity between one identity and another. Turner & Abrahams, (1969) identified the concept of Liminality. It is a way to describe the transitional states in which individuals are ‘neither here nor there...betwixt and between the positions’ (Turner et al, 1969; p. 95). Within an organisational setting, liminality is commonly understood as ‘a position of ambiguity and uncertainty’ (Beech, 2011, p. 287). This concept of identity describes a space in between one identity and another and this has been used to describe the role of peer workers, who are in between a service user and a professional role (Simpson et al., 2018) and peer researcher, describing ambivalent and transgressive identities (Faulkner & Thompson, 2021).

This theory may be useful in its application to understanding the roles of lived experience researchers and providers, in general, who may fall somewhere in between mental health and professional identities. However, the field of Liminality is currently an under researched area and warrants further exploration as it may be able to explain the identity constructions of service users that are also professionals, and the many identities within clinical psychology that also have lived experience. Therefore, there appears to be usefulness in applying this theoretical framework to this body of work. This will be investigated further in the thesis to understand its explanatory power as a theory from which to understand the impact of less clear and ambiguous identities. However, Liminality as a theory and its relevance to lived experience researchers and providers is problematic as it suggests individuals are between identities and may be considered to undermine the complexity of the identity of those in these roles, as it suggests an absence of identity.

3.1.3. Intersectionality

Whilst accounting for multiple personal roles and social identities, Social Identity theory and Identity theory do not explain the emotional impact of holding these identities at the same time. The idea of belonging to multiple identities is referred to in much of the identity literature including both Social Identity theory (Tajfel & Turner, 1979) and Identity theory (Stryker, 1980). However, Crenshaw (1989) goes further in understanding the interaction of these different identities, identified through the concept of intersectionality. This concept refers to the overlapping and intersecting identities of an individual such as race, gender, class, ethnicity, sexuality, and other personal characteristics. It is the combined experience of these multiple identities and where they intersect in relation to existing hierarchies that compound the experience of discrimination or prejudice. For example, different identities may hold different levels of power, emotion, or stigma, that collectively impact and burden the individual. The Social Graces framework was developed by Burnham, (1993) that identifies the many characteristics of individuals that differ that can impact through the process of intersectionality. However, this does not include mental health experiences. The personal identities of both mental health and professional identities may be influenced by intersectional influences and further exacerbate marginalisation and stigma of service user providers who are both patient and professional. For example, the mental health identity is likely to be considered more burdensome, emotional, and stigmatised. Whereas the Professional identity is likely to be considered more powerful, with the perceived expectation that it is distinct and independent of the mental health identity. These roles may therefore span multiple identities that are not accounted for by the Social Graces framework and may burden those with these roles that interact through the process of intersectionality. Building on the concept of intersectionality, Fricker, (2007) identifies the idea of epistemic and hermeneutical injustice whereby individuals' testimonies and knowledge produced from them are questioned and doubted due to judgements regarding the multiple identities they belong to and where they intersect within the hierarchy. This concept may support in understanding the challenges Experts by Experience face in their roles as teachers and people to learn from, when they are viewed through the lens of being a service user and the associated stigma that belonging to that role brings. This then influences how others view and perceive them, and the value placed on knowledge that can be gained from them when in their roles as Experts by Experience.

3.1.4. Social Identity theory

Social identity theory arose as an explanation of intergroup conflict that developed a theoretical basis from which to understand how identity is constructed through the groups we belong to (Tajfel & Turner, 1979). Social Identity theory has three stages, self-categorisation, social identification, and social comparison. It suggests that the groups we belong to contribute to our identities and how we think about ourselves and others. For example, belonging to a profession, an ethnic group, or a specific gender can be considered social identities and influence how we think of ourselves and the members within the group, through feeling as though we belong to these groups. Within the context of this PhD these social groups could be Experts by Experience and Experts by Qualification or the wider social identity of Clinical Psychology training. Following self-categorisation, also termed self-definition, with groups, results in group membership where individuals evaluate whether they think and feel they belong to the in-group, termed social identification. Social identities are reinforced through the individual making social comparisons between in groups and out groups. Favourable comparisons are generally made regarding groups we identify with, the in-group, and unfavourable comparisons with the out-group. These positive and negative social comparisons between groups are termed positive distinctiveness and reinforces the identification with the social identity. The individual tends to feel more similar to their in-group and different to the out-group in terms of values, beliefs, attitudes and experiences (Hogg & Abrams, 1988). For example, Experts by Experience within clinical psychology may find themselves in opposition to professions such as Psychiatry. Tse et al., (2012) suggest that service user involvement provides the right environment to lead to changes in identity. This theory may explain the differences between lived experience researchers and providers and the other people they work with and highlights how ‘Them and Us’ divisions are created and maintained.

Social identities have the potential to be either positive or negative. The self-esteem hypothesis suggests that when social identities are positive, they make the individual feel more positive, and this then further reinforces their identification with the in-group. When social identities are negative, the self-esteem hypothesis suggests group members shift their perceptions and scales from which they perceive the group to be able to make more favourable comparisons and further unfavourable comparisons towards the out-group. This again then further reinforces identification with the in-group. Group members tend to take on the beliefs, values and behaviours of their social group that happens unconsciously through adopting group norms and behaviour. Therefore, the concept of social identity may not always be visible as a construct and therefore may be more difficult to observe and empirically measure. The influence of unconscious processes and deindividuation suggests there is a lack of control or autonomy over how individuals are affected by their social identities and removes the idea of choice or control. This suggests the institutions in which individuals work such as experts by experience, carers, trainee clinical psychologists and experts by qualification are confined and influenced by the wider beliefs and values of Clinical Psychology or Psychiatry.

Social identity theory also suggests that we can hold and belong to multiple groups or identities at the same time. Additionally, there is evidence to suggest that, despite negative feelings attached to belonging to a Social identity, that may for instance be stigmatised (Kachanoff et al., 2016) such as a service user identity, it is likely to have perceived benefits due to the self-esteem hypothesis, which posits the more social identities we belong to, the better we feel about ourselves (Stets & Burke, 2014). However, Social identity theory does not adequately explain the challenges of belonging to conflicting identities at the same time. Therefore, the theory may not adequately explain the unique roles and social groups of lived experience researchers and providers or experts by experience.

3.1.5. Self-Categorisation theory

Self- categorisation theory (Turner & Onorato, 1999) is an extension of social identity theory and shares some of the same theoretical basis, partly due to the collaboration between some of the same authors. Self-categorisation theory suggests that there are distinctions between social identity and personal identity and that these identities guide the way we think about ourselves. These different types of identity can exist at the same time and can also vary.

Therefore, Personal and Social identities are not two separate ends of a continuum but that they co-exist and can influence and guide cognition, behaviour, values, and attitudes at the same time. These different processes of depersonalisation (adopting a social identity) or personalisation (adopting a personal identity) are context dependent and triggered by cues and stimuli in the environment that activate these different identities (Trepte & Loy, 2017). When depersonalisation occurs, the individual understands themselves through the Social Identity as opposed to their self-concept. This process means that the individual's beliefs and behaviours are motivated through the group's identity rather than motivated by their own individual needs. This process means the individual takes on the identity of the social group that determines their values and behaviours. Whereas personalisation is where the individual draws on their personal identities to guide their understanding or behaviour. These different personal and social identities may explain the individual identities of service user, carer, trainee and professional and their wider social identity of clinical psychology.

3.1.6. Social Identification

Social identification is a process that may influence an individual to think and feel like they belong to the group through cognitive and affective processes. It is important to explore what processes influence an individual to identify with a group and how this occurs. Haslam et al., (2009) suggest that Social identity is changeable depending on identification with other groups. Therefore, the level of identification increases the permeability of in-groups and out-groups, and this may lead to changes to group membership.

Mechanisms that have been identified to encourage a sense of belonging and social identification with a group by various researchers identify cognitive and affective mechanisms that encourages identification to occur (Johnson, Morgeson & Hekman, 2012). It is found that these factors are the motivations and drivers behind identification to reduce the uncertainty hypothesis and to enhance self-esteem. Affective and Cognitive factors have been shown to be related to the Social identity approach but also within Identity theory, and so there are grounds to explore the influence of these factors within the identity formation of groups in clinical psychology training and lived experience work further.

Research by Armenta et al., (2017) into the permeability of group boundaries explores how individuals belonging to one social identity permeate the boundaries of another and the causes and explanation for this. They find that movement between groups occurs for different reasons including motivations to change status. The perception of an increased level of permeability of a group is likely to reduce the amount an individual self-defines within that social identity as there is a lack of clear boundaries or parameters to the group. When groups are considered less permeable there is a stronger social identity and identification associated with them (Ellemers et al., 1990). Status seeking is also likely to influence a motivation to move between one group and another. The researchers find that these are, in part, causes of movement between the in-group and the out-group. This suggests that movement between groups is dependent on the permeability of the group, a lack of clarity of one's own social identity and motivation to increase status by belonging to another social identity. This may have power is describing the process of service users who are also mental health professionals and the extent to which they identify with these respective social identities based on clarity and status. The status and clarity that comes from the wider clinical psychology identity may influence a sense of belonging for experts by experience, carers, trainees, and psychologists and buffer the impact of any stigmatised identities.

Social identity theory is therefore deemed to focus more on inter-group relations whereas Identity theory is more focussed on intra-group relations. The difference between social identity theory and identity theory is that within social identity theory an in-group identity encourages a homogeneity of perception and behaviour within their own groups and encourage differences between out groups and facilitates belonging to the in group. However, this differs from Identity theory where perceptions of meanings attached to individuals with distinct roles encourage the individuals to differentiate the self from the other to preserve a unique identity. Therefore, if the researcher is interested in connecting groups and roles it seems more relevant to collectively draw on the explanatory power of the existing identity theoretical base. However, there is limited quantitative literature on role identities, whereas social identification has extensively been researched through this methodology (Leach et al, 2008) suggesting a multiple methods approach may be useful in understanding the identity constructions of groups and identities within mental health, education and research, and different approaches in measuring both role and social identities in this thesis.

3.2. Limitations of the theoretical basis of identity

The application of these theoretical bases for identity (Tajfel & Turner, 1979; Stryker, 1980; Turner & Abrahams, 1969; Crenshaw, 1989) leads to a prediction that involvement of individuals as Experts by Experience, Carers, Trainees and Experts by Qualification within mental health, education and research is likely to be formative to their identity constructions.

These aforementioned theories are applicable to understanding identity that is drawn from belonging to a group, a role, and somewhere in between and the collective burden of multiple identities. However, the theories fail to address how identity may be constructed when membership to roles and/or groups hold differing levels of power and meaning, such as mental health professionals with lived experience, or service users that work as experts by experience. Intersectionality can explain this to some extent, but the unique identities that exist of simultaneously occupying identities of mental health and professional roles warrants further exploration and a clearer understanding of the unique identities of these individuals, specific to the mental health sector. It will give greater clarity of identity to those in these roles, and additionally provide greater certainty to the meanings and expectations individuals can expect from those in these roles. These roles that span multiple identities that consist of mental health and professional identities are not adequately understood through the current theoretical frameworks, and therefore further research to understand identity constructions in these groups and roles is essential. With the advent and motivation to speak about lived experiences within practitioner roles and parallel to this service user who are experts by experience means there is a need to examine how these roles and identities of these individuals are impacted.

3.3. Further research

Social Identity theory suggests that there are in-groups and out groups that enhance the differences perceived between groups and enhances the similarities within-groups. By distinguishing groups in this way, it enhances the sense of belonging to a particular group that encourages a sense of Identity construction. This separation of in-group and out-group allows an Identity to form. However, identities are usually formed in opposition or reaction to a counter identity or group. Therefore, the idea of identity is constructed in a relational and social way and both Identity theory and Social Identity theory account for this. However, identities tend to create barriers with others and are formed in conflict and opposition to others. However, the theoretical basis does not account for identities that are made up of conflicting and oppositional positions. Within the context of mental health training, it is important to understand how individual roles and social identities can function as a whole, drawing on their personal and social identities. Therefore, it would be essential to understand how the in-groups can connect with the out group to encourage unity for groups that make up the collective identity within, for example, clinical psychology training. This may have implications for Identity construction and Social Identity and how in-groups can connect with out-groups. The dimensions relating to social identification may hold the answer in being able to connect out groups with one another, despite its only application relating to in-group identification. It would therefore be important to consider the components it would take to connect out-groups so that individuals can better relate to one another and learn from each other. This would have useful utility and application to understanding how to reduce them and us divisions, and better connect groups in clinical psychology training to work more effectively together and function as one.

Affective and cognitive states are considered essential for in-group identification. In addition, similarly these components may also function to separate and divide out groups from one another. Social identification is therefore considered a mechanism that could potentially reduce them and us divisions and exploring the role of emotion and cognitive mechanisms to achieve this are essential.

3.3.1. Application to Clinical Psychology groups

Tse et al., (2012) suggest that service user involvement provides the right climate to lead to changes in Social Identity. Therefore, there are likely to be identity changes to groups within Clinical Psychology. Through the idea of social identification, it is hypothesised the efficacy of Expert by Experience (EBE) involvement may depend on the resonance and identification of the Clinical psychology trainees with the EBE, likewise effective Expert by Qualification (EBQ) teaching may be more effective when the clinical psychology trainee identifies more with their profession. Haslam et al., (2009) also explore how social identity impacts health and wellbeing in the clinical psychology and health domain. Hill, (2021) also explore the identity of service users and carers in clinical psychology training. However, there are limited studies that apply social identity to clinical psychology training. This application of these theoretical frameworks can give insight into how groups within clinical psychology can be understood and function in a healthier way. Belonging to the in-group is perceived to be better for wellbeing (Stets & Burke, 2014). However, there are multiple social identities that make up the identity of clinical psychology training. Therefore, it is important to understand how different groups within this context, can function as one collective group and connect through this social identity or even understanding whether identification with their own in-groups such as service users, carers, trainees or psychologists may be better for the wellbeing of these groups, or whether a collective identity as clinical psychology is better for wellbeing. This may be dependent on status of the groups and the permeability and clarity of these roles (Kachanoff et al., 2016). Through reducing the them and us divisions between these groups, may make the identity of clinical psychology much clearer and distinct, but may also have an impact on these individual groups working more effectively as one collective identity.

There has been limited research exploring Social Identity and social identification within the clinical psychology literature. It is therefore important to measure within Clinical Psychology whether there are social identities and role identities within the many groups that are involved in clinical psychology training. Given that social identities are likely to influence values, attitudes, behaviour and learning, and role identities influence interactions and expectations, it would be important to assess whether these influence identities that exist between the many groups involved in clinical psychology training. It is important to understand whether identification between trainees and their trainers, influences their learning and clinical practice in any way to understand how lived experience supports the training of mental health professionals. It would also support in establishing how to support trainees to better connect with their trainers. Further to this, it would be important to see if insight from identity constructions can better connect in-groups and out-groups and identify how these groups can work more effectively together.

Nario-Redmond et al., (2004) suggests some individuals are more inclined to identify with their social identities than others. For example, those from ethnic minority groups are more likely to identify with their Social Identity than individuals from ethnic majorities. It is imperative to assess whether groups who are more vulnerable and from minority backgrounds within clinical psychology training (service users and carers) have a greater tendency to self-define themselves as part of a Social Identity compared to groups within clinical psychology who have a higher status (Clinical Psychologists) as the theoretical evidence base suggests.

The application of the social identity approach has had a limited application to the field of clinical psychology training which might be because social psychology and clinical psychology fields have progressed in parallel to one another with limited interdisciplinary work. They have each focussed on different research priorities and methodologies. For example, social psychology research has largely remained focused on population level data (Leach et al., 2008), but has also shifted to helping understand organisational identities (Johnson, Morgeson & Hekman, 2012). Although, its application to the organisational identity of clinical psychology training and those who perform roles in it such as experts by experience, carers, trainee clinical psychologists and clinical psychologists is limited and has not been explored as a collective identity. Therefore, the application of social identity to these groups and context would be novel and provide a unique insight into the dynamics of such groups through an interdisciplinary lens.

3.3.2. Next steps

The following systematic review explores the identity conceptualisation of lived experience researchers and providers in mental health, education, and research. Following this, empirical studies are presented, ordered according to the dynamics of social identity theory. The first will attempt to explore the self-definition and categorisation of social identities within clinical psychology training to understand if there are 'Them and Us' divisions and how groups within the profession construct both their personal and social identities. The second study will be a pilot study aiming to understand the social identification factors that enable trainees to identify with their trainers within clinical psychology training. This pilot study will aim to explore how trainee clinical psychologists identify with their trainers, whether cognitively or affectively or identify additional forms of identification, and whether this is determined by individual differences in personality or mental health or professional identities. The research will aim to develop a social identification measure that will be assessed for reliability and validity to be used with trainee clinical psychologists, to assess how they identify with their trainers and determine the factor structure that motivates this. The final study will be preliminary research inspired by the final stage of social identity theory, that of social comparison, where there will be an attempt to bring learning together from each study to help create a supervisory guide for lived experience researchers and providers to explore their identity and relation to their work and the people they work with.

3.3.3. The aims of the thesis

:

- To understand the identity of lived experience researchers and groups in clinical psychology training through multiple methods.

- To identify recommendations to support groups in clinical psychology training to work together more effectively and reduce them and us divisions.

- To identify the needs of those with lived experience working in mental health, education, and research settings and how to support them.

CHAPTER FOUR

UNDERSTANDING THE IDENTITY OF LIVED EXPERIENCE RESEARCHERS AND PROVIDERS

A SYSTEMATIC NARRATIVE REVIEW

“My fractured self was pieced together in my pursuit of my newly formed service user identity... I once had only a tiny seed of hope, now this has blossomed giving me a new sense of identity, purpose and direction.”

~ Alison Bryant, Service user Advisor

UNDERSTANDING THE IDENTITY OF LIVED EXPERIENCE RESEARCHERS AND PROVIDERS: A SYSTEMATIC NARRATIVE REVIEW

Abstract

Identity is how we understand ourselves and others through the roles or social groups we occupy. This review focusses on lived experience researchers and providers and the impact of these roles on identity. Performing roles simultaneously embodying professional and lived experiences contributes towards a lack of clarity to identity. This is not adequately explained by the theoretical evidence base for identity. This systematic review and narrative synthesis aimed to provide a conceptual framework to understand how identity of lived experience researchers and providers is conceptualised. A search strategy was entered into EBSCO to access Academic search complete, CINAHL, MEDLINE, PsycINFO, Psych Articles, and Connected papers. Thirteen qualitative papers were eligible and synthesised, resulting in a conceptual framework. Five themes explained identity positions: Professional, Service user, Integrated, Unintegrated and Liminal. The EMERGES framework, an original conception of this review, found themes of: Enablers and Empowerment, Motivation, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots contributed to lived experience researcher and provider identities. The EMERGES framework offers a novel way to understand the identities of lived experience researchers and providers, helping support effective team working in mental health, education and research settings.

4.1. Introduction

There is a movement to integrate lived experience into professional domains with many mental health professionals now speaking out about their own mental health experiences (Adame, 2011; Fox, 2016; Richards et al., 2016). Service user and carer involvement is a mandatory requirement for all Health Care Professions Council (HCPC) regulated healthcare training programmes in the UK, including, clinical psychology and social work. It was introduced after a commissioned review by HCPC into the benefits, facilitators, and barriers to service user involvement from healthcare contexts (Chambers & Hickey, 2012). The sector finds service user involvement is integral to the effective training of healthcare professionals according to the British Psychological Society (BPS) (Sheldon & Harding, 2010).

The involvement of lived experience researchers occurs in universities, through professional bodies such as the BPS's Group of Trainers in Clinical Psychology (GTICP) involvement group and patient and carer representatives within the Royal College of Psychiatrists (RCPsych). The BPS's Division of Clinical Psychology (BPS, 2020) also released guidance on valuing the lived experience of trainee psychologists and how to integrate it into their work. Whilst healthcare professions' training and service improvement is informed through service user feedback akin to consumer and market-led approaches (Noorani, 2013), disability activism is more concerned with emancipatory outcomes, achieving greater citizen control and rights for disabled people and survivors, led by democratic models (Beresford & Campbell, 2004).

There is increasingly more participatory involvement in research and policy development within healthcare. In the UK, the National Institute of Health research (NIHR, 2019) provides guidance and mandates the process of involvement in research. Externally other research organisations in the UK such as McPin Foundation, National Survivor User Network (NSUN), Survivor Researcher Network (SRN) and Shaping Our Lives (SOL), to name a few, integrate and value lived experience. Due to the exponential growth in lived experience work, understanding how this work impacts people in these roles is essential.

Integration of lived experience in healthcare educational settings is achieved through the expert by experience role, where they act as "critical friends." Their involvement provides trainee healthcare professionals with insight into the challenges and experiences service users and carers have whilst navigating their mental or physical disability and of using services (Sheldon & Harding, 2010). The expert by experience role contradicts the traditional role of the service user and positions them as experts and people to learn from, as opposed to contexts where they are perceived as passive recipients of care (Fox, 2016). However, this contradictory positioning can be complex, leading to poorly understood identity constructions of lived experience researchers, and providers. Hodge, (2005) identifies limits to patient and provider roles that are dichotomous and assimilated into experiential and professional knowledge bases exclusively. The identity of the lived experience researcher and provider do not clearly fit into these exclusive categories. The process of lived experience involvement may therefore give rise to novel formations of identity, requiring greater lucidity.

Benefits to integrating lived experience in mental health education and research results in empowerment (Omeni et al., 2014), improved empathetic responses from healthcare professionals, influencing mental health institutions to be person centred (BPS, 2010) and supports the learning of healthcare professionals (Schreur et al., 2015). Oliver et al., (2019) describes the benefits of service user involvement but highlight the negative aspects of this work, including practical and personal risks to those engaged in this work. Resistance to the integration of lived experience by some service providers occurs through exclusion and tokenistic involvement (Cameron et al., 2019), and queries over fitness to practice (de Ruysscher et al., 2019; Simpson et al., 2018; Wilson et al., 2018; Newcomb et al., 2017). In addition, sometimes there are queries regarding the representativeness and authenticity of service users who are considered too professionalised (Andreassen et al., 2014). These roles can cause emotional burden to those that perform them (Faulkner & Thompson, 2021).

Further barriers to meaningful integration of lived experience can occur for several reasons. Service providers may want to maintain positions of power, they may lack experience in this type of work, or involvement may be at odds with the models within which they work, such as the medical or recovery model. Service providers may lack funding for these roles or may have negative views on the benefits of lived experience, or even may vary in their subjective conceptual understanding of what it means to integrate lived experience (Tambuyzer et al., 2014; Bee et al., 2015).

These illustrations of risk to the lived experience researcher or provider, suggest the role may be unsafe and cause harm. Richards et al., (2016) reported that the mental health sector is not yet ready or safe regarding integration of lived experiences. It is essential, and of great ethical necessity, that service providers do not cause harm to service users in these contexts. These roles, in which there is integration of lived experience in professional spaces, is likely to impact identity, an under researched area.

4.2. The theoretical basis of Identity

Research on identity of healthcare professionals has tended to focus on the development of professional identities in, for example, medical students (Goldie, 2012; Cruess et al., 2015), nurses (Johnson et al., 2012), clinical psychology trainees (McElhinney, 2008) and social workers (Wiles, 2017). This research identifies the importance of clarity regarding identity, resulting in better team working, wellbeing, and resilience. Additionally, experiences of mental illness, such as Psychosis, also influence changes in identity (Conneely et al., 2021). Mental illness and disability are the basis for undertaking lived experience researcher and provider roles and so it is essential to understand how these roles might further influence identity.

Identity theories suggest identities are formed via group membership (Tajfel & Turner, 1979) or the roles we occupy (Stryker, 1980), and intersectional (Crenshaw, 1989) and liminal processes (Turner & Abrahams, 1969). For example, Social Identity theory (Tajfel & Turner, 1979) can be used to explain the service user identity, who may self-define with an expert by experience group as their in-group, and from which they begin to share similar values, beliefs, and behaviours. They identify differences between themselves and others. Experts by experience in clinical psychology may find themselves in opposition to psychiatry. Tse et al., (2012) find service user involvement provides the right context to lead to changes in identity. Social Identity theory suggests identities are formed in opposition to other social identities. However, the theory does not account for simultaneously occupying the oppositional positions of lived experience and professional identities.

Identity theory (Stryker, 1980) suggests identity is drawn through the roles we occupy in a structured society. Individuals attribute meaning and expectations to these roles through interactions with others. We seek to preserve the clarity of one's own role, resulting in more certainty and satisfaction with our own identities (Thoits & Virshup, 1997). The role of the lived experience researcher and provider, that spans both patient and professional, results in contradictory meanings which are likely to be unsatisfactory, due to a lack of clarity. This suggests a complexity to these roles that identity theory cannot account for.

Liminality (Turner & Abrahams, 1969) better accounts for 'in between states.' Liminality is understood as "a position of ambiguity and uncertainty" (Beech, 2011; p. 287).

The concept describes the role of peer workers and peer researchers (Simpson et al., 2018; Faulkner & Thompson, 2021). Liminality may be useful in explaining lived experience roles. Although, the concept undermines the complexity of the lived experience researcher or providers' identity due to the suggestion of an absence of identity.

Intersectionality, (Crenshaw, 1989) refers to the intersecting personal elements of an individual such as race, gender, class, ethnicity, sexuality, and others, that in conjunction with each other, compound the experience of discrimination. Mental health identities and professional identities may also be influenced by intersectionality, suggesting the role may be burdensome. Additionally, Liminality (Turner & Abrahams, 1969) may also be burdensome, and interact and impact identity, similarly to the process of intersectionality.

The theories do not explain the identity of lived experience researchers and providers. Considering lived experience researcher and provider roles are increasingly common, a better understanding of how these roles impact identity is required. This will support others to better understand those in these roles, encourage better team working and identify influencing factors relating to the formation of identity.

Systematic reviews have focussed on service user involvement, the process of involvement and, but to a lesser extent, on the impact of involvement on learning and clinical skills (Repper & Breeze, 2007; Terry, 2012; Happell et al., 2014; Townend et al., 2008). A systematic review and conceptual framework of recovery of mental health patients has been conducted (Leamy et al., 2011), a conceptual understanding of identity changes in psychosis (Conneely et al., 2021), and a literature review into service user involvement and identity (Emery, 2015). However, currently there is limited research into identity formation of lived experience researchers and providers and no systematic review that provides a synthesis and conceptual framework of factors relating to identity development of lived experience researchers and providers in mental health, education, or research.

The aim of the review is to identify how identity has been conceptualised in relation to lived experience researchers and providers in mental health, education, and research settings.

4.3. Methodology

4.3.1. Conditions or domain being studied

The systematic review explored lived experience researchers and providers and how their identities were impacted by these roles in mental health, education, and research.

4.3.2. Positionality and Reflexivity

The review was conducted by VG, PhD researcher, and PF, LG, BG, Clinical psychologists, and CE, research psychologist. VG is also an expert by experience for two involvement groups for clinical psychology programmes and is a service user advisor to national research projects related to her own individual experiences. The research team see this as a strength but are aware of the potential biases each of their own experiences may cause in relation to the design and analysis of the research. This was mitigated by themes and findings of this review being discussed as a team. The review held pragmatism as its epistemology to understand findings and collate studies that differed in methodologies and philosophical perspectives. SA and RQ were independent PhD students each with their own lived experience and academic knowledge contributing to quality appraisal alongside VG. Service user advisor AB also brought her own lived experience to help assess validity of the findings.

4.3.3. Search strategy

Table 4.1. A search strategy to identify relevant articles

1.	Service user involvement OR Service user participation OR Service user engagement OR Service user advisors OR Expert by experience involvement OR Expert by experience participation OR Expert by experience engagement OR Expert by experience advisors OR Patient involvement OR Patient and Public Involvement OR Patient and Public participation OR Patient and Public engagement OR Patient and Public advisors OR Service user and Carer involvement OR Carer involvement OR Carer participation OR Carer advisors OR Coproduction OR Collaboration OR Peer worker OR Peer support OR Peer researchers OR Peer engagement OR Peer participation OR Peer involvement Or Survivor researcher OR Survivor participation OR Survivor involvement OR Survivor engagement
2.	Clinical psycholog* OR Social work OR Mental health nurs* OR Research OR Service provider OR Mental health professional
3.	Training OR Education OR Mental health education
4.	Identity OR Mental health identity OR Service user Identity OR Recovery Identity OR Illness Identity OR Dual Identity OR Becoming OR Identity construct
This search strategy was put in place with and/or terms as follows: 1 and 2 and 3 and 4.	

The search strategy was co-created as a team, including the service user advisor, and with a university librarian, detailed in Table 4.1. The search terms were identified from existing literature where VG identified the terms that lived experience researchers and providers were referred to in each study, in addition to consulting with experts in the area to inform the search strategy. The search strategy was inputted into the University of Liverpool database, on 21st November 2021 and rechecked on 17th May 2022 using EBSCO to access journals from Academic search complete, CINAHL, MEDLINE, PsycINFO, Psych Articles, and University of Liverpool Catalogue was used for this. These databases were identified as most relevant to the sector. Hand searching of references from papers was conducted. Connected papers website was used to search for related papers, this helped support the identification of further articles that may not have been captured by the search strategy. Figure 4.1 reports the selection procedure.

VG initially assessed eligibility of studies. Where there were queries over eligibility the supervisory team were consulted, PF, CE, LG, and BG.

Table 4.2. Eligibility and Inclusion and Exclusion criteria

The SPIDER tool for qualitative research (Cooke et al, 2012) was used to screen the eligibility of articles included in the review. This methodology is commonly used in qualitative syntheses. The review only included articles focused on the identity of those who performed lived experience researcher and provider roles in the context of mental health, training, and research settings and not for example in medical settings. Only participants of adult age were included. The grey literature, whilst offering rich insight into the subjective experience of those in lived experience roles, was not included as this has not undergone typical academic peer review and so the themes and findings from the grey literature may not accurately reflect the experience of those in lived experience roles. It was thought necessary to provide detailed exclusion criteria highlighting how ethnic, political, national, racial, LGBT, gender and social class and psychoanalytical models of identity development should be excluded, as these are captured by the search strategy. The detailed SPIDER criteria support replication of the review in the future.

	Inclusion criteria	**Exclusion criteria**
S	**Sample** Population of sample were lived experience researchers and providers (defined as those with mental or physical disability). Mental or physical disability are not specified. Participants aged 18 years old and above	

	Lived experience researcher and providers who may also be referred to as experts by experience, peer researchers, co-researchers, lived experience researchers, service user researchers, disability researchers, survivor researchers and/or practitioners with lived experience including mental health professionals with mental or physical disabilities and also peer support workers and peer workers. In the context of mental health, education and research.	Lived experience researchers and providers in the context of physical healthcare conditions and contexts outside of mental health, education and research. Medical students and medical doctors.
PI	**Phenomenon of Interest** The study had to explore the effect lived experience researcher and provider roles on identity	Studies that did not focus on the effect of lived experience roles on identity. Studies on identity in relation to aspects of identity such as LGBT, gender, social class and ethnicity, national and political. Studies that used Erikson's model of identity development and Freud's Id, Ego and Superego theory.
D	**Design** Qualitative interviews, not limited by design, methodology or philosophical epistemology	
E	**Evaluation** Conceptualisation of identity, causes, effects, related factors, sample size, year published, methodologies, philosophical epistemology, key findings and study location. Published in the English language but not limited by country of origin.	
R	**Research type** Peer reviewed studies Qualitative empirical studies Published between January 2000 and May 2022	Purely theoretical or conceptual papers

4.3.4. Data items extracted

The characteristics of the studies, type of study, method used, sample size, participant demographics, research aims, and findings were extracted. More specifically, effects and impact of lived experience researchers and providers' work on identity were extracted through preliminary summaries and themes extracted of each study.

4.3.5. Synthesis methods

The review followed the PRISMA protocol for conducting systematic reviews (Page et al., 2021) to apply a systematic approach to the conduct of the review. The modified version of Popay et al., (2006) stages of developing a conceptual framework was applied to the synthesis. This has been used successfully in developing a conceptual framework in the context of mental health and recovery (Leamy et al, 2011), psychosis and identity changes (Conneely et al, 2020) and post-traumatic growth and psychosis (Ng et al, 2021), using the same 3 stages used in this review. The stages were 1) Develop a preliminary synthesis of findings, 2) Explore relationships in the data within and between studies and 3) Assess the robustness of the synthesis.

4.3.6. Stage 1 Preliminary synthesis

This stage involved tabulation and a thematic analysis of the identity of lived experience researchers and providers. An overview of the characteristics and themes of each study is detailed in Table 4.3. This preliminary synthesis informed the development of a coding framework and each article within the review inductively coded to identify additional themes, using NVIVO.

4.3.7. Stage 2 Exploring relationships within the studies

The studies were assessed for similarities and differences to identify emerging themes that explain identity. The studies in the three different settings, mental health, education, and research, for example, mental health professionals with lived experience, peer workers, lived experience researchers, and experts by experience, were analysed sequentially in this order. They were analysed separately and the results were compared and synthesised to see if the research areas held different or similar conceptualisations of identity, and these supported in translating the initial synthesis into a conceptual framework.

4.3.8. Stage 3 Certainty assessment: Checking the robustness of the synthesis

Quality appraisal was conducted using Joanna Briggs Institute (JBI) critical appraisal tool (Lockwood et al., 2015). This was considered appropriate as the tool asked whether researchers of articles in the review considered their relation to the research. There was also a consideration of both the author’s theoretical, and cultural perspectives that were identified through this tool. This was deemed relevant and important to the nature of this review in understanding whether authors considered their positionality and their own impact on the research process. Quality appraisal was conducted by three independent researchers, VG, SA and RQ, using the same procedure and variation discussed until consensus reached. The reviewers were each PhD researchers and two of these reviewers with lived experience. To understand the robustness of the synthesis service user advisors (1), lived experience researchers (3), and academic mental health professionals (3) were consulted to see whether the conceptual framework fitted with the way they understood their identities as lived experience researchers and providers. This involved asking them the question, 'Does this fit with how you understand your experiences as a lived experience researcher/provider?" The purpose of this was to check the validity of the conceptual framework. This is evidenced through a reflective account by Service user Advisor, AB.

4.4. Results.

The following details the results of the review, including the selection process, preliminary synthesis, quality appraisal and the translation of the findings into a conceptual framework.

Figure 4.1: PRISMA Flow diagram of selection process

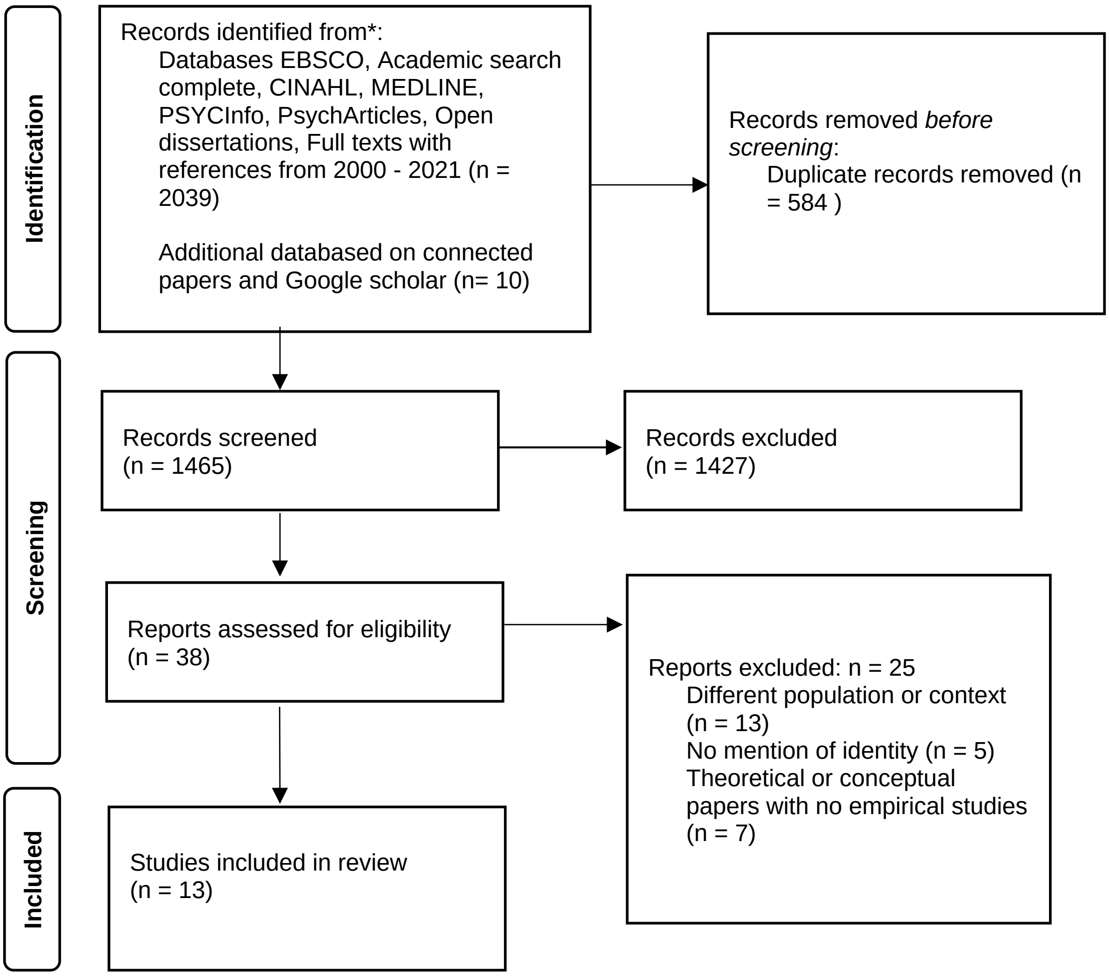


Table 4.3. Stage 1 A preliminary synthesis

First Author (Year)	Aims	Study population					Method	Summary of findings and core themes relating to identity
Adame (2011) USA	To explore the implications of being a survivor and mental health professional and the impact on identity	5 participant interviews of therapists who are also survivors.	Age not reported.	Gender not reported.	Ethnicity not reported.	Type of mental illness not reported.	Holistic content analysis.	Themes identified the foundational nature of the survivor identity. Risks and benefits of self disclosure of lived experience were identified. They find they have a greater understanding of their patients but also identify a risk of overidentification. Us and Them divisions were found between survivors and professionals. Differences between psychiatric and psychological models was also discussed.
Newcomb et al (2017) Australia	To explore how social work and human services students with service user experience integrate their lived experience in training.	20 Undergraduate Social work and Human services students who had accessed services.	Age not reported.	Gender not reported.	Ethnicity not reported	Type of mental illness not reported.	Inductive thematic analysis	Five key themes; motivation to enter social work and human services due to personal experience as a service user and a motivation to help others like themselves. There was also the idea of positive role modelling and supporting others in ways they have been supported. The idea of being unfit to practice stopped disclosures. Both service user and service provider identities were not easily integrated.
Richards et al (2016) UK	To explore identity of mental health professionals with mental health service user experience	10 participants who were mental health professionals with experience of being a service user.	Age not reported.	5 male and 5 female.	7 White British, 2 Asian, 1 South African.	Type of mental illness: depression, suicidal ideation, paranoia, schizophrenia, Bipolar disorder, Psychosis, Anxiety and Bulimia.	Discourse analysis A social constructionist epistemology	Themes found included separate unintegrated and integrated identities of "Professional" and "Patient." Discourse on Professional identity attributed power, knowledge, and expertise whereas Patient identities were perceived as stigmatised, influencing a lack of disclosure. Integrated identities led to a new sense of self. Integration of mental health patient identities and professional identities gave new skills and power.
Simpson et al (2018) UK	To explore the occupational and liminal identities of peer support workers	8 Peer support workers and 13 Service users	Age range between 20 and 55 years old	5 male and 3 female peer support workers 8 male and 5 female service users	White Irish, White other, Bangladeshi, Black Caribbean, White British, White other, Black British, Black African, Mixed, Black/British African and Black European	Service user mental illnesses reported but not peer support workers Depression, Paranoid Schizophrenia, Psychosis, Unknown, Schizoaffective disorder	Thematic analysis with deductive application of Liminality theory	The analysis revealed lived experience influenced service users to better connect with peer support workers who were like them and understood them and who were able to model recovery. The role supported in fostering a new identity and motivation to move past the service user identity. Occupational training and learning new skills legitimised occupational identity. Relationships with peers had positive effects and likened to a friendship but were also confusing. Peer worker identities were somewhere in between service user and professional, leading to liminal identities.

Wilson et al (2018) Canada	To identify challenges of peer workers and provide recommendations based on emerging themes of identity	11 peer workers and 6 informants were interviewed. Peer workers who are previous drug users supporting drug users in harm reduction.	At least 18 years of age	4 Male informants and 2 female informants 4 male and 7 female Peer workers	Ethnicity not reported.	Previous or current drug users, but other mental or physical disabilities not reported	Grounded theory analysis and symbolic interactionist analysis.	The drug user and peer worker identities were perceived as distinct. The identities of peer workers relied on the idea that they were in recovery and no longer using drugs, impacting disclosure and health seeking behaviour. The second theme was that of Triggering, where the role often made it difficult for the peer worker to remain well. There was pressure to perform, and they held themselves to a certain expectation they perceived a peer worker should be held to. The role also meant that they were stuck with the stigmatising drug user label in their peer working roles.
Toikko (2016) Finland	To understand the learning process behind becoming an Expert by Experience.	12 participants Mental health service users that become experts by experience	Age range 28 - 57 years old.	Gender of participants unclear.	Ethnicity not reported.	Type of mental illness not reported.	Thematic analysis	Four different themes. 1. Creating distance from experience: This meant having distance from the emotion of mental health experiences through storytelling. 2. Sharing experiences with peers and friends: this process describes how listening to the stories of others and sharing experiences facilitated recovery 3. Combining experiences with existing competences and skills learned through previous professional roles or personal experiences were formative to identity. 4. The roles also led to developing an orientation to the future.
Jones et al (2020) Finland	To explore the identities of service users who become Experts by experience.	13 participants, Service users and/or Carers that are Experts by experience. 11 of which has mental illness.	Age range 23 - 62 years old	Gender not reported.	Ethnicity not reported.	Type of mental illness: Bipolar disorder, Schizophrenia, Psychosis and Depression.	Thematic analysis	Being an expert by experience helped to reframe lived experience through constructing and sharing stories, creating distance from it. Illness experiences were sources of motivation to change their narrative to recovery with opportunities for self-discovery and personal development. The illness identity was constructed as being in the past and recovered identities in the present. Professional identities were constructed through learning new skills and combining them with existing skills to elevate their status. Social connections and collective shared grievances motivated politicised identities.
Hutchinson et al (2013) UK	To describe the identities of service user researchers and the effects on identity.	6 Co-researchers interviewing 30 services users. Mental health service users and co-researchers that are also mental health service users.	Age range 30 - over 65 years old	5 Female and 1 Male	Ethnicity not reported.	Type of mental illness: Bipolar Disorder, Depression, Anxiety Disorder, Postnatal Depression and Eating disorder.	Interpretive Phenomenological analysis	Two themes were found within the research of co-researchers connecting with the service users' stories. There was an idea of unrestricting lives and reciprocity. This theme represents connections with others and feeling belief in themselves through belief from others in you. Hearing others' stories enabled empathetic connections. The second theme was reframing the illness narrative, where the process of hearing other people's stories of mental distress humanised the people behind the diagnosis. The medical model made individuals feel inferior but involvement as co-researchers empowered them.

Cameron et al (2019) UK	To understand the impact of service user involvement on identity.	22 disabled individuals who are service user researchers	Age range Under 40 to 70 years old	12 women, 9 men and 1 nonbinary.	Ethnicity not reported	Type of impairment: sight loss, being deaf, acquired brain injury, cognitive impairment, learning disability, mental illness, non-epileptic seizures, multiple sclerosis, cerebral palsy, mobility impairment, wheelchair users and Carers	Thematic analysis	Involvement as experts by experience was found to give them more power but was sometimes tokenistic. The same individuals when perceived as service users held different levels of power, respect, and value. Good outcomes and meaningful involvement lead to empowerment, purpose, feeling valued, and validated, gaining new skills, knowledge, and social connection. However, service providers unintentionally oppress experts by experience through reverting back to medical model approach that diminishes identity and power of experts by experience.
De Ruysscher et al (2019) Belgium	To understand the recovery process of a patient who becomes a peer worker.	1 Peer worker and expert by experience	Age not reported.	Gender 1 male peer worker and 1 female academic researcher.	Ethnicity not reported.	Type of mental illness: Paranoid delusional psychosis, drug addiction	Bricolage method with a thematic analysis	Four themes found including 1) Life rebuilding encompassing ideas of living a meaningful life with responsibilities such as having a job, hobbies. Social circles were seen as essential in rebuilding life because of stigma and discrimination, 2) The patient identity was seen as salient when undergoing treatment and stigmatised. 3) Continuity of care, and person-centred care were essential to effective service provision and recovery. 4) The role of drugs theme explained that it was difficult to disclose and seek help when relapsing due to the expectations of the peer worker role and stigma of drug use.
Faulkner & Thompson (2020) UK	To identify the emotional impact of lived experience work, effects on identity and challenges and benefits and methods to support these researchers.	10 lived experience researchers	Age not reported	Four male and 6 female.	Ethnicity, 8 White, 2 South Asian.	People with lived experience at various levels and stages in their roles. One had a physical disability.	Thematic analysis	Themes found the idea of negotiating identities of lived experience researcher in their roles and showed there was emotional burden and labour associated with embodying lived experience roles and they found experiences of alienation and exclusion in research and how they had to navigate the bureaucracy of the systems and they identify support strategies within their key findings.

Hill, Tickle & DeBoos (2021) UK	To explore personal effects of involvement as service users and carer representatives within clinical psychology training	14 service user and carer representatives	Ages 25-79 years old	6 Male 8 Female	Ethnicity White British, British, Asian British, British Indian, Mixed, Italian, German Syrian	Type of mental illness or disability not reported but type of services accessed reported	Thematic analysis with critical realist approach and deductive application of psychological theory	5 themes including Theme 1: Environment determines sense of safety including the influence of supportive relationships in the team and by staff. Theme 2 was about "meeting challenges" and feeling empowerment and a sense of belief in the self. Theme 3 was about gaining a sense of purpose through being listened to and making a difference. Theme 4 was about "The person you see now is not the person I was," and Theme 5 was about "breaking the glass ceiling" and a sense that involvement was controlled by staff.
Cooke, Daiches & Hickey (2015) UK	To explore the narratives of experts by experience of people with personality disorders delivering training	8 Experts by Experience	Age ranges from 25-65 years old	8 Female	Ethnicity were all White	Borderline personality disorder	Narrative analytical framework and holistic analysis Social constructionist approach	Themes found were termed chapters. Chapter 1 detailed the "screaming in a milk bottle" theme identifying acute experiences prior to becoming an expert by experience where their needs were not always visible or heard. They were also excluded from life changing decisions regarding treatment and diagnosis. Chapter 2 was a turning point where they understood their experiences because of problems with services and not themselves. Chapter 3 was about taking up the expert by experience role and how it turned experiences into something positive. Chapter 4 also discusses the emergence of the professional identity where they gain more power and value. Chapter 5 talked about impact on the self and others resulting in self-worth, and self-esteem.

Table 4.4. Mode responses to quality appraisal

JBI Quality appraisal checklist for qualitative research	Adame (2011)	Newcomb et al (2017)	Richards et al (2016)	Simpson et al (2018)	Wilson et al (2018)	Toikko (2016)	Jones et al (2020)	Hutchinson et al (2013)	Cameron et al (2019)	DeRuysscher et al (2019)	Faulkner & Thompson (2020)	Hill et al (2021)	Cooke et al (2015)
1. Is there congruity between the stated philosophical perspective and the research methodology?	✓	?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Is there congruity between the research methodology and the research question or objectives?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Is there congruity between the research methodology and the methods used to collect data?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Is there congruity between the research methodology and the representation and analysis of data?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Is there congruity between the research methodology and the interpretation of results?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Is there a statement locating the researcher culturally or theoretically?	✓	✕	✓	?	?	?	✓	✓	✓	✓	✕	✓	✓
7. Is the influence of the researcher on the research, and vice versa addressed?	✓	✕	✓	✕	✓	✕	?	✓	✓	✓	✕	✓	✓
8. Are participants and their voices adequately represented?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	?
9. Is the research ethical and according to criteria for recent studies and is there evidence of ethical approval by an appropriate body?	✕	✕	✓	✓	✓	?	✓	✓	?	✓	✓	✓	✓
10. Do the conclusions drawn in the research flow from the analysis or interpretation of the data?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Of the 1465 articles screened, thirteen articles met the inclusion criteria, as shown in Figure 4.1. These were published between 2011 and 2022 and originated from USA, Australia, UK, Canada, Finland, and Belgium, and sample size of the studies ranged from 1 to 46 participants. These studies explored the identities of mental health professionals who were also survivors or service users (Adame, 2011; Richards et al., 2016); the identities of peer workers (Simpson et al., 2018; Wilson et al., 2018; de Ruysscher et al., 2019) social work students (Newcomb et al., 2017) service user researchers, experts by experience and co-researchers and peer researchers (Toikko, 2016; Jones & Pietilä, 2020; Hutchinson & Lovell, 2013; Cameron et al., 2019; Faulkner & Thompson, 2021; Cooke et al., 2015) and service user and carer representatives (Hill, 2021). All studies were qualitative but varied in methodology, epistemology, and analysis and so a pragmatic approach was used to synthesise different approaches. One of the studies was part of a randomised controlled trial and another part of a pilot study and all, empirical qualitative studies. A synthesis of the findings follows, followed by a translation of these findings into a conceptual framework.

4.4.1. Quality appraisal

The Joanna Briggs Institute (JBI) (Lockwood et al., 2015), quality appraisal tool for qualitative research was used to assess the quality of each paper using 10 items that were scored as yes, unclear, and no regarding quality. Three independent researchers assessed the 13 papers. Following discussion over differences in ratings, consensus was reached. Fleiss' Kappa interrater agreement was moderate, k = .485, p<.001. Kappa agreement for ratings of No, k = .769, p <.001, Yes, k = .554, p <.001 and Unclear, k = .184, p < .001. The mode quality appraisal ratings can be seen in table 4.4. Ethical approval was not stated in some studies (Adame, 2011; Newcomb et al., 2017; Cameron et al., 2019). There was some bias in the recruitment process in 1 study (Adame, 2011). Each of the studies lacked diversity in their sample regarding ethnicity and gender. 8 studies did not report demographics on ethnicity (Adame, 2011; Newcomb et al., 2017 ; Wilson et al., 2018; Toikko, 2016; Jones & Pietilä, 2020; Hutchinson & Lovell, 2013; Cameron et al., 2019; de Ruysscher et al., 2019). 3 studies did not report gender (Adame, 2011; Newcomb et al., 2017; Jones & Pietilä, 2020) and 1 study reported this ambiguously (Toikko, 2016) and Cooke et al., (2015) included a sample of only white females. Age was not reported in 5 studies (Adame, 2011; Newcomb et al., 2017; Richards et al., 2016; de Ruysscher et al., 2019; Faulkner & Thompson, 2021) and 1 study reported that participants were of adult age but no descriptive statistics were included (Wilson et al., 2018). Each of the studies varied in philosophical approaches and methodologies. There were also limited statements identifying the researchers' own positionality in relation to the research, either theoretically or culturally, (Newcomb et al., 2017; Faulkner & Thompson, 2021) and it was unclear in 3 studies (Simpson et al., 2018; Wilson et al., 2018; Toikko, 2016) and very limited acknowledgement of the researcher's impact on both the research and vice versa, which was not identified in 4 studies (Newcomb et al., 2017; Simpson et al., 2018; Faulkner & Thompson, 2021; Toikko, 2016). Different lived experience researcher and provider roles were treated as a homogenous group within 2 studies (Adame, 2011; Richards et al., 2016). All but one study allowed for heterogeneity regarding type of lived experience of mental or physical disability. Cooke et al., (2015) only included people with a personality disorder diagnosis. 2 studies were heavily theoretically driven without the researchers acknowledging the deductive approach they used and its influence on findings (Simpson et al., 2018; Hill, 2021).

4.4.2. Stage 2: Exploring the relationships within the studies

Through the process of stage 1, synthesising studies of lived experience researchers and providers in mental health, education, and research, involving summarising, tabulating and critically appraising. Five main themes of identity positions were identified and seven themes relating to identity development. The following section explores these themes and their similarities and differences across the studies. Table 4.5 details each theme and how the studies contribute to the development of the framework.

Table 4.5. A Translation of findings into a conceptual framework

Positions of identity and causal factors	Studies and their original conceptions
Professional	Newcomb et al (2017) Positive/Negative role modelling; Richards et al (2016); Simpson (2018) Occupational training. Wilson (2018) Peer worker. Toikko (2016) Combining experiences with existing competences. Jones (2020) Competences and skills. Use of existing skills in involvement work (Hill et al, 2021). (Cooke et al, 2015)
Service user	Richards et al (2016) Wilson (2018) Drug user. Cameron et al (2019) disability identity locates problem in individual, activists reframe this to society not meeting their needs and being the reason for impairment. Cooke et al (2015)
Integrated	Richards et al (2016) Personhood; Adame (2011) Benefits of disclosure: Newcomb et al (2017) Personal experiences help professional identity. Embodied experiences (Faulkner & Thompson, 2020)
Unintegrated	Richards et al (2016) Adame (2011) Risks of disclosure; Newcomb et al (2017) Disclosure difficulties, Not easily integrated. Reluctance to share lived experience (Cooke et al, 2015) Toikko (2016) Creating distance from experience. Alienation (Faulkner & Thompson, 2020)
Liminality	Simpson (2018) Liminality of PSWs. Faulkner &Thompson, 2020)
Empowerment	Simpson (2018) Occupational training leads to competence, empowerment, skills, knowledge. Toikko (2016) Developing an orientation to the future and politicised identities. Jones (2020) politicised identities through shared grievances and collective identity. Hutchinson & Lovell (2013) Reframing of illness, sharing experiences and listening to each other’s stories enabled and empowered co-researchers to be less critical of the self and normalise experiences of distress. Cameron et al (2019) Good outcomes of involvement lead to empowerment, purpose, value, skills, and knowledge. DeRuysscher et al (2019) Life rebuilding. Disempowering through the system and bureaucracy but enablers through personal, collective, work, and system level strategies (Faulkner & Thompson, 2020) Hill et al (feeling listened to, valued and with purpose and making a difference. Cooke et al (2015) impact on self and others.
Motivation	Newcomb et al (2017) Simpson (2018) Model recovery and inspire others. Toikko (2016) Motivation to share experience and reduce stigma/raise awareness. Jones (2020) Motivation to move from illness identity to a positive one. Cooke et al (2015) Taking up the trainer role - It just all took off.
Empathy of the self and others	Simpson (2018) (Identity and relationships, connection with peers); Wilson (2018) Drug talk can be triggering. Toikko (2016) Sharing experiences with peers and friends. Jones (2020) Sharing of experiences leads to common shared experiences and politicised identities. Hutchinson & Lovell (2013) Unrestricting lives and Reciprocity - connections with others affirmative experiences and belief in others and the self, hearing others’ stories enabled empathic connections and normalised experiences of distress. Cameron et al (2019) find that social connections are a result of involvement. Hill et al (2021) being understood by trainees and feeling connected to each other as survivors. “Band of brothers” (Cooke et al, 2015)
Recovery model/Medical model	Adame (2011) Differences between psychological and psychiatric models; Richards et al (2016) Jones (2020) Cameron et al (2019) service providers do harm when reverting to the medical model lens and resulting in diminished identities. Decisions, diagnoses being made for them in secrecy (Cooke et al, 2015)
Growth and Transformation	Richards et al (2016) Personhood; Jones (2020) Becoming an EBE changed illness identity to a more positive one. Hutchinson & Lovell (2013) process of hearing others’ stories humanised the experience of distress and transformed and reframed service user identities. Hill et al (2021) I am not the same person I was. Emergence of professional identity linked to value and power (Cooke et al, 2015)
Exclusion/Stigma and Discrimination	Richards et al (2016) Unintegrated; Adame (2011) Us and Them divisions; Newcomb et al (2017) Disclosure difficulties. Simpson (2018) Identity and relationships (PSWs Excluded by other professionals). Wilson (2018) Barriers to accessing services when relapsing as a PSW, Difficult to move beyond Drug user identity to professional opportunities. Jones (2020) Cameron et al (2019) service providers choose who is listened to and who has power. Alienation and exclusion of diversity in white spaces (Faulkner & Thompson, 2020). Hill et al (2021) breaking the glass ceiling. Information, diagnosis of personality disorder not shared (Cooke et al, 2015)
Survivor roots	Richards et al (2016) Adame (2011) Foundational nature of survivor identity. Jones (2020) Cameron et al (2019) Screaming in a milk bottle (Cooke et al, 2015).

4.4.3. The Positions of Identity

Five identity positions became apparent; each of these is described below. The lived experience researcher or provider moved between these different positions.

4.4.3.1. Service user and Survivor identities

Service user and survivor identities were common across all studies. The data identified service users, survivors, drug users and experts by experience. These identities were separate to the service provider and held less power, control, and respect. Cameron et al., (2019) reported that services perceived the service user or disabled person as the one with a problem. Their identities are also perceived as "limiting" (Newcomb et al., 2017, p 2). de Ruysscher et al., (2019) also found that service users were defined and overshadowed by their service user identities. Service user involvement work provided the opportunity to transform these identities and move beyond the stigma associated with it to more positive identities not rooted in deficit (Hutchinson & Lovell, 2013) The idea of role reversal, where the service user became the provider through the expert by experience role, changed the power differentials and enabled service users to be seen as people to learn from (Toikko, 2016).

4.4.3.2. Professional Identity

Across the 13 studies the professional identity of lived experience researchers and providers was constructed. This consisted of having skills and competences to effectively carry out these roles (Cameron et al., 2019) and motivation to combine existing competences from personal lives into professional roles (Toikko, 2016). Richards et al., (2016) found those with professional identities were seen as knowledgeable, and competent, with more power than those with just service user identities. Peer workers were focused on developing professional identities which were legitimized through training (Simpson et al., 2018) and appropriate titles (Jones & Pietilä, 2020). There were allowed and disallowed characteristics, such as it "not being acceptable to become angry" (Richards et al., 2016, p 6), "having everything together" and "never having a bad day" (Wilson et al., 2018, p363). Jones & Pietilä, (2020) reported, being an expert by experience required that one must communicate articulately and clearly. Cooke et al., (2015) find that the development of a professional identity shifted service users to feel as though they have greater value and power. Within these studies it was reported that service user researchers and providers were more likely to want to convey their expertise as people with knowledge who were skilled at their jobs to detract from their stigmatised service user identities.

4.4.3.3. Integrated identities

Integrated identities were discussed within the research as individuals holding service user and professional identities simultaneously, and this was problematic and conflicting for the individual. There were differently held beliefs of whether integration was useful or not. Richards et al., (2016) found within an "integrated" identity, participants drew on all their identities to inform their practice, but this was rarer than the unintegrated identity as it was more difficult to accomplish. Newcomb et al., (2017) found when academics shared their lived experience in professional contexts it reduced stigma and provided student healthcare providers with examples of how to integrate their own lived experiences. However, Adame (2011) found integrating lived experience excluded them from being accepted by colleagues within the profession and by other survivors of the mental health system. The idea of integration was spoken of as embodiment but was emotionally burdensome in peer researchers (Faulkner & Thompson, 2021).

4.4.3.4. Unintegrated

This theme addressed the issue of being unable to hold identities of service user and professional simultaneously. Richards et al., (2016) reported the "mad man versus someone who got a reputation for being highly professional they're worlds apart unfortunately." (Richards et al., 2016, p7). Service user and professional identities were understood as separate and either good or bad. Adame (2011) found that, despite mental health professionals having personal experience of mental illness they were likely to keep that hidden. Cooke et al., (2015) also find that being perceived as the one with lived experience in the room was conflicting, leading to a reluctance in wanting to share. Newcomb et al., (2017) reported this was due to stigma and fear over queries over fitness to practice. This fear stopped some peer workers from seeking help when they relapsed (Wilson et al., 2018). Cameron et al., (2019) also identified the conflicting positions experts by experience occupy, where in one context they are sources of knowledge, and other contexts as consumers of care. The service user representative role required service users to share their stories but with an expectation to separate the emotion from storytelling, to create distance from the service user identity to support learning from experience that could be tolerated by healthcare professionals (Toikko, 2016; Faulkner & Thompson, 2021; Jones & Pietilä, 2020).

4.4.3.5. Liminality/Ambivalence

The concept of liminality (Turner & Abrahams, 1969) posed by Simpson et al., (2018) described the experiences of peer workers who occupy a space in between being a service user and professional. The role ambiguity through occupying in between identities meant that it was difficult for peer workers to understand how they should interact with the people they support and the teams they work in. There was a lack of understanding whether they were friends or peers or a different dynamic. This had consequences for how others perceived them, and unclear expectations of the role and services they provided. This identity ambiguity led to differences in respect and power associated with these roles. This posed similar dilemmas to the lived experience researcher holding ambivalent identities (Faulkner & Thompson, 2021).

4.4.4. The EMERGES framework

The data in the studies informed the EMERGES framework that were found to be themes relating to identity development, encompassing: Empowerment, Motivation, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots. The framework is illustrated in Figure 4.2. This is presented in reverse and ascending order starting from survivor roots through to enablers and empowerment replicating the journey that the current research suggests lived experience researchers and providers go through to develop their emerging identities.

4.4.4.1. Survivor roots

Adame, (2011) found the survivor identity were the roots and drivers of their need to work in the system. “The survivor part of me is what gets me out of bed each morning, and thinks that what I’m doing is important, and meaningful, and really needed…Like this background motor, I guess. It’s its own string of conviction, this motor, this energy that’s all in the background.” (Adame, 2011, p327). Jones & Pietilä, (2020) found that participants were likely to draw on their acute struggles of lived experience in their roles. Toikko, (2016) identified how having lived experience of mental distress was the foundation to becoming an expert by experience. A parallel identity to that of survivor roots was that of disability roots, and this was the source of motivation to challenge and disrupt the system which is disabling (Cameron et al., 2019).

4.4.4.2. Exclusion/Stigma and Discrimination by services

This theme covered how lived experience researchers and providers felt they must hide their lived experience due to queries over competence and fitness to practice (Adame, 2011; Newcomb et al., 2017). Service providers also chose who they listened to, and involvement could be tokenistic, recycling oppression lived experience researchers and providers experienced in contexts where they were service users (Cameron et al., 2019). Certain voices were excluded that were more chaotic and less professionalised (Jones & Pietilä, 2020). Cooke et al., (2015) also identify how the label of personality disorder is shaming and stigmatising, and diagnostic practices operated in an inclandestine way excluding their involvement. Exclusion and alienation of those from minority ethnic backgrounds within these spaces was also discussed (Faulkner & Thompson, 2021). Hill, (2021) also related service user and carer involvement to a need to “break the glass ceiling” as staff were seen to hold the power and control the agenda.

4.4.4.3. Growth and Transformation

This theme encompassed experts by experience and co-researchers discussing effects of involvement leading to a metaphorical growth and transformation. “Seeing everybody still ‘fighting for it’...the enthusiasm is more than ever... these are different people to the ones three years ago, I’ve been able to watch my teammates blossom!” (Hutchinson & Lovell, 2013, p646). Richards et al., (2016) found the impact of these roles resulted in positively framed identities, facilitating recovery. It enabled individuals to have alternative, additional identities where the service user identity did not overshadow them. “So, it’s not the most central thing anymore, that you’re a mental health patient, but rather that you are a lot more as well.” (Toikko, 2016, p303). Hill, (2021, p 9) also found the theme of, “The person you see now is not the person I was.” This growth and transformation was related to the emergence of a professional identity, moving further away from the service user identity (Cooke et al., 2015).

4.4.4.4. Recovery model versus medical model

This theme found the recovery model was a facilitator in changing mental health identities to be seen as recovered. However, both the recovery model and medical model could both empower and disempower. Across the studies identities of lived experience researchers and providers were rooted in and influenced by these models. Despite models such as the social model of disability not locating the problem within the service user, the lens in which service providers worked "gets shifted back to medical model approach" (Cameron et al., 2019, p 1323) influencing identities to be seen as disordered. Richards et al., (2016, p 10) found that those who drew on a "personal recovery" had more positively framed identities because it placed less emphasis on being "stuck". Adame, (2011) identified an alternative discourse regarding the medical model, some service users found it helpful, and when the provider challenged the service users' alignment with the medical model, or of diagnosis, it was invalidating to how service users understood themselves and their experiences. Cooke et al., (2015) felt the process of diagnosis was disempowering but became empowering once service users understood that the damage that came from diagnosis came from service providers. Hill, (2021) also found that relations between service users and carers within involvement groups required a management of power dynamics.

4.4.4.5. Empathy of the self and others

This theme covered how the experience of being a lived experience researcher and provider led to an understanding of the self and others. Service user representatives found sharing stories of personal experiences turned them into common shared experiences of distress, enhancing empathy and reducing stigma. The PSW discussed the importance of being 'one of them' and able to 'get it.' (Simpson et al., 2018, p 665). Richards et al., (2016) and Newcomb et al., (2017) also found that personal experiences of distress enabled better understanding of those they worked with. Providing a social domain in which individuals shared their experiences as co-researchers meant they felt, understood, and better understood others (Hutchinson & Lovell, 2013; Jones & Pietilä, 2020; Toikko, 2016; Hill, 2021). In relation to each other they also felt like they had similar experiences and a sense of "group survivorship." (Hill, 2021, p 6). Richards et al., (2016, p 9) also identify a similar group identity through the idea of a shared "personhood." Cooke et al., (2015, p 239), also identified how experts by experience found it useful to connect and work with others who are similar like a "band of brothers." Adame, (2011) found empathy of the self and others was impacted by overidentification, blocking a therapist's understanding of those they support. This meant that these roles sometimes supported or hindered understanding the self and others.

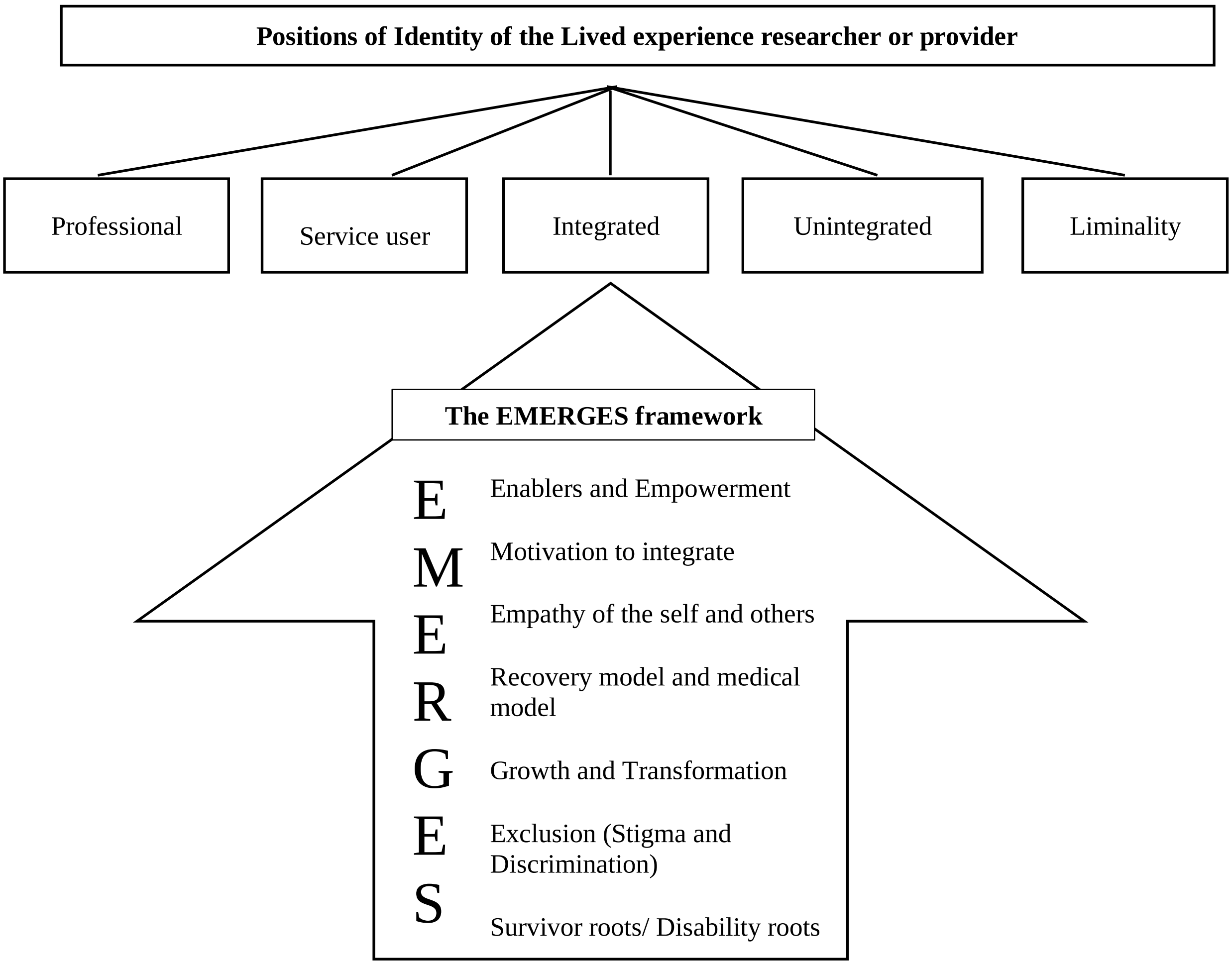
4.4.4.6. Motivation to integrate

Adame, (2011) and Newcomb et al., (2017) identify that lived experience providers were motivated to make a difference to others, due to their own lived experiences and wanted to prevent others experiencing the same injustices of the system. Positive experiences of services were motivators for becoming lived experience researchers or providers and modelling this experience in their own practice. Additionally, motivations to apply professional knowledge to better understand their own experiences was important (Richards et al., 2016). Cameron et al., (2019) found a motivator to continue in the work as a service user representative was to purposely disrupt the power dynamics in these contexts. There was a need to move beyond the service user identity (Hutchinson & Lovell, 2013) and change their own narratives to more positively framed senses of self with a purpose in life. Faulkner & Thompson, (2021) also identified that it was not simply enough to be working as lived experience researchers but to actively be integrating their lived experience into their work. Cooke et al., (2015, p 239) also find that expert by experience roles were motivated in making use of past struggles “It almost comes worthwhile because you can almost see you’re doing something with it.”

4.4.4.7. Enablers and Empowerment

The lived experience researcher and provider role enabled moving beyond the service user identity (Hutchinson & Lovell, 2013). This was influenced by learning and combining new and existing skills (Simpson et al., 2018; Wilson et al., 2018; Cameron et al., 2019; Jones & Pietilä, 2020; Toikko, 2016; Hill, 2021), and contexts situated in the recovery model, gave hope (Richards et al., 2016). Toikko, (2016, p 303) found that through being an expert by experience led to an orientation towards the future. They were empowered after involvement (Jones & Pietilä, 2020) and through being listened to, heard, and meaningfully involved (Cameron et al., 2019) It also gave meaning and purpose through “planting a seed” (Cooke et al., 2015, p 240). Hill, (2021) also found that meeting challenges, resulted in self-belief by having control over decision-making. Activism, social change, politicised identities, and positive identities were developed because of these roles and were thought to facilitate recovery (Hill, 2021; Adame, 2011; Jones & Pietilä, 2020; Cameron et al., 2019; Cooke et al., 2015). However, some providers maintained there were fewer opportunities for those with drug user identities that were disempowered in their roles due to stigma and the permanence of a service user identity (Wilson et al., 2018).

Figure 4.2. A visual representation and summary of findings in the review



4.5.1. Stage 3: Checking the robustness of the synthesis: Reflections by Alison Bryant, Service user Advisor

“I am in awe of the EMERGES framework and thoroughly relate to the themes and how my experience is integrated into those themes.”

The robustness of the synthesis was checked by each member of the research team (VG, PF, LG, BG & CE) and researchers at McPin Foundation (RT & TM). AB, service user advisor uses the EMERGES framework to reflect on her lived experiences and evidences its utility as a reflective tool. An extended reflective piece by AB describing her involvement in clinical psychology training as an expert by experience is provided in Chapter 8.

Survivor roots “*My long history of mental health presentations has defined me at every stage of my life. My experiences of services have been very varied, adding to the burden of my lived* *experience. Clinical psychology, and specifically mindfulness, has helped me to survive and be able to acknowledge that I have survived, and is now deeply meshed as part of my lived identity.*

Exclusion/Stigma and Discrimination: *I know holding my lived mental health experience and identity as being valuable to others (let alone myself) has been a hard road to travel. At times, my own perception of stigma, initiated feelings of exclusion, but also, I acknowledge that I have 'lost', through smoke and mirrors, some of my history and identity when I realised this was neither valued nor accepted, if not absolutely rejected. When the presence of imposter syndrome arises regarding my identity whilst working alongside academic or professional identities with no lived experience, I try to comfort myself that this is to be expected and to work towards reducing my feelings of exclusion.*

Growth and Transformation: *I and my family know how much my identity has been shaped by my involvement as a service user/provider. Both self-stigma and societal stigma have been a lens through which I have viewed my lived experience of mental health, this view having now been reframed in the context of my service user involvement. These experiences validate me and acknowledge my voice is heard. My knowledge sharing has empowered me so much, to the extent that sometimes I consciously listen to my voice that was once so subdued with a sense of surprise and ownership previously lacking.*

Recovery model versus medical model: *My clinical psychologist, in presenting me with the then novel concept that my experiences would be valued by others, was instrumental in me taking on the role of service user/provider. My initial involvement was at times bewildering, often surprising, but allowed my identity to develop bit by bit over time. My recovery from psychosis has been reinforced through my service user identity and involvement, but I am all too aware that there are periods when my mental health is less stable, and my service user involvement may be seen as less productive or useful. This presents me with an insurmountable hurdle to achieving full involvement unless, in the future, the "goal posts" are shifted with mental health adjustments to better support service user providers.*

Empathy of the Self and others: *My service user involvement was a seed planted by my clinical psychologist that related to part of my identity which had always been at the forefront, and a heartfelt wish that others never had to go through the experiences in life and in managing mental health that I had done. Being able to demonstrate as a service user provider to those in* *training the reality of my lived experience helps shape them as practitioners. Sharing with other service users, identifying with them and offering support and solidarity through the challenges of shared lived identity is very empowering.*

Motivation: *For many years, my sense of self and identity had been eroded by the effort of constantly battling my mental health and despair at the impact on my quality of life and that of my family. My ability to be confident, to interact socially, my sense of self-esteem and sense of purpose had become lost in the struggle to become well. My most recent contact with services was a key factor in my recovery, and the incentive generated because of the therapeutic alliance with my clinical psychologist to help others was an overwhelming driver in my journey to recovery and new identity. My fractured self was pieced together in my pursuit of my newly formed service user identity.*

Enablers and Empowerment: *I had over time lost sight of skills or abilities I had held as part of other identities. Becoming a service user/provider allowed me to revisit those identities, to tease out what would sit alongside my mental health lived experience, to empower other service users, health professionals, trainees and ultimately myself. I now have a new perspective on my experiences gleaned from this new vantage point. I once had only a tiny seed of hope, now this has blossomed giving me a new sense of identity, purpose and direction.*”

4.6. Discussion

The review aimed to understand how the process of working as lived experience researchers and providers in mental health, education and research settings impacted identity and to develop a conceptual framework. The framework identifies five different positions of identity: Service user, Professional, Integrated, Unintegrated and Liminal identities and details themes of the EMERGES framework consisting of Enablers and Empowerment, Motivation, Empathy of the self and others, Recovery Model and Medical Model, Growth and transformation, Exclusion (Stigma and Discrimination) and Survivor roots. The EMERGES framework is a novel conception and has common themes of emotion and power running throughout, with some overlap between themes.

4.6.1. The Positions of Identity

The service user position is characterised as being disordered, limiting and considers the individual as the one with the problem. This is consistent with research in mental health settings, where illness identities are detrimental to hope and recovery, resulting in poorer mental health (Yanos et al., 2010). The lived experience researcher or provider is expected to control their emotions and keep a distance from their illness, detracting from diversity and representativeness of service users who are chaotic or suffer with severe mental illnesses, influencing the type of identities within these roles (Beresford & Campbell, 1994). The service user has to switch between positions, for example, having to move between service user and expert by experience, where there are different levels of power, and control in decision making, requiring negotiation (Fox, 2016).

Professional identity was reinforced through training and labels used to describe them, giving them the skills and competences to work in their roles. This is consistent with, the Academy of Medical Royal Colleges, (2020) that identify skills and knowledge to perform a professional role are key to developing a professional identity. Mayer & McKenzie, (2017) also find professional identities of experts by experience are influenced through interactions with experts by qualification and through performing these roles.

The Integrated identity was characterised by sharing lived experience both in research and clinical practice. Beames et al., (2021) find the integration of lived experience in all stages of research supports meaningful research and outcomes. Arroll & Allen, (2015) find self-disclosure results in greater therapeutic rapport and empathy. However, Bray, (2019) identifies the risks of self-disclosure and how it de-centres the service user. Alternatively, the peer support worker role requires them to work with patients through a shared experience of distress, but they do not necessarily need to disclose as there is already a visibility of lived experience. Sharing of lived experience by professionals is likely to de-stigmatise the idea of mental illness (Corrigan & Watson, 2002; Thornicroft et al., 2016). Integrating lived experience in professional roles is related to being an authentic version of the self. Research into authenticity suggests that when we are authentic it is better for our health and wellbeing (Grijak, 2017) providing support for the benefits of lived experience roles.

The Unintegrated identity of the service user and professional identified how these identities were conflicting and could not be held simultaneously. Research suggests that experiential knowledge comes predominantly from the expert by experience, suggesting learning about experiential knowledge cannot come from mental health professionals. Additionally, professional knowledge is better assimilated when it comes from healthcare professionals as opposed to those with lived experiences (Hodge, 2005). This is explained by epistemic and hermeneutical injustice which poses limits on where knowledge is learned from (Fricker, 2007). Lived experience researchers and providers are also required to separate emotion and maintain professionalism in their roles. They must convey "affective intensity, while not spilling over into uncontrolled illness" (Näslund et al., 2020: p10). Researchers and professionals with lived experience are also impacted by stigma in the profession of lived experience that may determine whether they integrate lived experience in their research or clinical work.

The process of liminality described the identity of peer workers and researchers (Simpson et al., 2018; Faulkner & Thompson, 2021). Wu et al., (2020) suggest that Liminal spaces negatively impact the mental health of individuals occupying this space. Warner & Gabe, (2004) identify how mental health social workers find it difficult to work with mental health patients who occupy liminal spaces as they are difficult to understand and support. This can also translate to the way lived experience researchers and providers are understood and worked with in clinical practice and research, by colleagues. This knowledge can support service providers and colleagues to better understand those with liminal identities and enable better team working. It also identifies how these roles have an emotional burden on those performing them.

4.6.2. The EMERGES Framework

Outlined below are the seven core elements of the EMERGES Framework. Each element is considered in relation to the evidence base and how lived experience researchers or providers can be better understood and worked with in mental health, research, and educational settings.

Survivor roots

This theme found becoming a lived experience researcher or provider was rooted in the history of being a survivor or service user of the mental/health system. The experience of trauma or iatrogenic harm from services can influence changes to identity. Through the process of having positive or negative experiences of services may be formative to self-identifying as a service user or survivor differently. Wallcraft et al., (2003) identify the diversity of perspectives within and between service users and survivors but identify shared motivations to improve the mental health system. The intersectional influence of lived experience and professional aspects to the role (Crenshaw, 1989) means that this researcher or provider has more complex needs and requires greater support.

Exclusion/Stigma and Discrimination by services

Stigma and discrimination were shown to negatively impact disclosure of lived experience and health seeking behaviour and this is seen in wider contexts (Martin, 2010; Brown & Basil, 2010). The review team's own observations find service user involvement is typically made up of white service users and is unrepresentative of the population which may be symptomatic of exclusion in the mental health system. There are also them and us divisions between lived experience researchers and providers and those they work with. For example, knowledge of stigmatised diagnostic labels, such as personality disorder, affects how experts by qualification perceive and work with them (Clark et al., 2015). There are also divisions between different lived experience researchers and providers, for example, experts by experience and mental health professionals with lived experience, meaning different lived experience researchers and providers do not belong to the same identity.

Growth and transformation

The review found a consistent theme of growth and transformation. This links to a broader body of evidence within literature on how service users or survivors of mental or physical disability experience post traumatic growth (Tedeschi & Calhoun, 1996). Theoretically driven research metaphorically likens the effects of service user involvement to growth and transformation (Tse et al., 2012) and research finds the expert by experience role results in transformative effects (McCoy & Aronoff, 1994; Onken & Slaten, 2000). Some lived experience researchers and providers also have a romanticised perspective and find transformative effects in identity following the experience of psychosis (Conneely et al., 2021). Schneider et al., (2019) find non-white people and those with serious forms of distress are more likely to experience greater post-traumatic growth, suggesting the trajectory of growth and transformation of lived experience researchers and providers may be variable.

Recovery model and medical model

The wider literature identified the recovery model was more likely to lead to feeling more hopeful and move individuals further from the service user identity (Buckley-Walker et al., 2010). The recovery model arguably has a negative side that promotes a certain journey for service users, modelling ideas about competence, expertise and health outcomes that reduce the ideal service user to someone that is recovered (Harper & Speed, 2014.). This limits the type of individual in lived experience researcher and provider roles, reducing representativeness and authenticity of service users. The recovery model ironically detracts from the service user identity. In contrast, the medical model reinforces the service user identity, positioning the service user as in need of help, as ill or disordered (Beresford et al., 2010). The context and models in which individuals are situated in can influence the way individuals conceptualise their own experiences. This aligns with social constructionism epistemology (Berger & Luckmann, 1991). The recovery model, medical model and social disability model are pervasive in the sector and explain findings in the review and how lived experience researchers and providers' differently construct their identities based on the models they identify with.

Empathy of the self and others

This theme found how sharing experiences within a social domain were used to connect with and understand others. The social identity of the lived experience researcher and provider role provided a sense of belonging to an in-group where we share similar values, beliefs, and experiences, supporting the formation of a social identity (Tajfel & Turner, 1979). The historical exclusion of this group of people in society means the role enables them to have a sense of belonging. Hawkins, (1999) suggests a desire to tell others about our own experiences becomes a desire to help others and this is a motivating factor in integrating lived experience. The process of lived experience researcher and provider identities may mean they better understand the people they research or work with and make them better person-centred practitioners (Rogers, 1959). However, issues relating to transference and countertransference can negatively impact understanding others through the projection of one's own lived experiences.

Motivation to integrate

This review identifies the idea of motivation to integrate lived experience and professional identities and hold them simultaneously. This motivation aligns with wider mental health contexts, for example, the division of Clinical psychology (BPS, 2020) released guidance on how trainee psychologists can integrate their lived experience into their work and training. This suggests the lived experience researcher or provider and mental health training are in alignment regarding motivations to integrate lived experience. This is likely influenced by changes in policy by the Department of Health (DOH, 1999, 2000, 2001) and the service user movement (Chambers & Hickey, 2012)

Empowerment and Enablers

The review found the idea of empowerment through lived experience researcher and provider work and this may occur through a social justice motivation (Huse, 2020). Through lived experience researcher and provider roles that are politically motivated, formed of activists and advocates means they are moving away from individual motivations to make a difference to a collective motivation to make a difference for others like themselves. This may be governed by social identities (Tajfel & Turner, 1979). Belonging to a social identity is likely to result in the health and wellbeing of members in the group, strengthening the group and empowering it and advocating for it. This can be explained through the social cure phenomenon in social identity theory (Jetten et al., 2012). Further to this, reaction against out-groups provides a motivation to disrupt and challenge other social identities such as Psychiatry or Psychology.

4.6.3. Links to other frameworks

The EMERGES framework conceptualises the identities of lived experience researchers and providers and builds on previous frameworks in other contexts, offering a novel way to understand identity. There are parallels with findings from the CHIME framework, which is made up of themes of Connectedness, Hope, Identity, Meaning, Empowerment (Leamy et al., 2011). Although the CHIME framework is critiqued as being overly optimistic and positive, and other researchers argue it does not account for difficulties that service users experience, advocating for an addition of D to the CHIME framework representing difficulties (Stuart et al., 2017)). In contrast, the EMERGES framework explicitly highlights the exclusion lived experience researchers and providers experience which is undermined by the retrospective addition of the D in CHIME-D framework. There is also overlap with Emery, (2015) literature review of service user involvement, finding themes of empowerment, recovery, and identity, giving validity to this review. Ng et al., (2021) find in their conceptual review of psychosis and growth and transformation the acronym of PROSPER, Personal identity and strength, Receiving support, Opportunities and possibilities, Strategies for coping, Perspective shift, Emotional experience, and Relationships. The EMERGES framework encompasses similar themes to these frameworks but specific to lived experience researchers and provider identities, offering a novel and accessible way to understand them.

4.6.4. Strengths of the review and framework

The review identifies the novel EMERGES framework which can be used as a reflective tool and has practical applications both within research and clinical settings with the heterogeneous population of lived experience researchers and providers. The framework was co-created with a multi-disciplinary team, including lived experience researchers and providers, at every level within the review, adding to the robustness and validity of the findings and additionally, peer reviewed by researchers at McPin Foundation. Quality appraisal was also carried out independently by three different PhD Psychology students, with different expertise in lived experience and research methods. The methodologies within the studies were informed by a wide range of philosophical approaches that contributed to this synthesis. The research questions and aims of the studies differed slightly and so their synthesis may not represent each individual study's findings cohesively, but instead the review identifies common themes across all. These are informed through a range of perspectives and philosophical underpinnings that supports the robustness of the synthesis. The framework has also been reviewed by researchers in other settings who suggest its value and application in mental health settings more generally, evidencing its versatility and wide-reaching impact.

4.6.5. Limitations of the review

It is acknowledged the review did not explore the grey literature, or literature on ethnicity, LGBT, and gender identity and this may have cast further insight into identity formation, but this was not a focus of the review. Most studies within this review failed to discuss the lack of diversity within lived experience researcher and provider roles. Only one paper (Faulkner & Thompson, 2021) addresses this issue explicitly, but this study's sample size was mostly white, meaning it is difficult to draw meaning from such conclusions. The reviewed studies highlight how the field is limited to lived experience researchers and providers who can communicate their experiences and manage their emotions with competence and professionalism. This excludes those with severe mental or physical disabilities and those with learning disabilities. The carer voice and their work as experts by experience or providers is also largely missing from the studies included within this review, only, Hill, (2021) included carers within their study. A proportion of the studies within the review are complex and academic in nature and may be difficult for lay people to understand, suggesting that the people who can benefit from the research may not, due to lack of accessibility. This meant that the review team were mindful of those who would benefit from reading the review and were motivated in communicating this in an accessible way. It is also acknowledged the field of lived experience work is referred to in a diverse set of ways nationally and internationally and so the search strategy may not have captured all research in the area. There is also a lack of literature exploring the effects of lived experience researchers and provider roles on identity, evidenced through only thirteen papers in this review, and so there is a recommendation for adding to the evidence base.

4.6.6. Conclusion

This review gives greater clarity to the identities of lived experience researchers and providers in mental health, education, and research, that are sometimes not understood by themselves or the people they work with. The EMERGES framework can be used as a reflective tool to better understand those is these roles and support effective team working. The review highlights how lived experience researcher and provider roles are performed by individuals with certain characteristics such as those who are professional, articulate and those who can separate and integrate, when appropriate, their lived experiences. However, people who do not have these characteristics and people from ethnic minority backgrounds, in addition to those with severe and enduring chronic mental, physical, and learning disabilities, are often excluded from these roles. Furthermore, it is evident that carer involvement in these roles is also underrepresented. Through the integration of more underserved communities in lived experience roles can lead to a depth of experience that can be drawn upon, leading to growth and transformation in the sector. However, the integration of lived experience within these contexts is limited, due to stigma and discrimination, limiting self-disclosure and health-seeking behaviours due to the professionalisation of these roles. Therefore, those working with lived experience researchers and providers need to be aware of their support needs which can be guided by the practical application of the EMERGES framework. There is also a need to integrate lived experience to be authentic and to promote social justice in the mental health system. Through the process of sharing lived experiences supports others to listen and learn from them and supports greater empathy of one’s own distress and that of others.

Through the process of performing these roles and through moving through the stages of the EMERGES framework leads to identity development. In some cases, the stigma of mental illness, and/or disability permanently marks the identity of lived experience researchers and providers, affecting their prospects and the lens through which they are viewed. However, the general trend among the literature highlights how lived experience researcher and provider roles moves them beyond the service user identity. This consequently transforms those with stigmatised identities to enabling and empowered identities, facilitating recovery.

CHAPTER FIVE

A SOCIAL CONSTRUCTION OF IDENTITIES IN CLINICAL PSYCHOLOGY TRAINING IN THE UK

"The bridge between two different types of knowledge"

~ Expert by Experience

5.1. Introduction

This chapter builds on the methodologies and findings of studies in Chapter 4. It aims to understand the identities that are constructed specifically in clinical psychology training, as this is an under researched area. Insight from this current study can enable a better understanding of groups in this context and support them to work together more effectively. Key contributors to UK Clinical Psychology training are research psychologists and clinical/academic psychologists. These staff have the relevant qualifications and training to perform these roles and are referred to in this chapter as Experts by Qualification (EBQ). Other equally important contributors are service users and carers, that are experts in their lived experience of disability and of services, who are referred to as Experts by Experience (EBEs: service users and expert carers). Both EBQ and EBE trainers select, teach, and evaluate UK trainee clinical psychologists' clinical and research skills. Involvement of both types of trainers has the purpose of enhancing trainees' learning that is perceived to be beneficial by both staff and service users (Sheldon & Harding, 2010). EBQ involvement in clinical psychology training has historically been the standard with the expectation that this will effectively train clinical psychologists to support their clinical, academic and research training. However, led by changes in policy (Department of Health, DOH, 1999, 2000, 2001), over the past two decades there has been significant momentum to additionally incorporate EBE involvement in the training of healthcare professionals. This is now a mandatory requirement for all Health Care Professions Council (HCPC) approved training courses, including clinical psychology. This change occurred through shifts in dominant narratives, moving away from the medical model towards more consumer led movements (Chambers & Hickey, 2012). The British Psychological Society, (2020) also documents the value of lived experience within clinical psychology training specifically.

5.1.1. Experts by Qualification (EBQ) and Trainee Clinical Psychologists

Trainee clinical psychologists have been shown to develop their professional identities through the performance of their roles and through interacting and working with EBQs (Ashby et al., 2016). EBQs and trainee clinical psychologists have personal and professional identities (Higson & Allan, 2019) which can be integrated or unintegrated (Richards et al., 2016). There is no formal expectation for trainee clinical psychologists to bring their personal lived experiences to their professional roles, although, some EBQs with lived experience of mental/health conditions actively choose to integrate this into their work (Richards et al., 2016; Adame, 2011; Fox, 2016; Simpson et al., 2018; Newcomb et al., 2017; Wilson et al., 2018).

Fox, (2016) who is a social work academic and service user, talks about their identity spanning both professional and lived experience and how this is a balancing act requiring negotiation, alluding to the challenges and barriers that arise through navigating these two identities simultaneously. A recent guidance document by the Division of Clinical Psychology (BPS, 2020) shows its support and value of lived experience within the profession and training of clinical psychologists. This movement to integrate lived experience in the field is likely to shift the visibility of lived experience in clinical psychology training going forward, thereby impacting the types of identities found in the profession, warranting further exploration.

5.1.2. Experts by Experience (EBEs) (Service Users and Carers)

EBE involvement supports the service user and carer perspective of lived experience of disability and of healthcare services. EBE involvement enables trainee clinical psychologists to be more person centred (BPS, 2010), positively enhances their learning and clinical skills (Sheldon & Harding, 2010; Clarke & Holttum, 2013; Schreur et al., 2015) improves communication skills and empathy (Repper & Breeze, 2007), and promotes critical approaches to thinking (Harper et al., 2003). The process of EBE involvement in clinical psychology is shown to empower EBEs and positively impact both recovery and identity (Emery, 2015; Hill, 2021). This is supported by research on EBEs in other professional domains such as participatory action research and disability activism (Hutchinson & Lovell, 2013; Toikko, 2016; Jones & Pietilä, 2020; Cameron et al., 2019). Research suggests that adopting an EBE role encourages professional and politicised identities, moving EBEs further away from their stigmatised service user identities (Hutchinson & Lovell, 2013; Toikko, 2016; Jones & Pietilä, 2020). There are, however, challenges relating to undertaking EBE roles. For example, some EBEs have been accused of being too professionalised, and their authenticity as patients has been questioned (Andreassen et al., 2014). The EBE role sometimes prevents individuals from disclosing or seeking support for their health difficulties due to the perceived expectations of what it means to be an EBE. For example, if the role is premised on the EBE being in recovery, they are able to effectively reflect on past lived experiences rather than draw on their current experiences in these roles (Wilson et al., 2018; de Ruysscher et al., 2019; Toikko, 2016), potentially impacting the diversity and types of people found within EBE groups.

5.1.3. Theoretical basis of identity

The extant theoretical basis of identity suggests the groups to which individuals belong lead them to see more similarities with their in-group and more differences with others, establishing the boundaries between one identity and another (Tajfel & Turner, 1979). Roles that individuals occupy and perform in a structured society are also formative to identity. These identities are reinforced through interactions and relationships with others that operate in a way that is consistent with the meanings attributed to the roles they perform (Stryker, 1980), such as EBE, trainee, carer and EBQ. Further details on these theories relating to identity are discussed in Chapter 3.

Tse et al., (2012) suggest that service user involvement is likely to lead to changes in social identity. Changes in identity are also likely to affect carers (Hughes et al., 2013; Andrasson et al., 2017). Healthcare professionals have been shown to have both professional and service user identities (Moorhead, 2019; Richards et al., 2016; Adame, 2011; Newcomb et al., 2017; Wilson et al., 2018; Simpson et al., 2018; de Ruysscher et al., 2019). This includes trainee clinical psychologists' identities spanning learner and practitioner (Woodward, 2014) and identities of clinical psychologists spanning practitioner and researcher identities (Garfield, 1966). Ashforth & Mael, (1989) identify how organisational identification in organisations that are made up of multiple identities occurs through factors such as the prestige, status, and the distinctiveness of a social identity. Individuals can be seen to work towards maintaining their social identity and engage in behaviours that reinforce this. This may also be seen in the context of clinical psychology training.

The systematic narrative review in Chapter 4 found that identities of lived experience researchers or providers, including the role of EBE and mental health professionals with lived experience, consisted of professional, service user, integrated, unintegrated and liminal identities. These positions of identity were influenced by themes of the EMERGES framework: Empowerment, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion. and Survivor roots. However, the studies included had methodological flaws, bias, and lack of diversity. There was a paucity of research on carers and only one study in the review was from the domain of clinical psychology training. This suggested a need to extend research in this field and further explore these areas. This therefore provided the rationale to understand the collective group identity of clinical psychology training as a profession, which was novel in its application of the social identity approach.

5.1.4. Labels as constructions of identities in clinical psychology

Labels carry meanings, with the power to impart and reduce privilege, power, and stigma (McLaughlin, 2009). This is seen through the effect of diagnostic mental health categories (Martinez et al., 2011). Labels are also responsible for how patients are treated (Dobransky, 2011). Some have highlighted the negative impact labels can have on those in the mental health sector, encouraging a motivation to reconstruct psychiatric labels that are less harmful (Ben-Zeev et al., 2010). Re-examining the labels used to describe groups in clinical psychology training is necessary to better understand the meanings and responses labels elicit and enable identification of labels that do less harm to individuals that work in this context.

Labels used to describe those who work from a lived experience perspective within clinical psychology training usually span, but are not limited to, service user representative, expert by experience, and patient representative. Certain labels are thought to help restore the power imbalance between EBE and EBQ and destigmatise the perception of the EBE roles, that historically has been unequal and oppressive towards the EBE. Reframing the service user as an EBE, as someone who is an expert in their lived experience and of services has the potential to shift the power so that EBEs are viewed as people to learn from (Fox, 2011).

The involvement of carers within EBE groups is another important identity and group to explore. The label of "Carer" gained legal status in 1995 as part of the Carers Act (Bytheway & Johnson, 1998) supporting carers to have greater rights and for others to understand their role in relation to both the people they support and to service providers. Carers' expertise gives them insight into the experience of caring for someone with a mental illness. They hold valuable knowledge that can support trainee clinical psychologists, and other healthcare professionals to better understand the difficulties that individuals with mental/health problems face (McIntosh, 2018) and offer unique insights into their health that may not otherwise be observed. Carers are referred to in their roles as unpaid carers, informal carers, or EBEs that may be formative to their identity and the power and respect they are given.

5.1.5. Moving away from Empiricism towards Social Constructionism

The idea of empiricism is essentialist in nature, suggesting that there is an observable and objective truth that can be empirically measured. This sits in contrast and direct conflict with the social constructionist approach of inquiry, that posits that there is no real world, and this cannot directly be observed (Burr, 2003). Our perception of truth is based on the social and cultural world that has been created, on which we base our understanding. The symbolic nature of language, that when deciphered through this analysis can reveal our social constructions and the meaning of the realities in which we exist (Shotter, 1993). For example, the pre-existing rhetoric and discourse related to class, ethnicity, gender, and dominant psychological perspectives within the field of clinical psychology may influence identity constructions within and between groups in clinical psychology. Everyone's experience or the sense and meaning they attribute to a certain reality is unique and rooted in their unique experiences (Abes et al., 2007) which might apply to groups in clinical psychology training that led them to be a part of this profession. The social constructionist approach suggests there are multiple realities, and these different realities and experiences compete for legitimacy through the interactions we have with others (Fairhurst & Grant, 2010). Focus group methodology enables participants to interact with one another and the researcher, and this dynamic may have influenced the way knowledge is constructed. A social constructionist approach to analysing the research is useful and justified in the pursuit of how knowledge of identity is constructed, and a critical realist ontology was applied to understand what perceptions of reality this knowledge of identity construction derived from.

5.1.6. Research aims and questions

The primary aim of this study was to understand identities within UK clinical psychology training, to explore how identities are socially constructed by groups in clinical psychology training of EBEs (service users and carers), trainee clinical psychologists and EBQs (research staff and clinical psychologists). To achieve this, participants were asked to self-define into the social group they belonged to within clinical psychology training. Focus group methodology was used to discern the influence of labels, social identities, and roles on identity. The aim was to understand the identity constructions and relationships between EBEs, carers, trainees and EBQs within clinical psychology training.

Cooke et al., (2015) suggest that service users and carers are qualitatively different, so within this study they were studied in separate focus groups. The study sought to explain whether groups in clinical psychology training constructed their identities similarly or differently. It aimed to provide recommendations for how these different groups are labelled, give greater clarity to these identities, and offer an understanding of the purpose of these different roles and whether labels used to describe them reinforce the meanings of their roles. It also aimed to provide insight to support these groups to work together more effectively as separate groups in clinical psychology training, in addition to working more effectively under the wider umbrella of the organisational identity of clinical psychology training.

5.2. Methodology

5.2.1. Design

Four focus groups were carried out to explore the identity of EBEs (Service users), Carers, EBQs (Clinical/Academic Psychologists and Research Psychologists) and trainee clinical psychologists. These groups were mutually exclusive based on how the participants self-defined in relation to their roles in clinical psychology training in the UK. The different focus groups artificially created a space specific to each social identity. Each focus group lasted approximately 90 minutes.

5.2.2. Inclusion/Exclusion criteria

Participants had to self-define as EBEs (service users), EBEs (Carers), Trainee Clinical Psychologists or EBQs (research staff or clinical psychologists) within clinical psychology training. They were not limited by gender, ethnicity, sexuality, or disability but were required to be 18 years or older. It was acknowledged that some individuals may hold multiple identities, such as a trainee being an EBE and a clinical psychologist being a Carer, but the participants' eligibility for joining a focus group was primarily based on their role within clinical psychology training. Where there were dual identities such as an EBE also being a Carer, they were given the choice to choose which focus group they would like to participate in, based on the identity that was most salient to them at the time.

5.2.3. Recruitment and sampling

Purposive sampling was used to identify participants who met the inclusion criteria. Participants were recruited through advertisements on Twitter and emails sent to all UK Doctorate Clinical Psychology programme directors and course specific email addresses. Recruitment advertisements were also sent via an email to the BPS's Group of Trainers in Clinical Psychology (GTiCP) network. GTiCP is a network of Doctorate in Clinical Psychology training programmes within the BPS which includes a sub-group of all service users, carers, and staff that work on clinical psychology courses. The PhD researcher and some of the supervisory team were members of the group and were given permission to advertise the research through this network.

5.2.4. Ethical considerations

Ethical approval was granted by University of Liverpool's ethics committee (REF ID 5417). Participants who responded to advertisements and wished to participate in the study were given an information sheet as part of the process to gain informed consent. Eligibility to participate based on inclusion/exclusion criteria was checked prior to participation. Consent for the focus groups to be audio-recorded was also obtained. Participants were debriefed on completion of the study. The data provided were kept confidential and identities pseudo-anonymised. Participants could withdraw their data from the research up to the point of anonymisation. All participants were offered the choice of receiving a £20 gift voucher. Travel expenses were also reimbursed.

5.2.5. Positionality and Reflexivity

The research reported in this chapter has been led and developed by an EBE, who is the PhD researcher, based on her own experiences of changes in identity through EBE involvement in UK Clinical Psychology training. The research team see this as a strength but are aware of the bias and subjectivity this positionality may have on the research and so themes were discussed with the wider research team, who have expertise regarding the research target groups, including research psychologists, clinical psychologists and other EBEs, all with their own lived experiences. Seeking views from across each team member including EBEs and EBQs was important in reliably interpreting the data from participants. It is also acknowledged perspectives across the team differed based on the different roles inhabited. These discussions supported in identifying nuances in identity constructions across the different groups considered. These different perspectives and conversations contributed to the coding of the data. The findings were additionally discussed with key stakeholders, supporting the validity of the findings. Further details of the PhD researcher's positionality are detailed in Chapter 1 and reflections on the focus groups detailed in Chapter 8, including the Service user advisor's (AB) experiences as an Expert by Experience. These steps to reflect on the researchers' positionality and discussions as a team helped interpret the data and supported in establishing its trustworthiness.

5.2.6. Focus groups and interviewing

Focus groups involve discussion with a small group of people on a specified topic that is moderated by the researcher (Blee & Taylor, 2002). The groups are effective methods that generate production of data on a specified question such as exploring the nature of identity (Munday, 2006). Focus groups have been shown to enable observations of "interaction, negotiation and affirmation" of social identities (Munday, 2006). On occasions it has been found that members of focus groups strive and work towards developing a social identity and offer discourse and behaviour that maintains this group identity (Gamson, 1992). This means it is important to understand the content of the focus groups, but also to reflect on the process by which identity constructions occur. Reflections on the focus groups can be found in Chapter 8. Touraine, (1981) believed that working with strangers in a focus group would come to recreate and mirror the wider social movement they belong to.

The focus groups in this study were either held in person at the University of Liverpool, where a room was sourced, appropriate for the needs of the participants or held via Zoom conferencing services remotely, due to COVID-19 restrictions. The groups were recorded through an audio recording device, transcribed via transcription services, and analysed using NVIVO qualitative software. Notes were also taken by a team member in each focus group (CE, BS). The PhD researcher was the interviewer for each focus group and followed a semi-structured interview schedule to guide the discussion to ensure the focus groups were run in the same way (see Appendix A). The interview schedule was created and tested with key stakeholders including EBEs, Carers, Trainee Clinical Psychologists and EBQs prior to use in the study. The researcher established ground rules with the focus group members and stated expectations of what participants could expect from the researcher and what was expected of them. The researcher also ensured that the participants were aware the focus groups were confidential spaces and to be respectful towards others during the discussions. To notice discussion points within the focus groups, prompts were used to allow individuals to elaborate on their points. The discussion started off broad with warm up questions, an exercise to reflect on their identities, prior to exploring the main questions of interest within the focus groups.

5.2.7. Thematic analysis

A social constructionist approach with critical realist ontology was taken and the results were retrospectively interpreted deductively through the EMERGES framework found in Chapter 4, and the theoretical basis of identity, Chapter 3. A thematic analysis was used to analyse the data, which is not bound by an epistemology and so can be effectively applied to research being conducted from a social constructionist and critical realist lens. It can also be used for multiple data sets (Braun & Clarke, 2006) which is relevant to the four different focus group datasets. Thematic analysis was used over grounded theory and interpretive phenomenological approaches in order to compare multiple different groups, sample sizes and data sets and can effectively be applied to focus group data. It is also a systematic approach to the analysis which occurs in a rigorous way to ascertain how identities across these groups are constructed.

A thematic analysis allowed the active generation of themes from the qualitative data in the focus group transcripts. Thematic analysis can be rigorously conducted from a position that the researcher is actively engaging with the data and generating themes through interaction with and analysis of the research and their own knowledge bases (Braun et al., 2016). The stages of the thematic analysis are as follows: familiarisation with the data through reading and listening to the data, coding meaningful segments of the data in line with the research question, generating themes, reviewing themes, and labelling and defining themes as a research team. Braun & Clarke, (2006) thematic analysis protocol guided the structure and order of the thematic analysis, but it is widely accepted that the process between each stage in the protocol is iterative and required going back and forth and revisiting stages within the analysis.

Familiarisation

The researcher first familiarised themselves with the data from the focus groups by reading and re-reading the transcripts as well as listening to the audio recordings of the focus groups. Reflections on the focus groups further supported the researcher to immerse themselves in the data, familiarise themselves with it and reflect on the impact of them as a researcher on the process, which can be found in chapter 8.

Coding

The researcher began to code the data through applying the social constructionist lens where the language and discourse was coded in meaningful segments in relation to ideas relating to identity. The codes were detailed and accounted for interaction and language used that communicated how identity was socially constructed. Each transcript of the different focus groups was coded separately. The supervisory team also saw these codes and discussed them to ensure a level of agreement across coders and the validity of these codes.

Generating themes

The codes were then actively generated into themes that accounted for the different areas of coding, based on the research question and method of analysis. Braun & Clarke, (2006) suggest that the researcher actively engages with and rigorously assesses the data to effectively generate themes that reliably reflect the meaning in the data.

Reviewing themes

The codes were then re-evaluated before being labelled as themes explaining the identities of those in clinical psychology training groups. The codes from each focus group, Expert by Experience, Carer, Trainee Clinical Psychologist, and Experts by Qualification were compared and overarching themes explaining social constructions of identity across these groups were generated, including areas that were similar or different.

Labelling and defining the themes

The themes were then labelled and defined based on how they represented the social construction of identity of groups in clinical psychology training. The themes were reviewed by the supervisory team, including experts within clinical psychology training, EBEs and EBQs, to ensure the themes identified reliably reflected the meaning and knowledge constructed within the data. The multidisciplinary supervisory and advisory team helped review, label, and define the themes together. The trustworthiness of the data and themes identified were established through seeking feedback from other EBEs and EBQs, external to the team, to see whether the themes resonated with them. BS also analysed one of the four datasets (trainee) and this analysis was compared to analysis by VG across the other datasets to establish consensus. The themes identified were similar to the overall thematic analysis across each dataset suggesting the trustworthiness of the analysis and themes identified by VG and BS, independent researchers.

Judgement about data saturation in qualitative research is dependent on the expert status of the participants, the richness and quality of the data and the researcher’s own knowledge base and understanding of the field they are exploring. There is no ideal sample size, but the participants and research team were experts in their respective roles and their insight was considered to adequately capture and answer the research questions. The quality of the data from the focus groups was rich in detail and offered a good understanding of the perceived identity constructions of these groups, although is limited to the context of UK clinical psychology at a point in time.

5.3. Results

5.3.1. Participants

A total of 25 participants took part across the four focus groups. Of the 25, eight trainee clinical psychologists, six EBEs, seven carers and four EBQs (two Clinical Psychologists and two Research Psychologists) made up the total sample. The participants were from nine English clinical psychology programmes. There was no formal expectation for participants to have lived experience of mental or physical disability, so these data were not collected. The demographics and breakdown of ethnicity, gender and age are generally representative of the demographics in clinical psychology currently, see Table 5.1. 1 participant removed their consent to their data being used, so their data have been removed and they have been excluded from the sample, and 2 participants asked for some of their data provided to be removed.

Table 5.1: Sample Characteristics

Focus group	Sample: N = 25	Gender 17 Female 9 Male	Age 28-75 years	Ethnicity	Context
Trainee Psychologist	N=8	7 Female 1 Male	28-36 years	White, White Other, Mixed race (White and Caribbean)	In person
Expert by Experience	N=6	2 Female 4 Male	35-65 years 1 participant did not disclose	White, British Cypriot	Online
Expert Carer	N=7	5 Female 2 Male	56-75 years	White and White other	Online
Expert by Qualification	N=4	2 Female 2 Male	37- 62 years	White, Latinx/Hispanic	Online

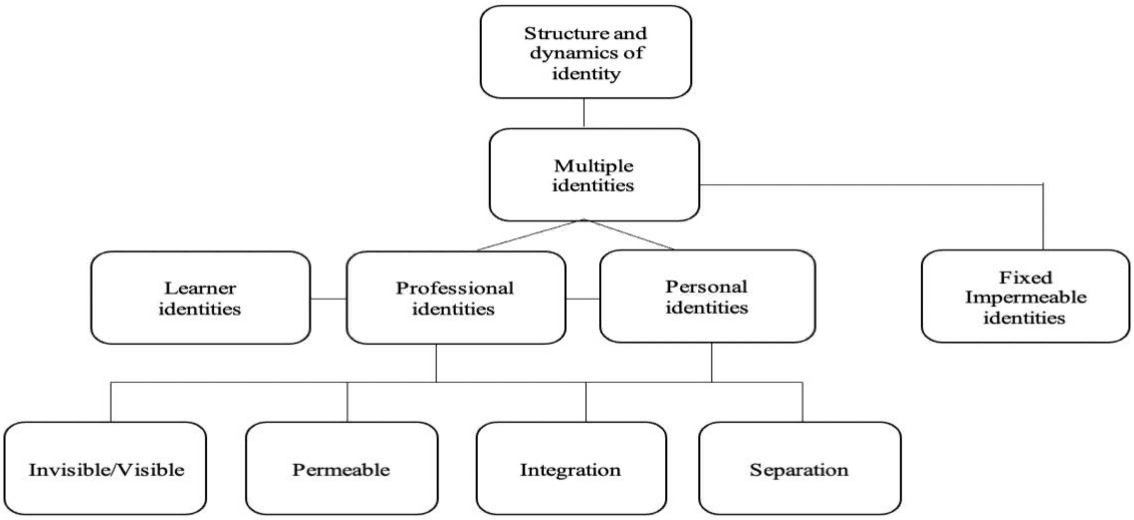
5.3.2. Results of thematic analysis

Four overarching themes were found that were common across groups. The first theme was the structure and dynamics of identity that found multiple identities, which could be split into personal and professional identities that were 'integrated', 'separated', 'permeable' and 'visible or invisible'. The second overarching theme was the impact of language and labels that found that labels used to describe these groups led to 'expectations of a label' and were burdensome, as described by 'the weight of the label' with motivations of 'rebalancing the power' between these groups. The third overarching theme was constructions of the learner and expert, suggesting that each group could be a learner or expert at different times regarding performance of their roles, and their ability to integrate lived experience and engage in coproduction work. The fourth overarching theme was that of fixed impermeable identities that essentially measured social identities described by themes of 'Feeling similar with common goals,' 'Feeling the same but different,' 'Feeling different to others,' 'Barriers between groups,' and 'Connecting groups,' that identified a need to connect and reduce 'them and us' divisions. A summary is provided in Table 5.2. Figure 5.1, provides a visual representation of the structure and dynamics of identity found.

Table 5.2: Overarching and subordinate themes

	Overarching themes	**Sub- Themes**	**Trainee**	**EBE**	**Carer**	**EBQ**
	Dynamics of Identity.	Multiple Identities	x	x	x	x
1.	The shape, structure, permeability and distinction of identity is differently constructed through the interactions and competing narratives.	Separation	x		x	x
		Integration	x	x	x	x
		Permeable	x	x	x	x
		Invisible/Visible	x	x	x	x
2.	**The impact of language and labels to rebalance power**	The expectations of a label	x	x	x	x
	The meanings and power attributed to labels and their effects on identity constructions.	The weight of a label	x	x	x	X
		Rebalancing the power	x	x	x	
3.	**Constructing the Learner and the Expert.**	Constructing the learner	x	x		x
		Constructing the expert		x	x	x
4.	**Fixed Impermeable identities**	Feeling similar with common goals	x	x	x	x
	A deductively coded theme relating to social identity in clinical psychology training	Feeling the same but different		x		
		Feeling different to others	x	x	x	
		Barriers between groups	x	x	x	x
		Connecting groups		x	x	

Figure 5.1. The structure and dynamics of identity



5.3.2.1. Overarching Theme 1: The structure and dynamics of identity

This overarching theme describes how identity is similarly and differently constructed with competing narratives within and between each social identity in clinical psychology training. There appears to be a fluidity to the structure and dynamics of identity and how professional and personal identities sometimes permeate each other, are actively separated, or integrated, depending on the motivations of the individual to hide or reveal lived experiences based on context and triggers.

Sub theme 1: Multiple Identities *"a strange mix of personal and professional and caring."*
This sub theme describes the multiple personal and professional social groups and roles the participants belonged to. Most of these identities were a result of personal or professional ties. Identification with different identities was triggered by emotional connections, different contexts, and time points. This was consistent across each participant group.

An Expert Carer, speaks of three distinct identities she belongs to, being a service user, carer and recovery worker, that also summarises the multiple components that make up her identity as a Carer. *"a strange mix of personal and professional and caring."* Carer, Rosetta.

A Trainee, also comes to the realisation of the multiple identities he belongs to "*I've got so many different identities… so you've got, obviously, trainee, student, researcher... they'll all be very important to me… it just made me realise how many different identities."* Trainee, Jack.

An EBQ also similarly identifies the personal and professional identities he belongs to as being different but important elements to him *"…we do have multiple parts of yourself…I have an identity as a psychologist that I live and that's different to me at home and that's different to me with my friends and that's different to me playing football and different to me who likes music. It's another element…"* EBQ, Simon.

An EBE, identifies how he also belongs to multiple groups but feels emotionally connected to the group he is working with at the time, suggesting context is important to the saliency of an identity. *"These sort of groups I pick and choose…I don't have affinity for any of them…, but if I'm involved in some work, then I'm emotionally linked with it."* EBE, Phil.

Sub theme 2: Separation *"I'm determined for those identities to stay separate"*

This sub theme describes EBQ, carer and trainee participants' need for separation between their personal and professional roles. This separation between their personal lives and professional lives performed a function to reduce the burden of lived experience and its impact on the individual. The general constructs of professional experiences and lived experiences were also thought to be distinct and perceived as though they cannot coexist.

An Expert Carer highlights how the Carer's experiences and identity are sometimes consumed by healthcare issues and how there is a need to escape the burden of this at times. "*…sometimes...everything's around service provision... rather than getting drip fed what was going on with health and social care..., sometimes carers just need that escapism to do something different."* Carer, Anthony.

A Trainee, spoke about maintaining a separation between her clinical work and the skills she learns and applies in that role as distinct and separate to how she wants to act in her personal life. *"I understand why reflective practice is really important...when you're working clinically, but I don't want to be reflective in my personal life...I want to be reflective in my professional role, when I come home…I'm a sister, daughter, partner…, I'm determined for those identities to stay separate..."* Trainee, Serena.

An EBQ, discussed how some engaged in coproduction work believed that lived experiences and professional experiences were often considered as distinct to one another and Sharon felt forced out of the lived experience conversation as a professional with lived experience. *"…they are social constructs that tend to be thought of as mutually exclusive. I mean they're not in reality...I do remember... someone was coming to train us about how to do service user involvement and he was making a virtue of... this isn't about professionals and… I felt like that professional bit of me was being pushed out of the room"* EBQs, Sharon.

Sub theme 3: Integration *"I'm almost wanting to bring those two senses of self together"*

Trainee participants described wanting to integrate their lived experiences into their roles but did not have the expertise to do this, whereas EBE participants described being able to do this more confidently by integrating models they personally identified with. Integration of lived experience by the EBQ participants performed a function in reducing their expert status and enabling others to connect with them.

A Trainee speaks of how she wanted to integrate both her lived experiences and professional experiences in her role within clinical psychology training, which was different to her earlier motivations which were to separate them. However, as she has grown in her role as a trainee, she wants to be a more authentic version of herself and maintain an integrated identity. *"…I'm almost wanting to bring those two senses of self together … much earlier on in my route into training…I wanted to push them separately... Whereas now I'm... keen to bring those two things together...and feel like a more coherent… version of me..."* Trainee, Ruth.

An EBE, speaks of how she seeks to integrate models she personally identifies with and embed them into the teaching she does as an EBE to help inform the training of clinical psychologists. *"I do quite a lot of teaching in…universities… working with people in crisis… coming from a very much trauma informed... what you can do is try and embed aspects of that in…, people's day to day working." EBE, Zara.*

Similarly, another EBE, identifies how the process of EBE work integrates lived experience into research and training. "*Firstly, a fundamental belief in service user involvement and how it can really channel people's experiences into the research.*" EBE, Michael.

An EBQ, suggests that speaking about her own personal experiences reduces her expert status and better connects her to the people she works with such as EBEs. *"I felt like because of my expert status they were like… here she comes telling us what to do… I had to really express where I come from more and more... so…they don't see me as the professional." EBQ,* Maria.

Sub theme 4: Permeable "*I don't think you can necessarily untangle the two identities*"

The sub theme of permeable identities represents the seeping of the professional role into personal life and vice versa. This was described by trainees and EBQ participants similarly. Carer participants spoke of how their own personal identities tied them to those they supported.

A Trainee, spoke of the HCPC regulations in her role as a trainee clinical psychologist and how there was an expectation to abide by the professional code of conduct in her role, but that this was also extended to how trainee clinical psychologists must conduct themselves in their personal lives. "*…...when you're in that profession there's a sense of responsibility... that doesn't just finish when you finish your day… you are expected to uphold the professional values in your personal life...*" Trainee, Ruth.

Another Trainee, who is both a trainee clinical psychologist and is someone with lived experiences who speaks about this often in her role and also outside of her role describes how her lived experience and professional experiences are perceived as inseparable to her and others who know her. "*... I think it depends on who sees me...I don't think you can necessarily untangle the two identities*." Trainee, Mary.

In a comparable way, an Expert Carer, speaks of how the Carer role and the health outcomes of those they support, are inextricably linked. "*… it's always the way that if the carer goes down, the person they care for is always down, so that's two people in hospital.*" Carer, Jane.

Additionally, EBQ, describes how he sometimes can't help but apply his clinical skills in his personal life, and that this was something he did not want to do, but highlights how the clinical psychologist identity can infiltrate his personal life. "*I find that… in some ways harder...trying to stop the work going in to my personal and not become a therapist for my friends..."* EBQ, Simon.

Sub theme 5: Invisible/Visible "*…sometimes our voices are just not heard and sometimes… we're going to be stepping on… people's toes… Because we need to be heard… the professors and the doctors can't admit to being a service user...*"

This sub-theme describes the invisibility and visibility of lived experience within clinical psychology training. Trainee participants described a need to share their lived experience but felt that clinical psychology spaces did not feel safe or accepting of this. The EBE participants talked about how the purpose of their roles was to work towards increasing visibility. In contrast, the carer group felt they were not visible, and they and others did not recognise their needs.

A Trainee identifies how the trainee clinical psychologist identity occludes the visibility of lived experience in their profession, which is often overlooked. *"I wouldn't describe myself as an expert by experience but... we had some trauma teaching, and it was quite distressing... but there wasn't any warning, there wasn't anything about looking after yourself in the lecture… the lecturer had almost come in on the assumption... this isn't going to affect any of you...*" Trainee, Jess.

An EBE, identifies how the EBE role is about being disruptive to the status quo and enabling lived experiences to be more visible and better heard because EBQs' lived experiences cannot be completely visible. "*...sometimes our voices are just not heard and sometimes... we're going to be stepping on... people's toes... Because we need to be heard... the professors and the doctors can't admit to being a service user...*" EBE, Denise. This suggests a real difference between the extent to which lived experience can be visible in the different EBE and EBQ roles.

An Expert Carer, Miriam, identifies how the Carer's needs are often seen as secondary to service provider priorities, but also secondary to their own priorities meaning their needs are not recognised by themselves or the people they support or work with. *"... one's own needs can get so suppressed that they're not being recognised, even by the individuals themselves."*

5.3.2.2. Overarching theme 2: The impact of language and labels to rebalance power

"In effect, any label, it's how it's used...so you can throw whatever label or term at me."

This overarching theme is about how labels used to describe groups in clinical psychology training acted as stereotypes and resulted in expectations of the labels, ascribing meanings through which they were understood. The theme also identifies how these labels had an impact on power dynamics between these groups. The theme also identified how the use of carefully chosen labels could rebalance the power between groups in clinical psychology training. There was a common thread that labels had an impact, put pressure on them and could result in emotional burden.

Sub theme 1: The expectations of a label *"…it's sometimes the messages, because I'm really conscious that I'm, white, posh, female..."*

This sub-theme captures the different perspectives of trainee clinical psychologist participants and EBE participants regarding the labels used to describe them. It describes how labels support in constructing identities through individuals being understood through stereotypes and expectations associated with these labels. It also describes the participants' feelings of validation or invalidation as a consequence of labels that are not meaningful when they do not capture who they are. Belonging to racial minorities, regional and class identities were discussed across trainees and how they felt they did not fit into the typical clinical psychologist identity.

Trainee clinical psychologist participants explored the stereotypes through which they are perceived and how this did not fit with how they viewed themselves.

A Trainee constructs a professional identity as someone who does not have a regional accent like her own. This means she does not feel like a typical trainee clinical psychologist. *"...I put trainee Clinical Psychologist first...I also put Scouser... And I sometimes... feel like they clash.... I think people have an idea of what a professional person is, and it's not necessarily someone with an accent."*- Trainee, Sophie.

Another Trainee also identifies how others do not construct a clinical psychologist to be mixed race and how she defies this expectation, but that the label and expectations can be invalidating to those who they do not represent. *"...I've had service users go, oh is it you that I'm seeing, I didn't think you'd look like that..., people often don't expect...a mixed-race young woman to turn up."* – Trainee, Jess.

Trainee Mary describes the stereotypes of the trainee clinical psychologist and how in some ways she fits with the typical and in some ways she does not, meaning the label does not capture who she is as a whole *"...it's sometimes the messages, because I'm really conscious that I'm, white, posh, female... But also... despite my best... plans... being late, things like this...but you often hear that you're the perfectionist, you're this, you're the that, which is completely not me at all...*"

EBEs in the focus groups spoke of how labels are often chosen by EBQs for them and feel labels can be damaging and do a disservice to those who occupy these labels that are not meaningful descriptors of their roles. They concurrently agreed that the EBE label was the best option they had but that it was still not adequate in conveying the complexity of their roles.

EBE Phil identifies how often labels are chosen for EBEs without thinking of the impact they have on those in these roles. Phil now feels that language and labels used to describe him are irrelevant to him in his role and he is resistant to being labelled by others with power.

"Language and labels have changed over the years. I started my journey through physical trauma...where you were labelled with whatever those outside were comfortable with, they didn't care how it affected the individual… I grew up with words like cripple... In effect any label, it's how it's used...So, service user, expert, it doesn't matter, I'm there to do a job at the university and help them create clinicians who do a cracking job, so you can throw whatever label or term at me, it won't affect me..."

Concurrently within the Carer focus group, each member rejected the label of Carer due to the stigmatised meanings associated with it, as it was not a meaningful descriptor of the complexity of their role. It was a clinical label being forced on them that they did not identify with that detracted from their personal connection to their loved ones they supported. Discussion of labels such as 'informal carer' and 'unpaid carer' were also rejected as they detracted from their expertise, and was another way for professionals to force labels that were invalidating onto them.

Sub theme 2: The weight of a label "*…the word expert feels a bit pressured...*"

This sub-theme described how language and labels used to describe groups in clinical psychology training had an impact, putting pressure on the Expert Carer or EBE, or an emotional burden that the label attributed due to stigma and the power it exerted on the individual.

An Expert Carer speaks of the burden the Carer label had on her, that replaced her personal identity of being a Mum with a more impersonable and clinical term, reframing her relationship towards her loved one. *"At the beginning being a Carer hit me like a tonne of bricks…I was a mum and the next thing I have this crisis worker... said I'm the carer. There was no warning... It was like someone had taken my role…as mum, put it in the bin and given me a new title..."* Expert Carer, Joy.

Another Expert Carer speaks of the stereotypes of the Carer label and the negative impact it has on all Carers. *"Sometimes you hear stories of carers being abusive and that is straight away coming on to every carer that come in that category." - Expert Carer, Anthony.*

An EBQ observes the effect of being described as an expert by qualification, reflecting on the expert label and how it can put pressure on the individual described in such a way. *"When I* *heard the title Experts by Qualification... the word expert feels a bit pressured and actually… I think of Experts by Experience all the time and I've never thought that could… put a lot of pressure on someone..." EBQ, Simon.*

Subtheme 3: Rebalancing the power *"...those structures give you power and authority... so it's how to rebalance that."*

This sub-theme identified the motivation of rebalancing power between EBE, carers, trainees and EBQ participants which was commonly spoken about across each focus group. Trainee participants felt a need to reduce their power. Carer participants wanted to increase their power as they felt disempowered by the labels used to describe them. EBE participants wanted to be equal to EBQs and to actively reduce the power of the EBQ to rebalance these power dynamics between them. The sub-theme identifies how language and labels can impact and address these power differences.

A Trainee identifies how the title of Doctor influences the power dynamics between the patient and the clinical psychologist, and the professional has the power to rebalance that power through asking others to refer to them by their name, as opposed to the title of doctor. *"there's a bit of a debate… when you get Doctorate…do you come in and say, "I'm Dr so and so," or…, "Just call me (name)? And obviously coming from that standpoint of, we are all equal… I guess... those structures give you power...So it's how to rebalance that."* – Trainee, Freya.

An EBQ, identifies how when referring to groups in clinical psychology training as experts in their respective areas not only has the impact of rebalancing power, but also that they are perceived as experts in their field. *"…it kind of puts us all as an expert, but it also puts us in to a domain, so we're not just experts...there are other types of experts..." EBQ, Sharon.*

Conversely, an Expert Carer, suggests how the word Carer is loaded with stigma and how alternative terms may support and enhance their power and value in society. *"...we need to come up with a new word. That word Carer...it's so undervalued…It's got so many negative connotations, like we are propping up members of society, but no one gives us value."* - Expert Carer, Miriam.

5.3.2.3. Overarching theme 3: Learner and Expert identities *"There are other experts at the table...we've all got expert parts and learning parts."*

This overarching theme identified how each group in clinical psychology training were constructed as both learner and expert in opposition to other groups. Trainee participants focussed on their own inexperienced identities through comparing themselves to EBQs, who they constructed as experts, consequently constructing themselves as learners. EBEs and Carers constructed learner identities of other trainee clinical psychologists due to their inability to critique their own profession. EBEs and Expert carer participants described other EBEs, Expert carers, EBQs and trainees as both learner and experts in relation to the ability to engage in lived experience work.

Sub theme 1: Constructing the Learner

This sub theme constructs the learner identity of trainee clinical psychologists and EBQs as people who are uncritical towards lived experience work, or towards the trends in their own profession and how they can be defensive of the profession of clinical psychology. EBEs and Expert Carers construct the trainee to be a learner who sometimes takes things at face value without critical thought or alternative perspectives to inform their positional stance.

"*......their inability to critique their own professional knowledge, if somethings fashionable within their profession at that time, they can't step back.. and see why they…might want to challenge... I think particularly for people…early on in their career are really precious of that knowledge and really… defensive..."* EBE, Michael.

An Expert Carer, constructs the trainee clinical psychologist as a learner in the profession as they do not feel their reality is heard or understood by them, suggesting trainee clinical psychologists take things at face value, rather than understand the complexity of the service user they work with and their needs. *"Sometimes, they don't want to hear what you say because it's not what they would expect...they can't imagine that somebody is saying… they're taking medication when they're not and I find sometimes… trainees have… resistance to the reality"* Expert Carer, Miriam.

Sub theme 2: Constructing the Expert

This sub theme describes how expert identities are constructed in opposition to the learner identity. The trainee participants described feeling distant from an expert identity and many of them alluded to occupying a space in between learner and expert. The EBQ constructed expert identities of other EBQs as those that listen to and learn from the experiences of others that has the potential to help shape the identity of clinical psychology training going forward. The expert is also constructed as someone that is able to reduce their expert status in order to facilitate connections with and learn more from EBEs and trainees.

An Expert Carer constructs the Expert Carer as someone who can spot the needs of other Carers, new to their role, because they can see themselves in that person, as they have been through that journey of learning to become an expert themselves. "*...we could see... perhaps it's their first time being there… they're asking questions, but they're not quite asking the question that they want to ask... We know what it is we're looking…because we've been that person.* Expert Carer, Joy.

Another Expert Carer identifies how others construct those in caring roles as lacking expertise but identifies the complexity and expert knowledge it takes to be a Carer. *"That's a ridiculous term isn't it, informal carer. I'm thinking of myself as manager of the social care department who negotiates grants...There's nothing informal about that. You're being interviewed by a manager...and depending on the results... that negotiation is how much money and care your loved one is going to get."* Expert Carer, Louise.

A Trainee constructs her supervisor as an expert who she aspires to be like, through comparison with herself, who she constructs as a learner. "*…When I think about...my supervisor, she...can come up with all of these amazing suggestions...I know about that theory, and… this theory but why did I not connect them in the same way…?* Trainee, Serena.

An EBQ, constructs the expert as someone open to listening and learning, which comes through parking their expert status. *"I don't know I identify with the term expert…. as a therapist… I've got better as I've unlearned my expert defence. I listen more…The thing I learned as a trainee was…to intellectualise and go into expert mode. That's when you miss what they're saying to you*." EBQ, Simon.

In a similar way, another EBQ, constructs how EBQs can learn from trainees and EBEs and their expertise that can help inform clinical psychology training. David suggests the profession and its expertise will improve through the process of listening and learning to different views and perspectives. "*there's been a lot of furore….in the last...18 months around ethnicity, race, representation, whiteness and expertise and saying what… psychological approaches are vs. learning and listening...the generational comment is... important…people coming… on to training ...social media, increased communication, increased access to very different views. These are powerful forces and we're feeling the effects now. It's going to be good to be part of that...And not me as an expert guiding it but seeing how those forces shape it...*" EBQ, David.

5.3.2.4. Overarching theme 4: Fixed Impermeable identity

This overarching theme identifies different identities of EBEs, Carer, Trainee and EBQs as exclusive, where they feel more like their own group members and more different to others. There were ideas suggesting there were unique identities within the roles of EBE, trainee and EBQ, but that common goals and shared experiences encouraged and reinforced their identity. Carers felt more similarities with other members, whom they felt understood each other and their experiences. Each group felt barriers to connecting with other groups and some felt it important to maintain that separation and others a motivation to reduce Them & Us divisions and actively connect these groups.

Sub theme 1: Feeling similar to the group with common goals "*I feel most connected to people who move beyond an individual experience and turn it into a collective change*."

This sub theme describes how each member in the focus groups felt similar to other members in the group and had a shared motivation to support and share experiences with those in their group.

This is articulated by an Expert Carer, who wanted to advocate for other EBEs and Expert Carers to effect change in the context of clinical psychology training. "*I feel connected to most of the groups I'm involved in. I don't see that I'm any different, I'm taking a set of views of all the groups I work with to try and change things... going with the mind... this is for everybody's benefit.*" Expert Carer, Jane.

An EBE, feels similarly and suggests that she relates to other EBEs who are not motivated by their own self-interest but who want to make a difference for group members as a whole, "*I feel most connected to people who move beyond an individual experience and turn it into a collective change*." EBE, Zara.

A Trainee participant felt that sharing experiences and being mutually supportive was something that connected each trainee clinical psychologist.

"*Sharing ups and downs…everybody's quite open with what they're struggling with, and what they're perhaps doing a bit better at... a sense of everybody wanting the best for each other....*" Trainee, Ruth.

Sub theme 2: Feeling the same but different to the group "… ***if someone's promoting a sort of purely medical perspective, I find that quite difficult to connect with....*****"**

This sub theme described how those from the same social identity also differed in their perspectives and lived experiences, such as EBEs differing in the way they understand and conceptualise their disabilities. Trainees felt a need to fit into their cohort and identified they would have more in common with some trainees rather than all trainees. It was important to each member to find ways to connect better with each other.

An EBE speaks of how the work includes many people with lived experiences, with different perspectives, and discusses how he finds it difficult to connect with those who conceptualise the idea of mental health in a medicalised way. "*It can be quite political at times… if someone's promoting a sort of purely medical perspective, I find that quite difficult to connect with....*" EBE, Michael.

A Trainee, suggests the importance of finding commonality with others to better connect you with other members of the cohort that can are often diverse, "*...starting on the course... meeting 20 odd people… navigating friendship groups... who do you find something in common with... where do you fit in terms of your peer group?"* Trainee, Ruth.

Sub theme 3: Feeling different to others "*I've… morphed into kind of fitting in, not always feeling like I fit in.*"

This sub theme described how each group within clinical psychology training felt different to other groups when being asked to compare themselves to others. Trainee participants drew on comparisons to nursing students and how they felt different to them. An EBQ participant felt different to others in the field due to her own lived experiences as well as how being a researcher is perceived in the context of clinical psychology training. EBEs speak of how they felt their perspectives could be different to the Carer perspective.

A Trainee, describes feeling different to nursing students in healthcare settings when working clinically, "*…easier to identify as a trainee when I'm with other trainees… I feel really connected with my cohort...outside of that context I feel uncomfortable because...with nursing students…. people don't see what the difference is, yet I'm very aware I'm getting paid at band 6 and I'm not being asked to carry the same workload as a Nurse*." Trainee, Lisa.

An EBE, felt they had different motivations to Carers and negotiating these different perspectives was challenging for both EBEs, Carers and EBQs. "*...I think there can be a real tension there between what the service user link was...and what they think can be a lot more conservative... they're trying to keep that person safe, whereas that person's....in the opposite direction... and can be difficult to navigate.*" EBE, Michael.

An EBQ, highlights the divisions between clinical psychology trainers. Sharon describes her own self-stigma and the perceived stigma that comes from the clinical psychology profession regarding lived experience, that exacerbates feelings of difference and not feeling like she fits into the context of clinical psychology training.

"...ended up on a clinical psychology... as a tutor and at first feeling they're all pussy footing around me, is it because I'd said to occupational health about my mental health, but I don't think anyone else knew at that time. I thought it's because I'm a researcher, they're thinking… she's going to discover we're crap at stats...Over the years… I've… morphed into kind of fitting in, not always feeling like I fit in." EBQ, Sharon.

Sub theme 4: Barriers between groups "*they're never going to feel equal. They're not on the same payroll, they're not embedded into the structure on our course......there is an us/them divide still.*"

This sub theme described how there were barriers to meaningful lived experience work created by EBQs. This had the consequence of reducing the power EBEs and Expert Carers had due to tokenistic involvement. EBEs and Carers also felt excluded in decisions regarding their own healthcare and some EBEs were excluded from professional networks.

An EBE, suggests that as she grew in her expertise as an EBE and more critical of services, she speaks of how EBQs prevented her from engaging in lived experience work. "*I described myself as a... puppet, I used to be wheeled out whenever they wanted and then put back in... the minute I started understanding...what it meant to be an EBE and stopped giving them what they wanted... work dried up a bit...*" EBE, Zara.

An Expert Carer speaks of how EBQs are slow to implement outcomes based on lived experience contributions. She speaks of how psychological models such as trauma informed services, that have been spoken about for years, have still not been integrated into services. She feels frustrated at the lack of impact lived experience work has due to feedback not being listened to or implemented. "*What worries me is in our involvement...people are still thinking... we could have...a trauma informed care for this service... These are not new ideas… yet they're still not being introduced.*" Expert Carer, Louise.

EBE Zara, speaks of divisions between lived experience practitioners and mental health professionals with lived experience and alludes to a hierarchy in lived experience work. "…*We have a lived experience network… open to professions with lived experience but is closed to lived experience practitioners. We had to start our own external group because we were not seen as professional...*" EBE, Zara.

Expert Carers felt that they were excluded from being listened to and heard when training clinical psychologists but also outside of clinical psychology training and this exclusion extended to clinical settings that excluded them from being involved in supporting their loved ones.

"*…the c word gets in the way, confidentiality… they say they can't talk to families, and I always say to them, you can listen to the family, you don't have to give any information... And a lot of the time they hide behind...confidentiality...*" Expert Carer, Anthony.

Some EBE participants, in contrast, felt that the Carer perspective was favoured more than their own, and they felt instead that service users were excluded from decision making in their healthcare. "*... the service user…weren't necessarily at the forefront of the meetings, it was literally about the carer's perspective…where even the clinicians in the room, will listen to… partners rather than the person*." EBE, Zara.

There was also a consistent narrative between trainees that the level of connection between EBE involvement was limited and led by EBQs, through allocated teaching timetabled sessions, that disconnected trainees and EBEs. "*It doesn't feel like there's really open communication…it feels very much that it's led by when they're on the timetable, that's when they're available.*" Trainee, Mary.

EBQ participants highlight the barriers between EBEs that makes it more difficult for them to engage in lived experience work and be integrated as part of the team. *"…we've got a limited budget…there might be lots of projects… we want them to be engaged with, but there's only so many…we can fund...* b*ut they're never going to feel equal. They're not on the same payroll, they're not embedded into the structure on our course...My guess is (they) don't feel like members of staff...there is an us/them divide still."* EBQ, Simon.

Sub theme 5: Connecting groups "*I feel like we are a sort of jigsaw puzzle and… there's mutual respect for the piece of the puzzle we each have.*"

This sub theme identifies the different factors that support connections between groups, including ideas of sharing and speaking about lived experiences and how emotion facilitated connections. It was also important to be supported to navigate and negotiate conflicts between groups in clinical psychology training. EBEs and Carers felt a motivation to encourage connections between themselves, trainees and EBQs.

An Expert Carer suggests that each stakeholder within clinical psychology training is an important part in the training of clinical psychologists and hold different perspectives that when combined complete the picture. "*I feel like we are a sort of jigsaw puzzle and ... and I feel that there's a mutual respect between the people who come in to talk to us… supervisors…EBQs or..., trainees. I think there's mutual respect for the piece of the puzzle we each have."* Expert Carer, Miriam.

Another Expert Carer identifies how sharing lived experiences facilitated trainee clinical psychologists to learn from them through an emotional connection, that came across differently to academic teaching. "*If you sort of sprinkle the emotion in there when you're... talking to them, that actually gets through to them...Better than if you're just quoting loads of technicalities.*" Expert Carer, Benjamin.

An EBQ, suggests that service user involvement work can be disappointing as service providers do not implement changes based on their feedback as quickly as they'd like, and the work requires greater support to navigate them and us divisions to promote better teamworking. "*...being disappointed when things don't change quickly enough... It's very difficult getting in that them and us space…but we've got a very good coordinator of service user experience who... pours oil on troubled waters and keeps us all… in line…steering that difficult path between how...we get things changed, but... not alienate everyone in the process*." EBQ, Sharon.

5.4. Discussion

The primary aim of this study was to understand identities within UK clinical psychology training. The findings provide greater clarity to how EBEs, carers, trainee clinical psychologists and EBQs construct their identities. The research found members in each group had multiple identities. These were both professional and personal within which sometimes participants wanted 'Separation', 'Integration' and 'Permeability' of these identities. Identities could also be 'Visible or Invisible' within the profession of clinical psychology, but there were competing narratives within and between these social identities regarding the acceptance and integration of lived experience in their different roles. The participants in this study also constructed fixed impermeable identities that emphasised greater similarities with their own groups and more differences and barriers between them and the other groups. There was a motivation to connect these groups and bridge the barriers. It was found these fixed identities could be permeated through emotional connections and communication between groups. The findings also identified 'Expert' and 'Learner' identities of each group. The labels used to describe these groups resulted in an ‘Expectation of the label,’ with some labels being burdensome described in ‘Weight of the label,’ with motivations to ‘Rebalancing the power,’ were found which were important to each group. The findings of this study were interpreted through social constructionism and critical realism and retrospectively understood through the deductive application of the EMERGES framework and the extant identity literature. The results of this study further support findings of the positions of identity detailed in Chapter 4, of professional, service user, integrated, unintegrated and liminal identities, adding further nuance regarding the nature of these identities and how they are socially constructed in the context of clinical psychology training.

5.4.1. The impact of labels

The research asked each participant to self-define into a specific social identity that represented their involvement in clinical psychology training. This seemed to be sufficient priming, providing the right context within which to measure their identities. This also meant that labels of groups in UK clinical psychology training influenced individuals to operate in a way that was consistent with the meanings attached to the labels of their focus group, which can be explained by labelling theory (Becker, 1963) and the process of identification in identity theory (Stryker, 1980). This reinforces the importance of developing labels that are representative of roles in clinical psychology training so they can work towards understanding the function of their roles and act accordingly. For example, if the EBE is described as a service user representative, they may actively draw on their lived experiences of being a service user as well as seek to represent wider service user views. Alternatively, if they are described as an EBE, the expert status may give them more power and enable others to view them as experts, giving greater validity to their knowledge production and their importance within clinical psychology training. Therefore, different labels can elicit different behaviours and responses, highlighting the importance of careful consideration of label use.

5.4.2. Multiple identities

The participants in each of the four focus groups identified that they belonged to multiple groups and their salience within a group was dependent on context, and emotional connections. The social identity mapping task at the beginning of the focus groups meant that individuals may have been primed to notice the different identities they belonged to, thereby influencing the manifestation of this theme. Crenshaw, (2017) argues that we experience the world through the intersections of our multiple identities based on where they are placed in a hierarchy that compound the experience of oppression. However, according to the self-esteem hypothesis (Burke & Stets, 2009) the more identities people belong to the better their psychological wellbeing. This positive effect of belonging to social identities is also the case when those identities are stigmatised (Kachanoff et al., 2016). This might explain the benefits of belonging to EBE and Expert Carer identities, identities that are typically stigmatised in society. The motivation to belong to multiple identities may be because they give increased access to social support from across these groups. Additionally, by being associated with the helping professions such as that of clinical psychology training may have an unconscious psychological benefit on the wellbeing of these groups. A sense of belonging to these groups might also be influenced by the status and prestige attached to the profession.

5.4.3. Separation versus Integration versus Permeable

The findings of this study suggest that each social identity in the four groups held personal and professional identities. However, there was a need for separation by carers, trainees and EBQs, but not for EBEs. This may be due to the perceived stigma and burden that integration of lived experience carries, which can result in queries over fitness to practice as healthcare professionals (Newcomb et al., 2017; Wilson et al., 2018). In contrast, findings from this study suggest that EBEs were motivated to integrate their experiences, rather than separate them, despite the pain caused by integrating lived experience. This is consistent with findings from Faulkner & Thompson, (2021) study that found that peer researchers wanted to actively integrate lived experience into their research. Similarly, Cooke et al., (2015) identified EBEs found meaning through integrating their lived experiences in their work.

In this current study, separation of personal and professional identities was important to both trainees and EBQ participants, so they did not have to be reflective and accountable in their personal lives, and for carers to reduce the emotional burden of their roles. This was achieved through setting boundaries. Llewelyn & Gardner, (2009) identify reasons for boundaries in clinical psychology, included maintaining distance from service users to maintain professional relationships. However, guidance for EBEs and Carers relating to personal disclosure is limited and is course specific and, therefore, may differ from programme to programme. It is also likely that there is variation in the extent to which such guidance is implemented.

Integration of lived experience between the four groups in the current study was fuelled by an emotional connection. Carer participants described how talking about their emotional experiences created better connections with trainees. Additionally, the EBQ participants described how connecting on an emotional level helped reduce their expert positions and promoted better coproduction and team working. This is consistent with the findings from Schreur et al., (2015) who found that emotional connections between service users and trainees reduced ‘them and us’ divisions and enabled trainees to learn from their trainers.

5.4.4. Learner and Expert

Trainee participants in this study were eager to integrate lived experiences in their training but felt they were inexperienced in understanding how to navigate this motivation. In contrast, EBE participants described integrating lived experience more effectively and in an expert way, through channelling theoretical frameworks in their roles, such as trauma informed models. However, this may be an effect of the label of trainee clinical psychologist, reproducing the learner role, and the EBE, reproducing the expert role which can be explained by labelling theory (Becker, 1963). Alternatively, it may be that EBEs may be motivated to introduce knowledge bases into their work, because they feel a need to justify their expert status. This is supported by research that has demonstrated that peer support workers rely on their training qualifications and professional labels to support them in developing professional identities (Simpson et al., 2018; Wilson et al., 2018). Li et al., (2018) discuss how expert identities are constructed of the self in opposition to learner identities of others, in Chinese media broadcasters. This fits with the findings of this current study where EBEs and Expert Carers constructed learner identities of Trainees and themselves as experts. Yu & Wu, (2021) identify how novice identities are constructed as needing help and guidance from others constructed as experts. This mirrors the learner and expert identity constructions of the relationship between the trainee clinical psychologist and the EBQ. Crane, (2012) identifies how expert identities are more likely to be constructed of one’s own social identity, as opposed to other groups. This can also explain some manifestations of the focus groups in for example EBEs and Expert Carers constructing themselves as experts and others as learners. In the current study, the trainee participants tended to take a learner position, and the EBEs, Expert Carers and EBQ participants took expert positions, their behaviours aligning with the purpose of their roles.

5.4.5. Visible and Invisible identities

Pilling, (2012) identifies how madness is an invisible illness that only becomes visible when individuals articulate this to others. The EBE participants in this study had to use their voices to be heard, for their disabilities to be perceived as legitimate and recognised. However, the labels of EBE and Expert Carer carry with them meanings that personify lived experiences, consequently making lived experience more visible. In contrast, Trainee clinical psychologists can choose whether they disclose or not, as there is no expectation for them to share their lived experiences. However, Trainee participants in the current study had a need to disclose their lived experiences in their training. Witnessing individuals disclose might encourage others to talk more openly about their own experiences, consistent with research by Byrne et al., (2022). Research also points to the motivation to be an authentic self, which comes through sharing and integrating invisible identities in public (Clair et al., 2005). The sharing of lived experiences encourages recovery, de-stigmatisation and help seeking behaviour (Vierthaler & Elliott, 2022). Byrne et al., (2017) however found there were risks to sharing lived experience within professions, such as personal information being publicly known and the long-term consequences of this. EBQs also have to decide whether disclosure is appropriate, necessary, or whether it performs a function. Tay et al., (2018) found that EBQs were more likely to disclose in their own social circles rather than within professional domains, consequently reducing the visibility of lived experience in the field. This may be due to the perception that the mental health sector is not safe for such disclosures (Richards et al., 2016). Despite these challenges to disclosure, some mental health professionals with lived experience talk openly about these experiences in their work (Adame, 2011; Richards et al., 2016; Fox, 2016). There may be differences within groups in clinical psychology training regarding the expectation for disclosure. A greater understanding of the boundaries of each social identity is important in managing expectations around disclosure for these different groups.

The study's findings show that lived experience applies to each of the four social identities, but that labels used to describe them occlude these needs. For example, the needs of carers who might also be service users, are masked as they are understood through the lens of those they are supporting, meaning they and service providers do not recognise their support needs, consequently rendering their identities as invisible (Andrasson et al., 2017; Broady, 2015). The EBE role also suggests they have lived experience and how they may be viewed as service users, consequently meaning their professional expertise may not be recognised. Conversely, the EBQ is perceived as someone with professional knowledge as opposed to someone with lived experience. These dichotomies regarding lived experience can be explained by epistemic injustice where the expertise of those in these roles may be doubted due to the social identities they belong to and where they are placed in a hierarchy (Fricker, 2017). This is likely to influence how groups in clinical psychology training are perceived.

Participants in all four groups in this study described motivations to have visibility of lived experiences. This may have manifested due to the context in which clinical psychology training is now situated. The BPS's Division of Clinical Psychology has published guidance on how trainees can integrate lived experience into their work (BPS, 2020). The findings of this current study bears similarity with research of mental health professionals with lived experience (Richards et al., 2016), reinforcing the validity of the findings of this study. However, this integration of lived experience by healthcare providers is likely to bring less clarity to the distinct roles of EBE, Carer, Trainee and EBQ. This highlights the importance of replicating this research in the future to understand the changing identities in the field.

5.4.6. Fixed Identities and 'Them & Us' divisions

Participants in the current study described 'Them and Us' divisions in each group. It is possible that the focus groups may have generated a space in which each social identity was enhanced, leaving the individuals in the group to identify with the in-group and exacerbated differences towards others. This may have resulted in the theme of impermeable fixed identities, that is consistent with the definition of social identity (Tajfel & Turner, 1979). Literature on focus group methodology identifies how it can reinforce individuals in a group to act as one social identity.

Within clinical psychology training, carers and EBEs are usually grouped together, but this research enabled an observation of them separately, and revealed that their needs and frustrations were sometimes the same and sometimes different. The findings in this study from, EBEs, Expert Carers, Trainee Clinical Psychologists and EBQs (Research staff and Clinical Psychologists) suggest there are 'Them and Us' divisions, articulated by each group. These 'Them and Us' divisions were not always recognised by those with the power, EBQs, but the impact of these dynamics and barriers and resistance to involvement were felt by EBEs and Expert Carers and Trainee Clinical Psychologists. The data also alludes to the idea that there is a maintenance of power by EBQs and a resistance to EBE and Expert Carer involvement when they start to gain power and expertise in their roles. The findings of this study relate to barriers in involvement and integration of lived experience which are consistent with findings by Tambuyzer et al., (2014). The research found that these fixed identities could be permeated through mediating factors such as emotional connections, that parallels findings by MacLean & Webber, (2015) describing how social identities can be bridged. This may hold the key in enabling the multiple groups in clinical psychology training to work more effectively together.

5.4.7. How the findings relate to the EMERGES framework

The EMERGES framework can be used to further understand the manifestation of the group identities explored in this study through ideas relating to Empowerment, Motivation to integrate, Empathy of the self and others, Recovery and medical model, Growth and transformation, Exclusion, and Survivor roots.

5.4.7.1. Empowerment

The four groups in the current study were empowered through connecting with others with similar experiences in the same roles. This may have been driven through group identity guiding behaviour, values and attitudes and advocating for others in their social identity (Tajfel & Turner, 1979). Beresford, (2021) suggests that empowerment comes from taking power from others and requires a redistribution of power that results in emancipatory and democratic, processes. This may have driven a motivation to rebalance the power across each focus group. The consumerist and market led structure of involvement, such as that of clinical psychology training, places limits on the extent to which EBE involvement can be democratic and empowering, resulting in dissatisfaction and tokenistic involvement (Ocloo & Matthews, 2016). Cameron et al., (2019) suggest that disrupting organisations that disempower and disable others is essential in creating systems that are enabling and inclusive. This might mean that EBEs need to organise outside of this system. Alternatively, to maximise the satisfaction of EBE groups in clinical psychology training and its effective utility in training clinical psychologists, means the profession need to do more to rebalance the power between groups.

5.4.7.2. Motivation to integrate

The focus group members in the current study displayed a motivation to integrate lived experience which was not only limited to EBEs but extended to trainee clinical psychologist participants who wanted to be a more coherent version of themselves by being able to integrate both their personal selves into their professional roles. Some EBQs wanted to integrate lived experience in their research but some EBQ participants wanted to remain more boundaried in their clinical work, and so there were competing interests to separate and integrate personal and professional identities. It appeared that the research psychologists in the EBQ focus groups were more inclined to be motivated to integrate their lived experiences in their research, whilst clinical psychologist participants were more reluctant to integrate this into their academic and clinical work. This might be because the field of research may be more experienced in integrating lived experience than clinical contexts. For example, National Institute for Health

Research, (NIHR, 2019) mandate the involvement of patient and public advisors in research. In a similar way Healthcare Professions Council (HCPC, 2018) mandates service user and carer involvement in the training of healthcare professionals. The effect of these standards in training can increase the visibility of lived experience in research and mental health settings that may be inspiring professionals with lived experience to also integrate their lived experiences in their own work. The clinical domain, however, may not be as far along in their journey of integrating lived experience. Although, the sample for EBQs was small (n=4) with two research psychologist and two clinical psychologists, so it is not possible to draw concrete conclusions. Grijak, (2017) suggests that being an authentic version of the self is beneficial to mental health. Research shows that doctoral students are more likely to have poorer mental health (Schmidt & Hansson, 2018). This necessitates support for trainees to integrate their personal experiences into the professional domains, to be authentic, which can positively impact their wellbeing. The EBQ and trainee participants in the current study were motivated to reduce their expert status in relation to their professional identities. They sought to integrate their lived and personal experiences, to reduce their power to aid connections with others. Research by Hutchinson & Lovell, (2013) found that the sharing of lived experience helped to humanise the people in their roles and rebalance the power dynamics.

5.4.7.3. Empathy of the self and others

The social domain of the focus groups in the current study enabled each group member to have an empathy for one another and feel connected to the group members, with shared motivations. The concept regarding empathy of the self and others through belonging to social domains that share similar experiences and motives has been described in different ways including “personhood” (Richards et al., 2016, p8) and “group survivorship” (Hill, 2021, p6). The current study found that some social identities behaved as one social identity, due to their shared group survivorship, encouraging an empathy and compassion for each member in the group. Tajfel & Turner, (1979) identify how social identities result in members of the group acting as one, through the process of in-group homogeneity and how an individual comes to understand the self through the qualities of the group. Research by Gardner, (2021) identifies how the extent to which we identify with a particular social identity result in the extent to which we empathise with those in the group, in research specifically about recognising racism towards Black people. It was, however, identified by EBE participants that they each had unique experiences but were connected through their roles and shared experiences of distress. They connected through shared motivations to make the mental health system better for others based on either positive or negative experiences of the system. This illustrates how having shared goals results in empathy and a motivation to work as one group identity (Ashforth & Mael, 1989).

5.4.7.4. Recovery and medical model

The current study found motivation to rebalance the power between groups in clinical psychology training. It may be that permeating models of recovery, medical and social disability models influenced the emergence of this theme. The person-centred approach (Rogers, 1959) to healthcare, and papers such as "No decision about me without me (Coulter & Collins, 2011), are popular themes within healthcare. It is widely understood that human beings are a product of their environment and the views they are exposed to. This means that lived experiences are understood through popular ideologies that occur outside of people's own consciousness (Beresford, 2021). It is inevitable that models within psychology may have influenced the themes found in this study. The recovery model, medical model and social disability model distribute power differently and there was a need to rebalance power between groups, and this is something that EBEs, Expert Carers and trainee clinical psychologist participants were concerned with.

5.4.7.5. Growth and transformation

Growth and transformation of identities within clinical psychology, is to some extent represented by the Learner and Expert theme. Across the focus groups there was a growth through being a learner to becoming more expert. Trainees have been shown to have learner and practitioner identities (Woodward, 2014), but this current study finds that learner and expert roles apply to each social identity in clinical psychology training. Persky & Robinson, (2017) identify how people do not just become an expert, and that there is a process one must go through to achieve expertise, largely dependent on time in the role and knowledge acquisition. They also highlight that not everyone becomes an expert. This might explain why Learner and Expert identities were constructed by each group in clinical psychology training. This also means that assigning the label of 'expert' to people in clinical psychology training does not necessarily make them experts, as expertise is dependent on time and experience in their roles. Expert identities were associated with thinking critically about dominant models in the system, application of theoretical models in practice, learning from others with greater expertise, challenging the status quo and re-evaluating where knowledge is gained from. Harper et al., (2003) find that EBEs shaped the critical thinking of healthcare professionals.

This suggests a growth in intellect and expertise that leads to listening and learning from new ideas, encouraging growth and development of identities in clinical psychology training.

5.4.7.6. Exclusion

The idea of exclusion manifested through a disconnect between trainee participants and EBE participants in the current study due to limited timetabled teaching and exclusion from payroll systems. EBEs and Expert Carer participants also felt excluded from decisions regarding their healthcare by EBQs. This may be explained through hermeneutical and testimonial injustice from which people make decisions about the value of knowledge based on who and where this knowledge comes from (Fricker, 2017). This often means that the EBE and Expert Carer and their perspectives are often secondary to EBQs. There also appears to be differences between identities that contribute to the EBQ identity, such as researcher and clinician knowledge bases that are stereotypically thought to be distinct (Garfield, 1966). Trainees and EBQ participants in this study spoke of how the profession of clinical psychology held stereotypes and excluded some people. They described experiencing this through messages they heard related to race, gender, class, disability and lived experience and personal attributes, thereby excluding, and reinforcing social inequalities within clinical psychology training. This may be challenged in the future through guidance by the (BPS, 2020a) on racial and social inequalities, taking the conversation forward within the psychological professions.

5.4.7.7. Survivor roots

Carr, (2019) identifies the emotional labour involved for service users and survivors engaged in lived experience work. The survivor roots theme may explain why EBEs engage in their work despite the work being painful at times, to make a difference and ensure others do not experience the same injustices of the system as they did. This motive may be influenced by a desire of EBEs to give back to services from which they feel they have personally benefitted, or conversely to actively change services due to their negative experiences of those services (Newcomb et al., 2017). Alternatively, it may be due to a desire to move beyond the service user identity (Hutchinson & Lovell, 2013) and the stigma attached to it. Being associated with the clinical psychology profession may also support in a status change, moving them beyond stigmatised identities.

5.4.8. Contextual factors that influence identity

The findings of this research may have been impacted by the COVID-19 pandemic and the effect this had on the clinical psychology training profession. One of the four focus groups was conducted prior to the lockdown restrictions in the UK, and subsequent others were conducted during the lockdown, when there were significant changes in the way training occurred, such as in more hybrid ways such as online and in person. This may affect the identities in clinical psychology training currently which may not be reflected in or measured by this current study. The discourse around the Group of Trainers Clinical Psychology Conference (2019) may have also influenced the identity constructions found. At this conference there was a martial arts performance of a re-enactment of a slave auction amidst an audience of predominantly white clinical psychology trainers and experts by experience from a diverse range of ethnic backgrounds, which was experienced as racist (Association for Clinical Psychologists, ACP-UK, 2019). In addition to this the Black Lives Matter movement has recently encouraged the questioning of representation and identities within institutions. These motivations may have also influenced the identity constructions found within clinical psychology training in this research. This may have led to motivations to integrate lived experience and further encourage diversity and representation at all levels within clinical psychology training. The mandatory requirement of service user and carer involvement within UK clinical psychology training (Sheldon & Harding, 2010) and the BPS (2020) guidance valuing lived experience in the profession, may also have contributed to changing attitudes towards lived experience within the profession.

5.4.9. Recommendations

Reducing 'Them & Us divisions'

A more open culture and dialogue between groups across clinical psychology, that is not limited by timetabled involvement and in more informal settings is advised to reduce 'Them & Us' divisions between EBEs, Expert Carers, Trainee Clinical Psychologists and EBQs. This can be achieved through embedding EBEs and Expert Carers onto the payroll system and employ them as members of staff.

Careful consideration of labels used to describe groups in clinical psychology training

Clinical Psychology training as a profession consists of EBEs, Carers, Trainees and EBQs, but it is evidenced there is an imbalance in power across these groups. The findings from this research and existing literature (McLaughlin, 2009) suggests labels confer and reduce power, privilege, and status. Labels for groups in clinical psychology need careful consideration to restore the power balance between them. The idea of being as “Expert” is a label that can enhance the power an individual has. There is a recommendation to ascribe Expert status to service users and Carers to reconcile power imbalances between groups. EBQs as a term exerts additional power, and so it is recommended to avoid this term. The terms may also benefit from greater specificity in representing the diversity of perspectives and approaches the individual members of groups in clinical psychology training belong to and that inform their work, as this is not represented in for example the terms Expert by Experience, or Expert by Qualification.

Guidance and support regarding disclosure for Experts by Experience and Expert Carers

The BPS recently published guidance to support trainee clinical psychologists in relation to their lived experience and disclosure (BPS, 2020). However, there is no published guidance on how EBEs and Expert Carers can protect themselves in their roles, boundary making and appropriate use of disclosure. Guidance is course specific and is implemented to varying degrees. Therefore, there is a recommendation to Experts by Experience and Expert Carers to identify areas they require support within their roles and find ways that reduces the potential harm their work might have on them through collaboration with the BPS.

Greater diversity across each group in clinical psychology training

A more diverse and representative clinical psychology workforce is recommended to support clinical psychologists to better meet the needs of those they serve. Additionally encouraging greater diversity in EBE and Expert carer groups is also advised to be able to better identify the different needs of the population. There is a recommendation to create separate guidance to support clinical psychology training courses to develop methods to increase representation in each group of EBEs, Expert Carers, Trainee clinical psychologists and EBQs within the field.

5.4.10. Strengths and Limitations

This study was the first to explore the collective social identity of clinical psychology training. It also enabled an observation of service users and carers separately, which were shown to be qualitatively different. The study identified barriers between groups and makes recommendations for reconciling these. A possible limitation of this study is that identifying the strength of the four social identities exacerbated perceived group differences via focus group methodology. If the focus groups were conducted with members from across disciplines, such as mixing groups of EBEs, Expert Carers, Trainees and EBQs in the same focus groups, it may have resulted in different identity constructions (Melucci, 1989). This type of study could be conducted in the future with mixed groups to understand how identities are affected when they are not considered in isolation to one another. This might be more representative of the way individuals work within clinical psychology training. Another limitation is the demographics of the sample which lacked diversity, but this is symptomatic of the wider demographics that currently exist within clinical psychology training, at this point in time. However, moving forward identities may shift due to a movement to encourage more representation and diversity within the profession. Therefore, it is recommended to replicate the research in the future to understand the changing identity of the profession. The sample sizes of each focus group were also small but meant more time for each participant to contribute to the conversation that resulted in a richer dialogue. Each participant was an expert of their role and so it was felt this was adequate for data saturation. The approach of social constructionism may have also been a subjective process, but the research team consisted of members within clinical psychology training including EBEs, Clinical Psychologists and Research Psychologists, experts in the field, suggesting a validity to the themes found.

5.5. Conclusions

This empirical study set out to identify how groups in UK Clinical Psychology training, EBEs, Carers, Trainees and EBQs, constructed their identities. The study found identity was constructed as being formed of multiple identities, that were integrated, separated, permeable, visible, and invisible identities, fixed impermeable identities, expert and learner identities and expectations and impact of labels. It also found imbalances in power and barriers between these groups, which could be reconciled through reducing expert status, increasing visibility of lived experience and careful consideration on labels used to describe these social identities to rebalance power differences.

CHAPTER SIX

DEVELOPING AN IN-GROUP IDENTIFICATION MEASURE IN CLINICAL PSYCHOLOGY TRAINING: A PILOT STUDY

"*I find it difficult to identify with the "Expert By Qualification" when they talk about mental health. I understand their expertise in the area, but something about those with lived experiences and the "Expert By Experience" seems to resonate and feels more authentic and powerful*."

~ Veenu Gupta (2019)

CHAPTER 6. DEVELOPING AN IN-GROUP IDENTIFICATION MEASURE IN CLINICAL PSYCHOLOGY TRAINING

6.1. Introduction

Historically there have been many labels used to describe the relationships in healthcare contexts between those using services and those providing services. Often these roles are dichotomised into separate and oppositional categories they are understood through, such as consumer and provider, or patient and professional, (Mayer & McKenzie, 2017). Although there are roles in which those who use services also provide services, such as Experts by Experience (EBE) who are service users and carers. This chapter will refer to service users as EBEs and Carers separately, referring specifically to those that contribute to the UK training of clinical psychologists. EBEs have experiential knowledge of disability and healthcare services, giving them expertise of their lived experience that they draw on in these roles. The historical progression of service user involvement to date is briefly outlined in Chapter 2.

Additionally, there may be clinicians and researchers who also have lived experience themselves, but in the context of this research we are interested in and will refer to research and academic/clinical psychologists that contribute to the UK training of clinical psychologists as Experts by Qualification (EBQ). They are trained specifically and qualified to perform their roles, irrespective of their lived experiences. The identities of EBEs and EBQs in the context of clinical psychology training is explored in Chapter 5. These two labels of EBE and EBQ will be used to differentiate between these two trainers, but also to equally distribute power and expertise through the ascription of the “Expert” label to each trainer. According to epistemic injustice (Fricker, 2007) there is bias in terms of where knowledge is gained from, suggesting “Expert status” would support learning from each trainer. Sheldon & Harding, (2010) suggests that training by EBQs has been the standard, but that learning is enhanced by EBE involvement. However, there is limited understanding of how these different trainers support the learning of trainee clinical psychologists and mechanisms that facilitate this. EBQ and EBE may elicit different responses and types of learning by trainee clinical psychologists, dependent on how the trainee relates to them and the extent to which they themselves hold mental health and professional identities. This research seeks to understand how trainee clinical psychologists identify with their trainers and the individual differences and processes by which this occurs through this pilot study.

Schreur et al., (2015) proposed that service user involvement facilitated trainee clinical psychologists to learn from EBEs though emotional connections. Similar results were reported in Chapter 5 relating to how connections between social groups, such as trainee clinical psychologists and EBEs and Expert Carers, occurred through sharing emotional content. For example, Expert Carers felt "*if you sort of sprinkle the emotion in there when you're... talking to them, that actually gets through to them...Better than if you're just quoting loads of technicalities.*" (Benjamin, Expert Carer, Chapter 5). Similarly, it has been found that when Carers share their lived experiences, the emotions these experiences invoked helped to facilitate formation of student mental health nurse identities (McIntosh, 2018). Oates, (2017) found that the identity of student mental health nurses was formed through a combination of their own lived experiences, clinical training, and interactions with services users, strengthening their identities as mental health professionals. This suggests that EBQ and EBE involvement are both instrumental in shaping the identity of trainee mental health professionals. Despite the evidence base in mental health nursing on identity formation (Happell et al., 2014; Oates, 2017; Crawford et al., 2008), there is limited research into identity formation of trainees in clinical psychology training, and more generally of the identities within the organizational context of clinical psychology training, although Chapter 5 goes some way in addressing this knowledge gap.

6.1.1. The theoretical basis and factor structure of in-group identification

Identity is a socially constructed concept and there are many definitions and explanations of what influences its development (Stryker, 1980; Tajfel & Turner, 1979; Turner & Onorato, 1999; Burke & Stets, 2009) as further detailed in Chapter 3. The existence and definition of identity is contested, and this influences its conceptual understanding, and consequently, its empirical measurement. Due to varying perspectives and theoretical positions of the concept it adds to the variability in methodology used to measure it and variability in factor structures that emerge as a result (Postmes et al., 2013; Leach et al., 2008; Karasawa, 1991). It is important to understand the existing measures of in-group identification and their factor structures to better understand what they are measuring and support in adopting a reliable and valid measure of identification for further study.

There are inconsistent views between researchers regarding whether in-group identification is a unidimensional or multi-dimensional process. Recent researchers have favoured the multi-dimensional approach based on this initial statement by Tajfel, (1978) describing Social Identity theory as "*that part of an individual's self-concept which derives from his (or her) knowledge of his (or her) membership of a social group (or groups) together with the value and emotional significance attached to that membership*" (p. 63). This approach has driven researchers to capture these words into measurable components within psychometric tools. For example, some researchers have interpreted these words as separate entities such as cognitive and affective components influencing investigations of the phenomenon to be consistent with this theoretical basis it derives from. Tajfel & Turner, (1979) posed that identification is specifically a cognitive process and not an emotional one. However, Johnson et al., (2012) argued that it was both a cognitive and affective process. Cognitive components encompass a person thinking that they are like others which leads to self-defining as a group member. Affective components refer to a person feeling like they are like others and is an emotional connection between them and the group. There is disputing evidence about which process occurs first (Johnson et al., 2012).

A review of the literature conducted for the purpose of this chapter found 14 studies which focussed on developing measures of identification which were tested for reliability and validity in their respective studies. Table 6.1 shows their factor structures in relation to one another and finds that the common themes across all the measures are cognitive and affective factors of in-group identification. Measures of identification have previously been used in many contexts including assessing ethnic, national and racial identification, reporting components that make up cognitive and affective identification that have been cross culturally validated (Leach et al., 2008; Roth & Mazziotta, 2015; la Barbera & Capone, 2016; Lovakov et al., 2015). There has also been exploration of identification in terms of gender identification (Cameron, 2004; Cameron & Lalonde, 2001), student in-groups (Hinkle et al., 1989), motivations behind identification (Mayhew et al., 2010), and organisational identification (Johnson et al., 2012; Brown & Williams, 1984) amongst other contexts. The factor structures presented in Table 6.1 capture broader factors relating to cognitive and affective components across each psychometric. Similar factor structures identified by different authors reinforces the face validity of each measure as theoretically derived from the Social Identity Approach and their effectiveness, reliability, and validity in measuring the process of identification.

Table 6.1: An overview of the factor structure of social identification measures

<table>
<tr><th>Study</th><th colspan="9">Factor Structure of Identification</th></tr>
<tr><td>Johnson et al (2012)</td><td colspan="5">Affective</td><td colspan="4">Cognitive</td></tr>
<tr><td>Leach et al (2008)</td><td>Satisfaction</td><td colspan="3">Centrality</td><td colspan="2">Solidarity</td><td colspan="2">Individual self-stereotyping</td><td>In-group homogeneity</td></tr>
<tr><td>Lovakov et al (2015)</td><td>Satisfaction</td><td colspan="3">Centrality</td><td colspan="2">Solidarity</td><td colspan="2">Individual self-stereotyping</td><td>In-group homogeneity</td></tr>
<tr><td>Roth et al (2015)</td><td>Satisfaction</td><td colspan="3">Centrality</td><td colspan="2">Solidarity</td><td colspan="2">Individual self-stereotyping</td><td>In-group homogeneity</td></tr>
<tr><td>Barbera et al (2016)</td><td>Satisfaction</td><td colspan="3">Centrality</td><td colspan="2">Solidarity</td><td colspan="2">Individual self-stereotyping</td><td>In-group homogeneity</td></tr>
<tr><td>Postmes et al (2013)</td><td colspan="5">Self-Investment</td><td colspan="4"></td></tr>
<tr><td>Cameron et al (2004)</td><td colspan="2">In group affect</td><td colspan="3">Centrality</td><td colspan="4">In-group ties</td></tr>
<tr><td>Obst et al (2005)</td><td colspan="2">In group affect</td><td colspan="3">Centrality</td><td colspan="4">In-group ties</td></tr>
<tr><td>Henry et al (1998)</td><td colspan="3">Affective</td><td colspan="4">Behavioural</td><td colspan="2">Cognitive</td></tr>
<tr><td>Mayhew et al (2010)</td><td colspan="5">Belongingness</td><td colspan="4">Self-Categorisation</td></tr>
<tr><td>Hinkle et al (1989)</td><td colspan="3">Emotional</td><td colspan="4">Group Opposition</td><td colspan="2">Cognitive</td></tr>
<tr><td>Brown et al (1984)</td><td colspan="3">Affect</td><td colspan="4">Self-esteem</td><td colspan="2">Self-definition</td></tr>
<tr><td>Bergami & Bagozzi (2000)</td><td colspan="3">Affect</td><td colspan="4">Self-esteem</td><td colspan="2">Self-definition</td></tr>
<tr><td>Nario Redmond et al (2004)</td><td colspan="5">Personal</td><td colspan="4">Social</td></tr>
</table>

6.1.2. Testing the relationship between identification, personality, mental health, and professional identities

Personality has been shown to influence the process of identification. Johnson et al., (2012) found that personality is linked to predicting types of identification differentially. For example, the uncertainty hypothesis (a need to identify with a group to alleviate uncertainty caused from not belonging to a group) is motivated by Neuroticism or Emotional Stability (Hogg, 2012). Extraversion has also been shown to be a motivator towards identification to enable the self-esteem hypothesis, driving individuals to identify with a group for self-enhancement and perceived positive benefits (Martiny & Rubin, 2016). This suggests that different personality traits have been shown to influence the process of identification, either cognitively or affectively, differentially dependent on the individuals' motivation behind this. Extraversion is associated with affective identification and Neuroticism with Cognitive identification. These findings underpin the hypotheses that like personality traits, professional identities, and mental health identities may also influence the process of cognitive and affective identification differentially, and this pilot research aims to understand this.

6.1.3. Rationale for the study

Chapter 3 discussed how identity is socially constructed through self-definition, the first stage in social identity theory, which is a cognitive process. This was empirically investigated in Chapter 5. However, more clarity is needed regarding the process of in-group identification, the second stage in Social identity theory, in the context of clinical psychology training. This is important in order to build on findings from Chapter 5. Despite there being literature exploring social identification in a range of settings, there has been limited exploration and application of this to organizational contexts, including UK clinical psychology training. At present there has been research into social identity and its influence on health in clinical psychology (Haslam, 2014) where it was found that trainee psychologists' ideas and behaviours resulted from social identification. There has been no specific attempt to measure trainee clinical psychologists' identification towards their trainers, and no measures of identification specific to groups in clinical psychology training. It is important to understand whether the context of clinical psychology training functions and is socially structured in a way that reflects the existing empirical and theoretical evidence base on identity, or whether it occurs differently. This would provide additional insight into the process of identification and support the organisational context of clinical psychology training by applying findings to support groups in clinical psychology training to work together more effectively.

6.1.4. Aims and Objectives

This research aimed to measure cognitive and affective identification for groups in clinical psychology (EBE, Carer, Trainee and EBQ) by adopting and adapting a measure of identification (Johnson et al., 2012), and assessing its reliability, validity, and factor structure by administering the measures to newly qualified clinical psychologists and trainee clinical psychologists in a pilot study.

This study also aimed to create measures of mental health and professional identities through identifying and applying single item measures to measure the identity of trainee psychologists. A further aim was to understand how trainee clinical psychologists relate to each of their trainers and observe whether there were individual differences that influenced the process of identification based on personality and mental health identity and professional identity variables. The relationships between these variables and type of identification will be measured through correlational analysis, and predictive validity to test the hypotheses outlined.

6.1.5 Hypotheses

H1: The factor structure of the social identification measure will be two dimensional

H2: Trainees will cognitively identify with EBQ

H3: Trainees will affectively identify with EBE

H4: Cognitive identification will predict Professional Identities

H5: Affective identification will predict Mental health identities

H6: Personality types will predict Identification differentially.

6.1.6. Reflexivity and Positionality

Jamieson et al., (2022) argue that reflexivity in quantitative research is essential. For this study, the research question came from a time when the PhD researcher was listening to an EBQ speaking of their experience as a Carer of someone with Psychosis, at a conference. The PhD researcher found she paid more attention and respected the expertise of this individual based on their personal connection to those with Psychosis, that held more weight as opposed to the qualifications they held as an EBQ. The researcher felt that she resonated more with them due to their shared common experience of mental health that connected them, enabling them to listen, understand and value their knowledge and expertise more. This observation inspired the idea that affective responses may connect people and informed the development and design of this study to test this. The study was therefore aimed at understanding the process of cognitive and affective identification in the context of clinical psychology training. The research team, consisted of EBEs and EBQs in clinical psychology training and so had expertise in the field. This study was co-created with a range of stakeholders including lived experience researchers, service user advisors and clinical/academic and research psychologists, trainee psychologists and assistant psychologists. They all provided input into identifying and rephrasing the items within the measure and selecting variables to measure. The interpretation of the results was largely undertaken by the PhD researcher who is an EBE, who identified the research question, and so acknowledges there may be bias to the interpretation of the findings.

6.2. AN OVERVIEW OF THE PILOT STUDY

6.2.1. Design

The pilot study was conducted in four phases. Phase 1 followed a cross-sectional design and participants were recruited and assessed at one time point only. For Phase 1, newly qualified clinical psychologists (n = 32) were recruited to pilot test items of a measure of cognitive and affective identification in relation to EBEs, carers, trainees and EBQs, and measures of personality, mental health identity and professional identity. The purpose of Phase 1 was to ensure item clarity and comprehensibility and test reliability, validity and factor structure of the identification measure. Phase 2 involved the recruitment of trainee clinical psychologists (n = 108) and a cross sectional study, using the same measures developed in Phase 1. The measure of identification was validated and used to assess trainee identification towards EBEs, carers, trainees and EBQs. The results were assessed for their psychometric properties, factor structure, internal consistency and convergent and discriminant validity. Phase 3 aimed to confirm the factor structure through a confirmatory factor analysis. Phase 4 was used to assess predictive validity using personality measures and mental health identity and professional identity as independent variables to predict type of identification.

6.3. PHASE 1. DEVELOPING AND PILOTING AN IN-GROUP IDENTIFICATION MEASURE IN NEWLY QUALIFIED CLINICAL PSYCHOLOGISTS

H1: The factor structure of the social identification measure will be two dimensional

6.3.1. Method

Phase 1 involved undertaking a pilot study to test the comprehensibility of items of a psychometric measure of identification, and assess its factor structure and internal consistency in order to effectively adapt and adopt the psychometric tool to measure social identification for groups within clinical psychology training.

6.3.1.1. Materials

Participants were administered a survey via Qualtrics which consisted of a range of items including the Cognitive and Affective identification measure (Johnson et al., 2012), Single item measure of identification (Postmes et al., 2013), the ‘Dirty Dozen’ (a measure of the dark triad; (Jonason & Webster, 2010), and the Ten Item Personality inventory (and a measure of the Big Five via, (Gosling et al., 2003). These measures were identified as they measure broad constructs with limited items so they can be completed quickly and have less of a cognitive burden on the participants. It was also important to measure variation in personality, hence capturing both light and dark personality types, to understand individual differences in personality type and their influence over the process of identification. Demographic information and additional variables were also collected (see Appendix B). Each participant was asked to rate the extent to which they agreed with the items using a ten-point Likert scale ranging from 1= "strongly disagree" and 10 = "strongly agree".

6.3.1.2. Social identification measure

Johnson et al., (2012) measure of cognitive and affective identification was adapted for use in the current study. The same 8 items were used as those within the Johnson et al (2012) study but phrasing was adapted to be applicable for groups in clinical psychology training, including EBE (Appendix C), Carers (Appendix D), trainee clinical psychologists (Appendix E), and EBQ (research and clinical psychologists, Appendix F) based on discussion with the research team and service user advisor with whom face validity and comprehensibility of the items were checked. Four items measured cognitive identification (e.g. *I think of myself as a member of an EBE group and this is very important to my sense of who I am*). Four items measured affective identification (e.g. *I feel happy to work with service users within a clinical psychology programme*.) An additional item measuring social identification, developed by Postmes et al (2012) was also added (e.g. *I identify with service users who are EBE*). Based on this pilot study and feedback from responses, some items and contextual clarifying statements were rephrased to enhance clarity for the participants completing the survey in Phase 2.

6.3.1.3. Personality measures

Jonason & Webster, (2010) Dirty Dozen tool was used to measure The Dark Triad (Narcissism, Machiavellian and Psychopathy) which consisted of 12 items, with 4 items measuring each component with excellent internal reliability $\alpha = .83$. Gosling et al., (2003) Ten-item personality inventory was used to measure the Big Five personality types, including 2 items measuring Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experiences. It was important to explore both "dark and light" aspects to personality, to capture the variation in trainee psychologist personality types and their influence over the process of identification. This was important in establishing individual differences that may contribute to identification with EBEs and EBQs differentially. The ten-item personality measure had a test-retest reliability of r = .63. Although, it is acknowledged the measure has low internal consistency, as it measures broad constructs with fewer items and was not originally designed for its reliability or its factorial dimensions. This was specifically chosen as it is a short-item measure and would reduce the cognitive burden on participants.

6.3.1.4. Professional identity and Mental health identity measure

Single item measures were generated based on discussion with the supervisory team and face validity, ensuring comprehensibility and clarity, to measure professional identity (*My occupational role defines who I am*) and mental health identity was also measured (*My experiences of mental health define who I am*).

6.3.1.5. Additional measures

There were other additional variables such as common factors, empathy, non-judgemental and genuineness that were also measured and religious identity in order to assess for convergent and discriminant validity. These additional 37 measures can be found in the Appendix B and were assessed using the same likert scale as all other measures.

6.3.1.6. Demographic details

The survey also collected demographic details including the participant's role in clinical psychology training and duration in their roles. Participants' university, age, gender, ethnicity and social class were collected. Participants were also asked if they were service users, carers or both.

6.3.1.7. Procedure

Ethical approval was sought and granted by the University of Liverpool ethics committee (Ref: 6275) and the survey was administered via Qualtrics and open for four months between November 17th 2020 and March 8th 2021. Newly qualified trainee clinical psychologists and trainee clinical psychologists were recruited via purposive sampling. An email invitation to participate and advertisement detailing the research and ethical approval letter was sent to each clinical psychology course in the UK. This was also circulated via the Group of Trainers in Clinical Psychology (GTiCP) network. The GTiCP is a British

Psychological Society network of clinical psychology trainers in the UK including EBEs and EBQs. The Association for Clinical Psychology (ACP-UK; a UK professional body representing clinical psychologists and trainee clinicial psychologists) also circulated this request via their trainee and newly qualified clinical psychologist networks. Participants who wanted to take part in the research and who responded to the advertisements were sent the Qualtrics link via which they could access the study's Participant Information Sheet. Participants were asked to read this information sheet which detailed inclusion criteria, risks and benefits of participation and researcher's contact details, and asked them to consent to participation only if they had read and understood this.

The survey, including all the measures, took approximately 20 minutes to complete, and a debriefing sheet was presented on completion, detailing the study's aims, researcher's contact details and details of the Samaritans (UK-based mental heath charity and helpline) should participation in the study cause any distress. On completion of the study participants were invited to enter into an optional draw to receive 1x £100 Amazon voucher and 2x £25 Amazon vouchers. Participants were re-directed to an additional survey if they wanted to enter this draw so they could enter their email addresses, that was not linked to the original survey data. Recipients of the draw were randomly allocated via the email addresses they provided once the study closed recruitment.

6.3.1.8. Phase 1. Participants

A total of 32 newly qualified clinical psychologists took part in Phase 1 from across 14 Clinical Psychology training courses. They have not been identified in order to ensure participants' anonymity.

Table 6.2. Phase 1. Participant demographics

Newly Qualified Psychologists	**Gender**	**Age range**	**Ethnicity**	**Time Qualified**
N=32 Also a Service user N = 8 Also a Carer N= 3	23 Female 7 Male 2 did not disclose	18 - 54 years old	19 White British, 5 White (Unspecified), 2 White other, 2 British, 1 Mauritian, 1 Chinese, 2.	1 week to 6 years

6.3.1.9. Phase 1. Data analysis procedure

Data cleaning was performed to exclude incomplete participant data. A principal components analysis was used to explore the factor structure of the Cognitive and Affective identification measure (Johnson et al., 2012). Four separate analyses were performed to identify newly qualified clinical psychologists' identification towards each population in clinical psychology training (EBE, Carer, Trainee and EBQ). Eigenvalues, Cumulative Variance and Scree plots and the Kaiser K1 method were used to confirm number of factors in the data. Internal consistency was also performed through measuring the Cronbach's alpha of the measure. SPSS software was used to perform the data analysis.

6.3.2. Results

A Principal Components Analysis (PCA) was run with 9 items measuring social identification in order to assess factor structure and newly qualified clinical psychologists relation towards trainees, EBE, carers and EBQs. Table 6.3 shows these results.

Newly Qualified Identification towards trainees

The PCA analysis towards trainees was 2 dimensional and identified affective factors (9 items loading onto this) and cognitive factors (4 items loading onto this). The single item of identification also loaded onto the affective factor. The affective component had an Eigenvalue of 5.102 and cognitive component of 1.389. Two factors consisted of 72.126% variance. According to the Kaiser1 rule this suggests that there are 2 factors in the data as Eigenvalues are above 1. Internal consistency is also excellent with a Cronbach's alpha of .898 for the total scale and .875 for affective identification and .868 for cognitive identification. This means the first hypothesis relating to the two dimensional nature of the measure can be accepted.

Newly Qualified Identification towards EBQ

A PCA analysis towards EBQs found the measure was two dimensional and consisted of affective and cognitive factors. All 9 items loaded onto the affective factor and 3 items loaded onto the cognitive factor. The affective factor had an Eigenvalue of 5.965 and the cognitive factor had an Eigenvalue of 1.142 with a cumulative variance of 78.975%. Internal consistency for the whole scale was excellent with a Cronbach's alpha of .929. Affective identification has a Cronbach's alpha of .907 and cognitive identification had a Cronbach's alpha of .876. Therefore, the first hypothesis, that the measure is two dimensional can be accepted.

Newly Qualified Identification towards EBE

A PCA analysis towards EBE found the social identification measure consisted of three factors. Eight items loaded onto the affective component, 3 onto the cognitive component and 2 that loaded onto a third factor in the data. The internal consistency and Cronbach's alpha of the total scale was, .762, affective identification .711 and cognitive identification .712. The affective factor had an Eigenvalue of 3.266, Cognitive factor Eigenvalue 2.032 and Unknown factor 1.399. Their cumulative variance was 74.407%. This means the first hypothesis that the measure is two dimensional cannot be accepted.

Newly Qualified Identification towards Carers

A PCA analysis towards Carers found the social identification measure consisted of three factors. Three items loaded onto the affective factor, 5 items loaded onto the cognitive factor and 2 items loaded onto the Unknown factor. The Cognitive factor had an Eigenvalue of 4.11, the Affective factor had an Eigenvalue of 1.948 and the Unknown factor had an Eigenvalue of 1.017 with their cumulative variance being 79.618%. The internal consistency for the total scale was excellent with a Cronbach's alpha of .849, Affective identification was .648 and cognitive identification .881. The same items that loaded onto the Unknown factor for Carers also loaded onto the Unknown factor for EBE, suggesting that the identification measure is three dimensional, thereby meaning the first hypothesis cannot be accepted. The items that loaded onto this additional factor are "*If any service user/carer was asked to leave their role I would be very disappointed*" and "*If service users/carers were criticised it would influence how I thought about myself.*" These items are related to evaluating the self through their identification with others and therefore suggests that the third Unknown component may explain an evaluative response and personal ties to the process of identification.

Table 6.3. Phase 1: Factor loadings based on a principal components analysis of nine items measuring cognitive and affective identification of newly qualified clinical psychologists towards each trainer

Items in Social identification measure	**Cognitive**				**Affective**				**Unknown**			
	EBE	**Carer**	**Trainee**	**EBQ**	**EBE**	**Carer**	**Trainee**	**EBQ**	**EBE**	**Carer**	**Trainee**	**EBQ**
I feel happy to work with ( ) in a clinical psychology programme	-.592	.264	-.564	-.306	.566	.745	.728	.857	-.400	-.363		
I feel proud to work with ( ) in a clinical psychology programme	-.625	.358	-.269	-.426	.702	.823	.888	.779	-.124	-.078		
It feels good to work with ( ) in a Clinical psychology programme	-.460	.572	-.410	-.107	.784	.643	.757	.826	-.088	.186		
If any ( ) was asked to leave their role I would be very disappointed	-.068	.522	-.122	-.384	.429	.133	.642	.758	.662	.759		
My self-identity is based in part on membership/connection to ( ) groups	.581	.798	.311	.524	.635	-.294	.753	.733	-.397	-.274		
I think of myself as a member of an ( ) group and this is very important to my sense of who I am	.701	.830	.370	.452	.432	-.321	.837	.841	-.343	-.162		
My sense of self overlaps with the identity of ( )	.389	.834	.673	.438	.710	-.132	.580	.813	.102	-.326		
If ( ) were criticised it would influence how I thought about myself	.068	.752	.317	-.191	.406	-.193	.751	.813	.651	.229		
I identify with ( )	.298	.852	-.168	.010	.629	-.201	.793	.894	.258	.088		
Eigenvalues (Cumulative variance	2.032 (58.865%)	4.111 (45.676%)	1.389 (72.126%)	1.142 (78.975%)	3.266 (36.287%)	1.948 (67.320%)	5.102 (56.69%)	5.965 (66.282%)	1.399 (74.407%)	1.017 (79.618%)		

6.4. PHASE 2. ASSESSING THE RELIABILITY AND VALIDITY OF THE IN-GROUP IDENTIFICATION MEASURE FOR USE WITH TRAINEE CLINICAL PSYCHOLOGISTS: A PILOT STUDY.

H1: The factor structure of the social identification measure will be two dimensional

H2: Trainees will cognitively identify with EBQ

H3: Trainees will affectively identify with EBE

6.4.1. Method

The survey developed in Phase 1 was adapted based on qualitative feedback from respondents to enhance its clarity and comprehensibility. Changes included clarifying terms such as Expert By Experience and Experts by Qualification. After assessing its internal consistency, validity and factor structure in newly qualified clinical psychologists in Phase 1 the survey was sent out to trainee clinical psychologists to complete in Phase 2. The same methodology used in Phase 1 was followed including a cross sectional design and the same measures identified in Phase 1 were administered in Phase 2. The same methodology was used to establish reliability and validity of the measure for use in trainee clinical psychologists and factor structure.

6.4.1.1. Participants

A total sample of N =108 participants took part in Phase 2 (90 females, 15 males, 1 nonbinary, 1 other and 1 not specified), recruited via purposive sampling. The inclusion criteria specified that participants had to be trainee clinical psychologists, enrolled on a clinical psychology training course in the UK. Participants took part from 14 different universities across the UK. Trainee Clinical Psychologists had been in their role for 6 weeks to 18 months. Participants identified as coming from different social classes, including Upper/Middle class (13.9%), Middle class (51.9%), Working class (32.4%) and Lower class (1.9%). Demographics are reported in Table 6.4.

Table 6.4. Phase 2. Participant demographics

Trainee Clinical Psychologists	Age	Gender	Ethnicity	Time Qualified
N = 108 Also Service users N = 15 Also Carers N = 8	18 - 44 years old Mean age range 25-29 years	90 Female 15 Male 1 Non-binary 1 other 1 not specified	55 White British , 17 White Unspecified, 13 White Other, 6 British Other, 4 Chinese, 2 Indian, 1 Arab, 1 Asian, 1 Black Caribbean, 1 Brown, 1 East Asian, 1 Greek, 1 Mixed, 1 Northern Irish, 1 Scottish and 2 Unspecified	6 weeks to 18 months

6.4.1.2. Phase 2. Data analysis procedure

After the data were cleaned, a multiple principal components analysis was run on the cognitive and affective identification scale of trainees towards EBE, Carers and EBQ using an oblique (oblimin) rotation. The Kaiser1 method was used involving eigenvalues and cumulative variance alongside, scree plot and parallel analysis, using Monte Carlo software, in order to determine the number of factors in the data. This is considered to be the most accurate and least subjective way to determine the factor structure (Glorfield, 1995). Parallel analysis was calculated from a 1000 randomly generated data sets with 108 cases and 9 variables. This involved generating a random data set and comparing it to the original Eigenvalues of the data, and where they intersect in the scree plot determines how many factors to retain. Internal consistency was also measured using a Cronbach’s alpha statistic of affective and cognitive factors and the total scale. Convergent and Discriminant validity were calculated through correlational analyses of hypothesised related and unrelated variables. Table 6.5 details the loadings of each item onto each factor. This information is provided for trainee clinical psychologists’ identification to each of their trainers, including their peers.

Table 6.5. Factor loadings based on a principal components analysis with oblique rotation of nine items measuring cognitive and affective identification of trainee clinical psychologists towards their trainers.

Items in Social identification measure	**Cognitive**				**Affective**			
	EBE	**Carer**	**Trainee**	**EBQ**	**EBE**	**Carer**	**Trainee**	**EBQ**
I feel happy to work with ( ) in a clinical psychology programme	-.119	-.077	.008	-.011	-.905	.925	.940	.898
I feel proud to work with ( ) in a clinical psychology programme	.105	-.081	-.119	.061	-.871	.954	.844	.874
It feels good to work with ( ) in a Clinical psychology programme	-.068	-.054	.078	-.072	-.896	.933	.943	.906
If any ( ) was asked to leave their role I would be very disappointed	.209	.222	.021	-.117	-.445	.595	.404	-.024
My self-identity is based in part on membership/connection to ( ) groups	.725	.790	-.858	.861	-.008	-.002	-.084	.014
I think of myself as a member of an ( ) group and this is very important to my sense of who I am	.763	.866	-.912	.882	.217	-.167	-.034	.102
My sense of self overlaps with the identity of ( )	.834	.843	-.897	.862	-.033	.102	-.045	-.067
If ( ) were criticised it would influence how I thought about myself	.607	.771	-.420	.275	-.250	.183	.349	.110
I identify with ( )	.743	.778	-.601	.747	-.118	-.090	.366	-.052
Eigenvalues (Cumulative variance)	3.692 41.02%	3.518 (39.09%)	1.559 (69.098%)	3.508 (38.91%)	1.878 (61.87%)	2.886 (71.158%)	4.480 (49.777%)	2.049 (61.745%)

6.4.2. Results

Trainee to Trainee Identification

The factor structure of the nine item Social identification measure towards trainees was tested. This was analysed by factor analysis through a PCA with an oblimin (oblique) rotation, as items were thought to be correlated. The sampling adequacy was acceptable (KMO = .837) and Bartlett's test of sphericity showed that correlations between items were large enough for a PCA ($X^2(36)=545.342$, $p <.001$). Four items loaded onto the affective identification factor, which had an Eigenvalue of 4.480 and a cumulative variance of 49.777%. The second factor was Cognitive Identification that had five items loading onto it, which had an Eigenvalue of 1.559, adding 20% variance with a cumulative variance of 69.098%. Using the Kaiser1 factor method to determine number of factors alongside parallel analysis and the scree plot, two factors were identified in this analysis and so the identification tool can be considered two dimensional. This means the hypothesis that the social identification measure is two dimensional can be accepted. Internal consistency was calculated using Cronbach's alpha statistic, $\alpha = .855$. This suggests items in the psychometric are closely related and can be assumed to measure the process of identification. The scree plot and parallel analysis are in Appendix G.

Discriminant validity was calculated through a correlational analysis between cognitive and affective identification and the extent to which someone is religious, which is thought to be unrelated. The relationship between cognitive identification towards trainees and religion was insignificant, $r = -.166$, $p < .087$. The relationship between affective identification towards trainees and religion was also insignificant, $r = -.083$, $p < .393$. Convergent validity was calculated through a correlation between cognitive and affective identification and mental health identity and professional identities. The relationship between cognitive identification towards trainees and professional identities was significant, $r = .440$, $p < .001$. The relationship between affective and cognitive identification towards trainees and mental health identities were insignificant. These findings suggest the process of cognitive identification is more relevant in explaining the process of identification between trainees and other trainees.

Trainee to EBE Identification

The factor structure of the nine item Social identification measure towards EBEs was tested. It was analysed by factor analysis through a PCA with an oblimin (oblique) rotation, as items were thought to be correlated. The sampling adequacy was acceptable (KMO = .80) and Bartlett’s test of sphericity showed that correlations between items were large enough for a PCA ($X^2(36)=380.07$, $p < .001$). Five items loaded onto the Cognitive identification factor, which had an Eigenvalue of 3.692 and a cumulative variance of 41.022%. The second factor was Affective Identification that had four items loading onto it, which had an Eigenvalue of 1.878, adding 20% variance with a cumulative variance of 61.87%. Using the Kaiser1 factor method to determine number of factors alongside parallel analysis and the scree plot, two factors were identified in this analysis and so the identification tool can be considered two dimensional. This means the hypothesis that the social identification measure is two dimensional can be accepted. Internal consistency was calculated using Cronbach’s alpha statistic, $\alpha = .799$. This suggests items in the psychometric are closely related and can be assumed to measure identification. The scree plot and parallel analysis can be viewed in Appendix H.

Discriminant validity was again calculated through a correlational analysis between cognitive and affective identification and the extent to which someone is religious. Cognitive identification towards EBE and extent to which they are religious was insignificant, $r = .041$, $p < .673$. Affective identification towards EBE and religion was also insignificant, $r = .033$, $p < .736$. Convergent validity was calculated through a correlational between cognitive and affective identification and mental health and professional identities. Cognitive identification towards EBE and mental health identities was significant $r = .233$, $p < .05$. Affective identification towards EBE and mental health identities was insignificant, $r = .099$, $p < .313$. These findings suggest that the process of cognitive identification between trainees and EBEs are related to mental health identities. It also suggests identification between trainees and EBEs is not related to the process of affective identification. Empathy, $r = .196$, $p < .05$ and Non-judgemental, $r = .371$, $p < .001$ were positively correlated with trainees affective identification towards EBE, suggesting that common factors of empathy and being non-judgemental is related to trainees who have more emotional connections with EBEs.

Trainee to Carer Identification

The factor structure of the nine item Social identification measure towards Carers was tested. This was analysed by factor analysis through a PCA with an oblimin (oblique) rotation, as items were thought to be correlated. The sampling adequacy was acceptable (KMO = .80) and Bartlett's test of sphericity showed that correlations between items were large enough for a PCA ($X^2(36)=609.33$, $p <.001$). Five items loaded onto the Cognitive identification factor, which had an Eigenvalue of 3.518 and a cumulative variance of 39.09%. The second factor was Affective Identification that had four items loading onto it, which had an Eigenvalue of 2.886, adding variance of 32% with a cumulative variance of 71.158%. Using the Kaiser1 factor method to determine number of factors alongside parallel analysis and the scree plot, two factors were identified in this analysis and so the identification tool can be considered two dimensional. This means that the hypothesis that social identification occurs two dimensionally can be accepted. Internal consistency was calculated using Cronbach's alpha statistic, $\alpha = .804$. This suggests items in the psychometric are closely related and can be assumed to measure identification. The scree plot and parallel analysis can be viewed in Appendix I.

Discriminant validity was calculated through a correlational analysis between cognitive and affective identification and the extent to which someone is religious. Cognitive identification towards Carers and religion was insignificant, $r = -.081$, $p < .402$. Affective identification towards Carers was also insignificant, $r = -.022$, $p <.824$. Convergent validity was calculated through a correlational analysis between cognitive and affective identification and mental health and professional identities which were all insignificant. However, the common factors of non-judgemental traits were positively correlated with Carer identification, $r = .433$, $p <.001$. These findings suggest that trainees do not relate with Carers either cognitively or affectively. Although trainees who were less judgemental were related to an association and identification with Carers.

Trainee to EBQ identification

The factor structure of the nine item Social identification measure towards EBQs was tested. This was analysed by factor analysis through a PCA with an oblimin (oblique) rotation, as items were thought to be correlated. The sampling adequacy was acceptable (KMO = .76) and Bartlett's test of sphericity showed that correlations between items were large enough for a PCA ($X^2(36)=414.49$, $p <.001$). Five items loaded onto the Cognitive identification factor, which had an Eigenvalue of 3.508 and a cumulative variance of 38.981%. The second factor was Affective Identification that had three items loading onto it, which had an Eigenvalue of 2.049, adding variance of 22.764% with a cumulative variance of 61.745%. Using the Kaiser1 factor method to determine number of factors alongside parallel analysis and the scree plot, two factors were identified. A third factor had an Eigenvalue of 1.052 and contributed 11.692% variance, however this was not considered an additional factor when parallel analysis is accounted for. Although the manifestation of this third component warrants further exploration. This means the hypothesis that the factor structure is two dimensional cannot be accepted and requires further confirmatory analysis, especially because three dimensions were found in Phase 1. Internal consistency was calculated using Cronbach's alpha statistic, $\alpha = .783$. This suggests items in the psychometric are closely related and can be assumed to measure identification. The scree plot and parallel analysis can be viewed in Appendix J.

Discriminant validity was calculated through a correlational analysis between cognitive and affective identification and the extent to which someone is religious, which is thought to be unrelated. Cognitive identification towards EBQ and religion was insignificant, $r = -.152$, $p < .116$. Affective identification towards EBQ and religion was also insignificant, $r = -.054$, $p <.581$. Convergent validity was calculated through a correlational between cognitive and affective identification and mental health and professional identities. Cognitive identification towards EBQ and professional identity was significant, $r =.412$, $p <.001$. Affective identification towards EBQ and mental health identities was insignificant. Affective identification towards EBQ and the common factors of empathy, $r = .294$, $p <.05$ and genuineness, $r = .207$, $p <.05$ were significant. Although, nonjudgemental attitudes were insignificant. This suggests the process of cognitive identification better explains how trainees relate to EBQs.

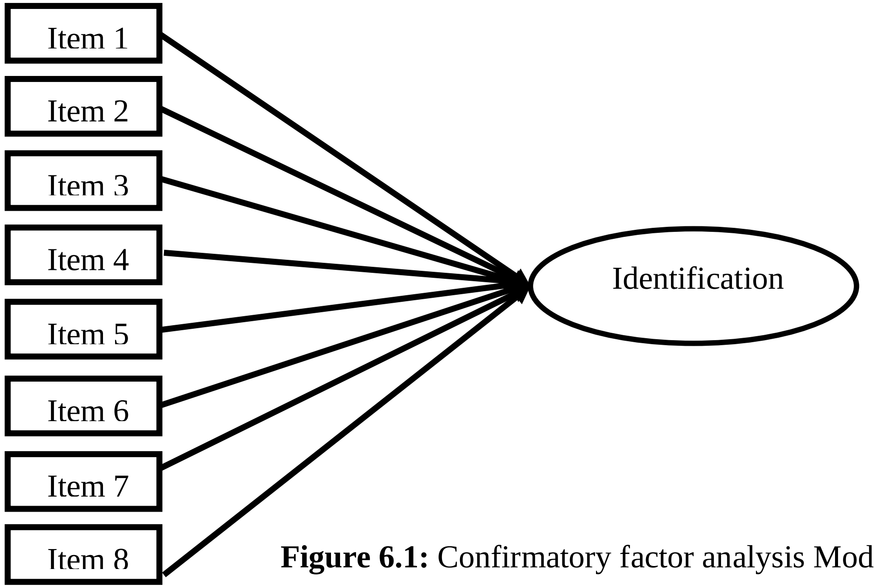


Figure 6.1: Confirmatory factor analysis Model 1

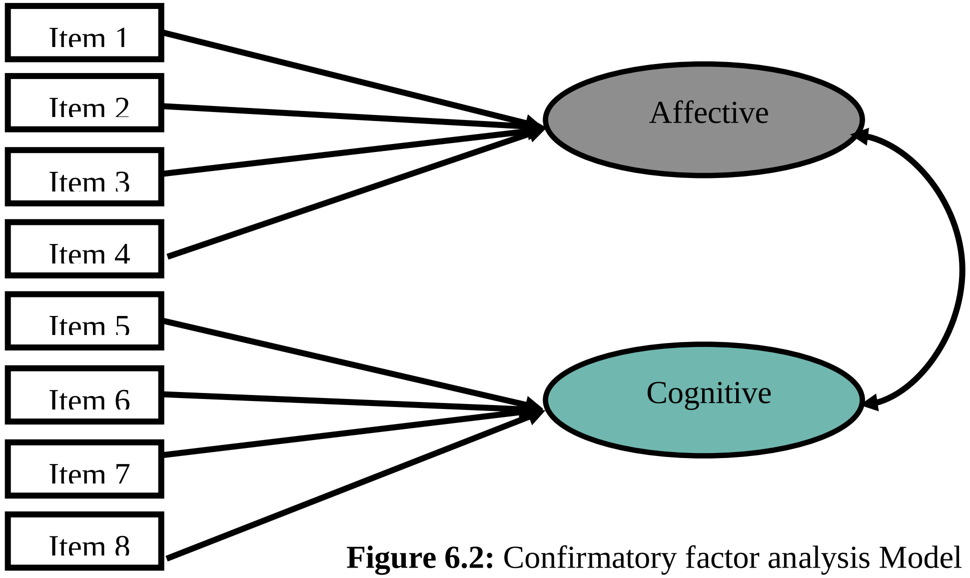


Figure 6.2: Confirmatory factor analysis Model 2

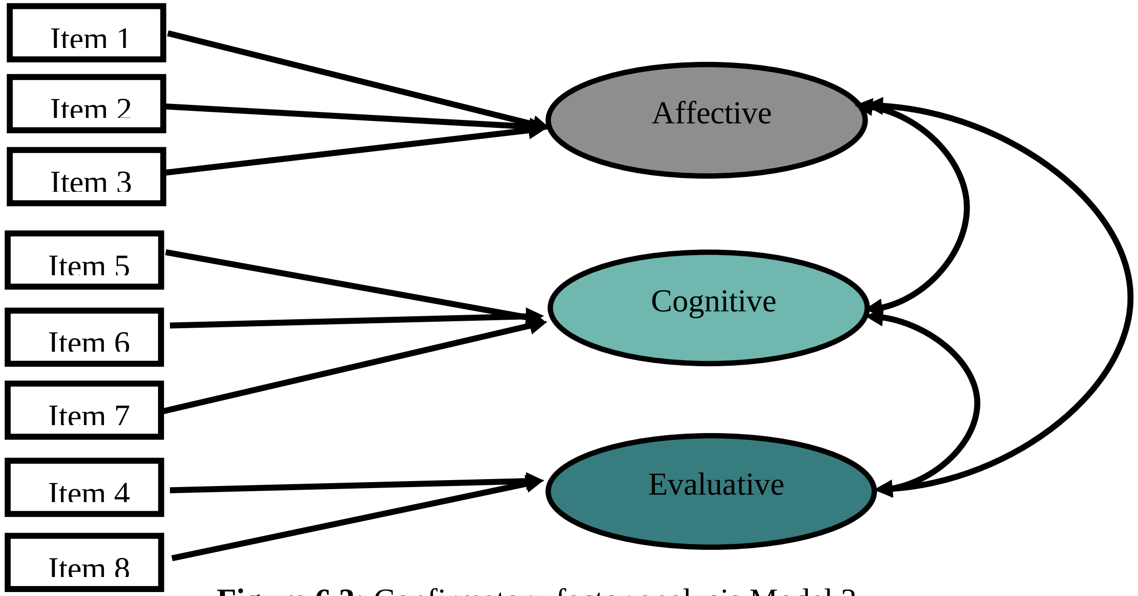


Figure 6.3: Confirmatory factor analysis Model 3

6.5. PHASE 3. CONFIRMING THE FACTOR STRUCTURE

Using data from Phase 2, a confirmatory factor analysis using Amos SPSS software was performed to examine how good the fit the proposed measurement model fitted with the Social identification measure. The eight observed factors were input into the analysis and the latent factors were based on the confirmatory models, including model 1 (identification factor), figure 6.1, model 2 (cognitive and affective factors), figure 6.2 and model 3 (cognitive, affective and evaluative factors), figure 6.3. The analysis was undertaken separately for each of the four in-groups: Trainee Clinical Psychologists, EBE, Carers and EBQ. Model 1 examined a one- dimensional model of identification for each of the 8 items. Model 1 did not fit any of the four groups' data. Model 2 was also used to see if the data confirmed a two-factor model of cognitive and affective identification, each made up of four items. Model 3 fit the data best and this confirmed that the data consisted of three factors of affective, cognitive and evaluative identification, 3 items loaded onto affective, 3 items loaded onto cognitive and 2 items loaded onto evaluative factors. Model 3 fit the data best across all four in-groups, as highlighted in Table 6.6.

Table 6.6. Confirmatory factor analysis

Measurement model	**X2**	**p**	**df**	**RMSEA**	**CFI**	**TLI**	**AIC**
Trainees							
Model 1	155.891	<.001	20	0.257	0.696	0.575	203.891
Model 2	32.931	<.024	19	0.084	0.969	0.954	82.931
Model 3	24.073	0.117	17	0.064	0.984	0.974	78.073
EBEs							
Model 1	107.83	<.001	20	0.205	0.708	0.591	155.83
Model 2	34.385	<.017	19	0.088	0.949	0.925	84.385
Model 3	30.678	<.022	17	0.088	0.955	0.925	84.678
Carers							
Model 1	223.334	<.001	20	0.31	0.614	0.46	271.334
Model 2	46.748	<.001	19	0.117	0.947	0.922	96.748
Model 3	52.287	<.001	17	0.14	0.933	0.89	106.287
EBQs							
Model 1	166.909	<.001	20	0.263	0.544	0.362	214.909
Model 2	22.627	0.254	19	0.042	0.989	0.983	72.627
Model 3	15.172	0.583	17	0	1	1.009	69.172

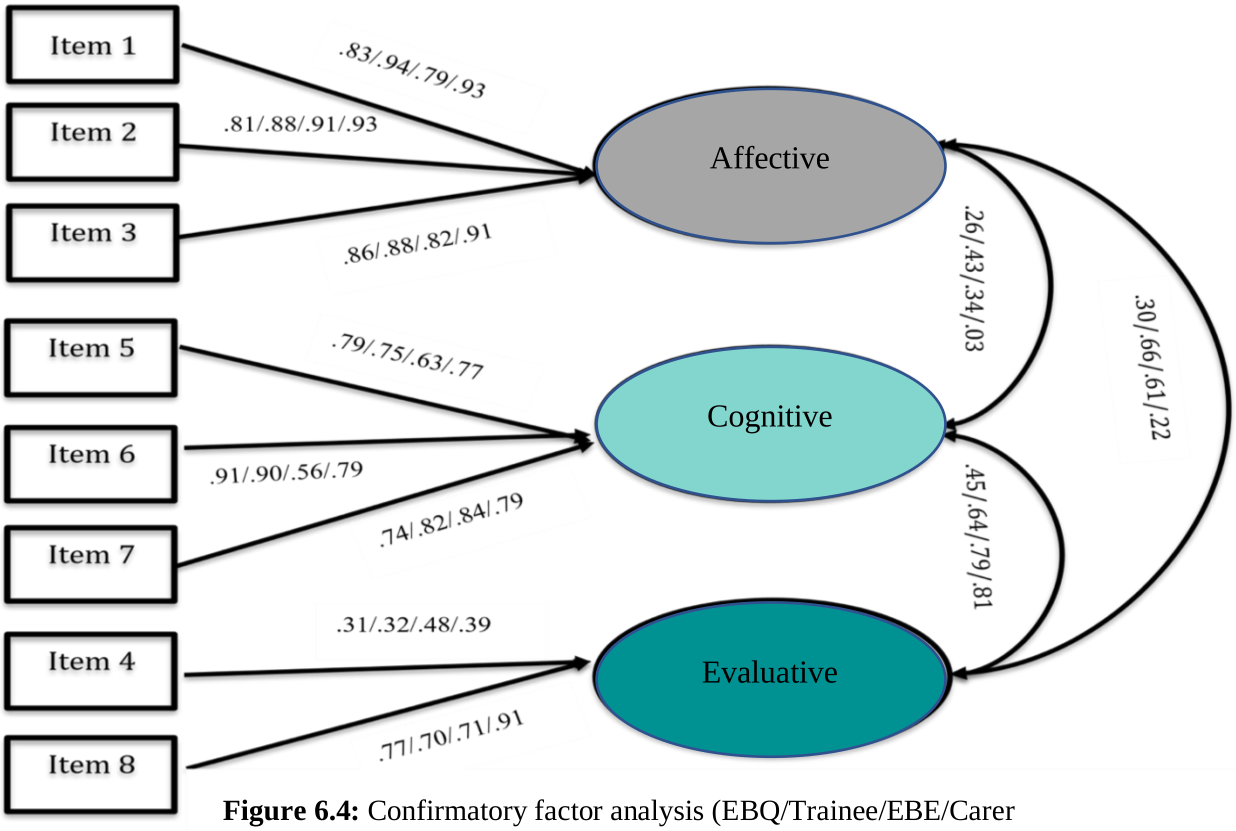


Figure 6.4: Confirmatory factor analysis (EBQ/Trainee/EBE/Carer Standard estimates

As shown in Figure 6.4, all standardised estimates and their loadings onto the affective factor was through 3 items which were all above .79 for each group. All loadings onto the cognitive factor of 3 items were all above .63 apart from one that was .56 for EBE in group. Loadings onto the Evaluative components made up of 2 items were lower in value with item 8 having loadings of .70 or above but the second item having item loadings of above .31. The covariances between the latent factors of affective, cognitive and evaluative were also calculated. The factors appeared to be distinct with estimates between affective and cognitive ranging between .03 and .43. Affective and Evaluative covariance ranged between .22 and .61 which also suggested they were distinct components. However higher loadings between Cognitive and Evaluative factors ranging from .45 and .81 suggesting an overlap between factors. These findings suggest that the psychometric of cognitive and affective identification is a three factor model with an additional component, labelled evaluative identification and so the initial first hypothesis can be rejected.

6.6. PHASE 4. ASSESSING THE PREDICTORS OF IN-GROUP IDENTIFICATION

6.6.1. Data analysis procedure

Data from Phase 2 were used to understand the mechanisms that influence social identification and a cognitive or affective connection, personality variables of the Big Five (John & Srivastava, 1999) (Openness, Conscientiousness, Extraversion, Agreeableness and Emotional stability) through the Ten Item Personality inventory (Gosling et al, 2003) and the Dark triad (Paulhus & Williams, 2002) (Narcissism, Machiavellian and Psychopathy) through the Dirty Dozen (Jonason & Webster, 2010). Additionally, single-item measures of mental health and professional identities were administered. The items that load onto each factor were computed into variables using the mean function. Personality variables of the Big Five and the Dark Triad were also computed into variables after reverse coding of items was accounted for. These were entered into a stepwise multiple regression analysis in order to see if they predicted type of identification differentially.

Table 6.7. Descriptive statistics and alpha of identification measures

Identification towards Trainees	**Affective**		**Cognitive**	
	Mean	**α**	**Mean**	**α**
Trainee ID	5.938	.809	4.89	.823
EBE ID	6.072	.664	3.866	.752
Carer ID	5.719	.633	3.112	.860
EBQ ID	5.910	.615	5.097	.774

6.6.2. Results

How trainees identify with their trainers

H2: Trainees will cognitively identify with EBQ

H3: Trainees will affectively identify with EBE

One of the main aims in the research was to establish that identification towards EBQs and EBEs would occur through different processes. It was hypothesized that trainees would cognitively identify with EBQs, as this was their predominant identity. The second hypothesis suggests trainees will cognitively identify with EBQ is shown to be true in the descriptive statistics with the mean score being the largest in cognitive identification, as shown in Table

6.7. The correlational analyses in table 6.9 also illustrate that trainees with professional identities cognitively identify with EBQs. Therefore, again the hypothesis can be accepted.

The third hypothesis suggests trainees will affectively identify with EBE as the EBE was thought to invoke more emotive responses. This hypothesis is shown to be true in the descriptive statistics with the mean score being the largest for affective identification, as shown in Table 6.7. This is also illustrated in Table 6.9 where trainees who affectively identified with trainees also affectively identified with EBEs. Therefore, again the hypothesis can be accepted.

The relationships between identification and mental health and professional identities

Table 6.9 shows the relationships between trainee identification towards each trainer and mental health professional identities. The extent to which the trainee identifies with their occupational identity and mental health identity is r = .542, p <.001 which suggests a strong association between the two identities for trainee clinical psychologists.

The extent to which the trainee had a mental health identity was also related to cognitive identification towards trainees (r = .228, p <.05), cognitive identification towards EBEs (r = .244, p <.05) and cognitive identification towards EBQs (r = .243, p <.05). There was also associations between occupational identity and trainees cognitive identification towards trainees (r = .481, p <.001) and cognitive identification towards EBQs (r = .440, p <.001).

There also appeared to be a relationship between evaluative identification and cognitive identification relating to trainee identification towards each trainer. Cognitive identification towards trainees and Evaluative identification towards trainees were significantly associated (r= .397, p <.001). Cognitive identification towards EBEs and Evaluative identification towards EBEs was also significantly associated (r = .490, p <.001). Cognitive identification towards Carers and Evaluative identification towards Carers was also associated (r = .574, p <.001). Trainee cognitive identification towards EBQs and evaluative identification towards EBQs (r = .314, p <.001). This suggests that the process of cognitive identification is significantly related to the process of evaluative identification. This suggests that the process of affective identification may be distinct to cognitive and evaluative identification. Table 6.9 shows other significantly associated variables.

Cognitive, Affective and Evaluative identification as predictors of Professional and Mental health identities

H4: Cognitive identification will predict Professional Identities

H5: Affective identification will predict Mental health identities

Table 6.8: A multiple regression analysis to understand how Cognitive, Affective and Evaluative identification of trainees towards groups in clinical psychology training predict professional and mental health identities.

		B	**T**	**R2**	**AR2**	**Sig**
Professional identity	**Cognitive Trainee ID**	.319	3.662	.231	.224	<.001
	Cognitive EBQ ID	.296	3.111	.285	.272	<.05
	Evaluative Carer ID	-.197	-2.512	.327	.307	<.05
Mental health identity	**Cognitive Trainee ID**	.465	3.832	.069	.060	p<.05
	Evaluative Carer ID	-.440	-3.705	.176	.160	P<.001
	Cognitive EBQ ID	.245	2.122	.211	.187	P<.05

Based on the observations of the PhD researcher regarding the power of emotional connections between those in a profession and in-group (as documented in the reflexivity section) and prior hypotheses of the study it was important to test the relationship between identification and professional and mental health identities. Correlational analyses found significant associations between professional identities and cognitive identification as shown in table 6.9. A multiple regression analysis was carried out to predict whether cognitive and affective identification variables predicted professional and mental health identities through a stepwise multiple regression as shown in Table 6.8.

Professional identity was predicted by three types of identification predicting variance of 32.7%, with a significant model ($F(3,103) = 16.645$, $p < .001$). Professional Identity was predicted by Cognitive Trainee ID ($B = .319$, $p < .001$), Cognitive EBQ ID ($B = .296$, $p < .05$), Evaluative Carer ID ($B = -.197$, $p < .05$). This means that the fourth hypothesis can be accepted. Cognitive identification of trainees and EBQs leading to a professional identity might occur because these roles are more associated with the idea of what it means to be a professional and a motivation to develop this professional identity as a result of their training. Being negatively related to an evaluative identification towards Carers might mean trainees are seeking to protect themselves from the burden of what it means to be a Carer.

Mental health identity was predicted by three types of identification predicting variance of 21.1% with a significant model (F(3,102)= 9.073, *p* <.001). Mental health identity was predicted by Cognitive Trainee ID (*B* =.465, *p* <.05), Evaluative Carer (*B* = -.440, *p* <.001), and Cognitive EBQ ID (*B* = .245, *p* <.05). This means the fifth hypothesis that predicted mental health identities would be predicted by affective identification can be rejected. Instead, cognitive identification is shown to predict this. Cognitive identification towards trainees and EBQs, may have occurred as the profession of clinical psychology may be formative to the development of a mental health identity and this might be facilitated by the idea that trainee and EBQ identification are their predominant identities, resulting through a cognitive and self-defining process. A negative predictor of an evaluative identification towards the Carer in predicting a mental health identity may again have occurred through the process of dissonance and a need to distance themselves from the burden of what it means to be a Carer.

The fourth hypothesis was that Cognitive identification will predict Professional Identities and this was true for identification towards trainees, EBQ and negatively associated to an Evaluative judgement towards Carers. Professional identities were also not predicted by affective identification.

The fifth hypothesis was that Affective identification will predict Mental health identities, however the only affective component that predicted this was Carer Evaluative identification and this was negatively associated. A cognitive identification towards trainees and EBQ also predicted mental health identities.

Table 6.9: Assessing the relationships between identification and professional and mental health identities through correlation.

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. My experiences of mental health define who I am	1													
2. My occupational role defines who I am	.542**	1												
3. Affective Trainee ID	0.068	0.163	1											
4. Cognitive Trainee ID	.228*	.481**	.362**	1										
5. Evaluative Trainee ID	0.011	0.104	.407**	.397**	1									
6. Affective EBE ID	0.044	0.096	.196*	0.04	0.115	1								
7. Cognitive EBE ID	.244*	0.156	-0.08	.228*	-0.011	.207*	1							
8. Evaluative EBE ID	0.008	0.016	-0.073	0.125	.334**	.383*	.490**	1						
9. Affective Carer ID	-0.088	0.012	.279**	.206*	0.097	.575**	0.095	.318**	1					
10. Cognitive Carer ID	-0.072	-0.14	0.037	-0.009	-0.012	0.014	.399**	0.129	0.03	1				
11. Evaluative Carer ID	-0.176	-0.18	-0.001	0	0.138	.221*	.443**	.574**	.371*	.559**	1			
12. Affective EBQ ID	-0.023	0.065	.444**	.212*	0.148	.390**	-0.04	0.134	.500*	0.093	0.108	1		
13. Cognitive EBQ ID	.243*	.440**	-0.008	.488**	.203*	0.019	0.177	0.153	0.003	0.097	0.086	.208*	1	
14. Evaluative EBQ ID	-0.07	0.082	0.072	.360**	.493**	0.141	0.014	.276**	.252**	-0.018	.232*	.208*	.314**	1

*Significant at p <.05, **Significant at p <.001.

A MULTIPLE REGRESSION ANALYSIS

Table 6.10: A Multiple regression analysis using personality variables as predictors of cognitive and affective identification.

Predictor personality variables The Big Five and The Dark Triad						
		B	**T**	**R^2**	**AR^2**	**Sig**
Affective Trainee	**Psychopathy**	-.746	-4.695	.098	.089	<001
	Emotional Stability	-.323	-3.340	.185	.170	<.001
Cognitive Trainee	**Narcissism**	.346	11.130	.114	.106	<.001
Affective EBE	**Machiavellian**	-.119	-2.437	.067	.058	<.05
	Agreeableness	.118	2.071	.104	.087	<.05
Cognitive EBE	**Openness**	.301	2.449	.054	.045	<.05
	Emotional Stability	-.235	-2.199	.096	.079	<.05
Affective Carer	**Psychopathy**	-.389	-3.526	.105	.097	<.001
Evaluative Carer	**Extraversion**	-.177	-2.214	.044	.035	<.05
Affective EBQ	**Machiavellian**	-.197	-2.659	.100	.091	<.001
	Narcissism	.176	3.033	.152	.136	<.05
	Psychopathy	-.281	-2.369	.196	.172	<.05
Cognitive EBQ	**Narcissism**	.338	3.912	.092	.083	<.001
	Conscientiousness	.244	2.604	.147	.131	<.05
Evaluative EBQ	**Machiavellian**	-.220	-2.341	.049	.040	<.05

H6: Personality types will predict Identification differentially

As shown in Table 6.10, a multiple regression analysis was carried out to predict whether personality variables of the big five and the dark triad predicted cognitive, affective and evaluative identification towards trainees, EBE, carers and EBQ differentially.

Affective Trainee identification was predicted by two personality variables accounting for 18.5% variance. The model was also significant (*F* (2,104) = 11.822, *p* <.001). Psychopathy (*B* = -.746, p <.001) and Emotional Stability (*B* = -.323, *p* <.001) both negatively predicted affective identification towards trainees. This suggests that instability is a motivating factor in the process of identification.

Cognitive Trainee identification was predicted by one personality variable accounting for 11.4% variance. The model was also significant (*F*(1,105) = 13.573, *p* <.001), with Narcissism (*B* = .346, *p* <. 001). This suggests that trainees with narcissistic traits were more likely to cognitively identify with trainee psychologists. This might mean that narcissim predicts trainees identifying with people who are the same as themselves.

Affective identification with EBEs was predicted by two personality variables accounting for 10.4% of variance. The model was also significant (*F* (2,105) = 6.079, *p* <.05). Machiavellian predicted (*B* = -.119, *p* <.05) and Agreeableness (*B* = .118, *p* <.05) suggesting that those with “lighter” personality types were likely to predict identification towards EBEs.

Cognitive identification with EBEs was predicted by two personality variables accounting for 9.6% of variance. The model was also significant (*F*(2,105) = 5.570, *p* <.05. Openness (*B* = .301, *p* <.05) and Emotional Stability (*B* = -.235, *p* <.05). This again suggests that instability motivated a cognitive identification with EBEs, which might suggest trainees with lived experience might predict this.

Affective identification with Carers was predicted by one personality variable, Psychopathy and accounted for 10.5% variance. The model was also significant (*F* (1, 106) = 12.434, *p* <.001). Psychopathy predicted (*B* = -.389, *p* <.001). This negative prediction of psychopathy predicting affective identification towards Carers is suggestive of the idea that those with “ligher” personality types and those who are caring are likely to identify more emotionally with Carers.

Evaluative identification towards Carers was predicted by Extraversion, accounting for 4.4% of variance. The model was also significant (*F* (1,106) = 4.901, *p* <.05). Extraversion predicted (*B* = -.177, *p* <.05). A negative predictor of Extraversion towards an evaluative response to Carers might be linked to those who are more introverted traits that are likely to be affected when Carers are criticized.

Affective identification towards EBQs was predicted by three personality variables accounting for 19.6% variance. The model was also significant (F (3,104) = 8.433, p <.001). Machiavellian predicted (B = -.197, p <.001), Narcissism predicted (B = .176, p <.05) and Psychopathy predicted (B = -.281, p <.05). This suggests that Narcissism in trainees is also related to an affective identification towards EBQs which might be because of trainees seeking to attain the professional level and status of an EBQ. Psychopathy and Machiavellian are negative predictors, suggesting that trainees are generally motivated through “lighter” traits and fits with the idea that psychology is a caring profession.

Cognitive identification towards EBQs was predicted by two personality variables and accounted for 14.7% variance. The model was also significant (F (2, 105) = 9.032, p <.001).

Narcissism (B =.338, p <.001) and Conscientiousness (B = .244, p <.05) predicted this which are both personality traits that are linked with ambition and status seeking and could be considered dark components to personality (Coleman, Furnham & Treglow, 2022) that may be responsible for an affinity to identify with EBQs.

Evaluative identification towards EBQs was predicted by one personality variable of Machiavellian, which accounted for 4.9% variance. The model was also significant (F(1,106)= 5.480, p <.05). Machiavellian predicted (B = -.220, p <.05). This suggests that the opposite of Machiavellian, a more caring response towards EBQs occurs when they are criticized where trainee clinical psychologists are personally affected by what happens to the EBQ.

The sixth hypothesis was that Personality types will predict Identification differentially and this can be accepted as shown in Table 6.10. For example, Psychopathy and Emotional stability predicted Affective identification towards trainees. Narcissism predicted Cognitive identification towards trainees. Openness and Emotional stability predicted Cognitive identification towards EBE. Extraversion predicted Evaluative identification towards Carers. Machiavellian, Narcissism and Psychopathy, all three components of the dark triad also predicted Affective identification towards Experts by Qualification. Narcissism and Conscientiousness also predicted Cognitive identification towards Experts by Qualification. Therefore, this variation in personality predictors of identification suggest unique mechanisms that influence this process and means we can accept the hypothesis that personality variables will lead to the process of identification in differential ways.

6.7. Discussion

The primary aim of this four-phase pilot study reported in this chapter was to develop a reliable and valid measure for in-group identification for use with groups in clinical psychology training (EBEs, Carers, Trainees and EBQs) and to establish mechanisms that influence identification. This involved adapting and using an 8-item measure of cognitive and affective social identification (Johnson et al., 2012) and the addition of a single item measure of identification (Postmes et al., 2013). Exploratory and confirmatory factor analysis was performed to understand the factor structure of the social identification measure, and reliability, convergent and predictive validity were also tested. The study highlights how trainee psychologists relate to peers and trainers within clinical psychology training, providing insight into individual differences in mental health and professional identities, and personality traits and their influence on the process of identification. The following discussion outlines the main findings across the phases of the study and how they relate to the hypotheses set out, which are discussed in relation to the wider literature.

The first hypothesis predicted that the factor structure of the social identification measure would be two dimensional. Each application of the tool measuring trainees' identification towards trainees, EBE, carers and EBQ, found two-dimensional constructs of cognitive and affective factors. However, a subsequent confirmatory factor analysis showed the measure to be three-dimensional. The findings illustrate that whilst a two-dimensional construct was sufficient and captured a lot of the variance, a three-dimensional model may better explain the process of identification. The final three factors of the identification tool were cognitive, affective and evaluative forms of identification. The standard estimates through items 1, 2 and 3 loaded onto the affective factor as predicted (*I feel happy to work with* ( ); *I am proud to work with* ( ) *within a Clinical Psychology programme*; *It feels good to work with* ( )) and 5, 6 and 7 onto the cognitive factor (*My self-identity is based in part on membership/connection to* ( ) *group* ; *I think of myself as a member of a* ( ) *group and this is very important to my sense of who I am*; *My sense of self overlaps with the identity of* ( )), and 4 and 8 onto the evaluative factor. On closer inspection of the items that loaded onto the third factor, these alluded to a sense of personal ties and evaluative responses to the other and was consequently labelled Evaluative (*if an* () *was asked to leave their role, I would be very disappointed* (item 4) and *If a* () *was criticised, it would influence how I thought about myself* (item 8)). Item 9 (*I Identity with* ()) loaded variably onto affective and cognitive factors. The research is the first to establish a reliable and valid measure of identification in the context of UK clinical psychology training, and the first to measure trainee clinical psychologists' identification to each of their trainers. Each of the three factors were distinctive in nature with clarity of items loading onto each factor that were reliably replicated across each sample, but collectively as a total scale reliably measured the process of identification.

The Social identification measure was adopted from Johnson et al., (2012) for its two-dimensional psychometric properties in order to measure cognitive and affective identification specifically, and so it casts doubt over the validity of its factor structure, as the confirmatory factor analysis unconvered a third latent factor in this research. Although, it contributes to the theoretical evidence base on the processes that determine social identification. Leach et al., (2008) found two broader dimensions in their development of a hierarchical measure of in-group identification suggesting that both cognitive and affective identification were made up of additional components. This highlights the importance of identifying the nuance to the composition of cognitive, affective and, additionally, evaluative identification factors. Further research in the context of clinical psychology training could extend this knowledge base to better understand the components that contribute to these three factors. This manifestation of the third factor suggests that the nature of identification may be more complex, and the two-dimensional nature found in previous research may not adequately capture the phenomenon of in-group identification. Other researchers have found three dimensions of in-group identification such as Obst & White, (2005) and Cameron, (2004) that bears similarity to the findings in this research. However, the third factor only accounts for a small proportion of the variance and items also loaded onto the other two factors. A three-factor model is supported by Postmes et al., (2013) suggesting cognitive, affective and evaluative components contribute to the process of identification.

Trainees identification towards EBEs was not affective in nature and did not predict mental health identities. This lack of emotional connection to EBEs may be to keep trainees safe from the emotional burden that may arise through connecting with EBEs and their lived experiences. This may, to some extent be explained by research into burnout of healthcare providers and their empathetic responses towards patients (Wilkinson et al., 2017). Alternatively it might be because EBEs might be sharing their experiences in a less affective and more professionalized way, so others can tolerate their experiences (Toikko, 2016) Most of the trainees were not service users or carers themselves which may have impacted the findings. However, another causal factor may have been a result of methodological issues resulting in a lack of detection of an affective identification. The use of the phrasing of "*defines who I am*" in the mental health and professional identity single item measures may have caused the trend towards cognitive identification factors, as self-definition is thought to be a cognitive process (Tajfel & Turner, 1979).

Single items have been used by Postmes et al., (2013) to measure identification, which demonstrated reliability and validity, however it accounted for more of an affective component (self-investment). This suggests that single item measures may not be adequate in measuring two dimensional components as documented by Allen et al., (2022) in understanding the advantages and disadvantages in using single-item measures. The authors identify how single-item measures may inhibit the measurement of more nuanced latent structures and which may explain why professional and mental health identities are one dimensional and in contrast, cognitive in nature. This may have consequently impacted being able to observe an emotional connection and the mental health identities between trainees and their trainers.

A cognitive connection towards mental health identities and EBEs may have occurred due to the professionalisation of these roles within clinical psychology training. EBEs conduct themselves in professional spheres and engage in professional behaviour (Norwood et al., 2019) and thereby may influence professional development (Tew et al., 2012). This may have influenced the cognitive connection between the trainee participants and EBEs, as opposed to an affective connection. Supporting literature in mental health nurse and counselling psychology training also suggests that trainee identification to mental health and professional identities may be a result of factors that are related to cognitive aspects of identification (McCrae et al., 2014; Gazzola et al., 2011). The findings of the cognitive factor dominating the process of identification fits with the discourse and historical tendency towards favouring cognitive processes and its efficacy in measuring the process of identification, suggested by identity researchers (Tajfel & Turner, 1979).

The trainee participants cognitively identified with other trainees and EBQs and this may be because that is their dominant social and aspired identity. Although this may have also been influenced by the influence of clinical psychologists and research psychologists being referred to by the label of EBQ, which may have exerted additional power and certainty to the trainee to identify with such an identity. This might be related to the effect of labelling theory that can result in a self-fulfilling prophecy where the individual or group of people are understood as exhibiting qualities associated with the label used to describe them (Becker, 1963).

The way the trainee participants identified with EBEs and EBQs was similar in nature and driven through a predominantly cognitive process. The factor structure between trainee identification towards EBEs and EBQs was also clearly defined with the same items loading onto each of the three factors. Mayer & McKenzie, (2017) identify how EBEs are roles that share some of the same characteristics as a service provider, which may account for the similarity in how the trainee participants relate to them, in a similar way to how they relate to EBQs, suggesting they are accepted as experts and trainers in clinical psychology.

Cognitive identification of trainee clinical psychologists towards EBQs was found to occur through traits of conscientiousness and narcissism. This coalesces with previous research that finds traits of conscientiousness is linked to professional development among healthcare professionals (McLachlan et al., 2009). The results of this study also showed that narcissism was linked to cognitive identification towards EBQs. This might be explained by research that explains how those with narcissistic traits are often status seeking (Grapsas et al., 2020), which might explain the need to identify with a prestigious profession such as clinical psychology training.

A lack of affective connection to EBE and mental health identities may be due to EBEs not being fully integrated into clinical psychology programmes (as demonstrated in Chapter 5) which may have also been further impacted by COVID-19 and the restrictions this placed on the relationship dynamics between EBEs and trainees. However, trainees who did affectively identify with EBEs did so through personality traits of agreeableness and negatively associated Machiavellian, which suggests face validity and relates to the common view of the clinical psychology profession being a helping professions (Kramer et al, 2019).

The negative predictor of cognitive identification towards carers and professional identities may indicate that carer identities are not seen as professionals or experts within clinical psychology training. This is reinforced in findings in Chapter 5, that finds that carers are not connected to by trainees in clinical psychology training and carers themselves feel like outsiders within the multidisciplinary team in clinical settings. The label of ’carer’ does not confer a professional status and thereby may negate from being perceived as a professional identity within their roles in clinical psychology training. Tambuyzer & van Audenhove, (2013) find that carer involvement is viewed as less important than service user involvement in mental health education. There may however be other reasons why the trainee participants in this research did not connect with carers such as their age, a lack of personal experience as a carer, and the focus within mental health services prioritising the needs and expertise of service users over carers, which all may have impacted these results. The triangle of care (Hannan, 2013) identifies three key roles in a patients' healthcare, including the patient, the carer and the healthcare provider. Its adaptation to the context of UK clinical psychology training may support understanding the value of each member in the triangle and highlight the importance of EBEs, Carers and EBQs and their influence on the training of trainee clinical psychologists and their equal importance. This might be further facilitated through giving carers expert status and labelling them Expert Carers.

Narcissism was found to be a predictor of cognitive identification towards trainees and EBQs. Similarly, findings suggest that Narcissism may encourage a cognitive identification towards professional identities. This might be explained through a theory akin to the self-esteem hypothesis (Stets & Burke, 2014). For example, in order to satisfy any negative feelings associated with their roles as trainee clinical psychologists they may seek prestige in the trainee or clinical psychology identity that influences their identification towards the profession and EBQs.

Emotional stability negatively predicted affective identification towards EBEs. This might mean that trainees who are less emotionally stable relate more with EBEs, and this fits with the previous hypotheses that those with lived experience connect with others who also have lived experience. Emotional stability is linked with better mental health outcomes (Hills & Argyle, 2001) and therefore a negative predictor of this could mean that trainees with experiences of mental illness relate more with EBEs, due to their common experiences of emotional instability. Emotional stability also negatively predicted affective trainee identification, and this may be explained through the certainty that comes through belonging to a social identity that reduces emotional instability (Hogg, 2012).

Another notable finding is that the dark triad appears to predict trainee identification significantly towards EBQ. Narcissism is positively related and Machiavellian and Psychopathy negatively related. This coalesces with an implicit and anecdotal view of the trainee clinical psychologist identity being ambitious and to some extent how they may feel special through their occupational identity. In contrast, Machiavellian and Psychopathy were negative predictors and fit with face validity as they may be considered undesirable traits in a healthcare professional. These findings may have manifested through social desirability effects, (Edwards, 1953) as items measuring these constructs were overtly measured, potentially biasing the findings of the study. The results however, do have face validity. These findings fit with the stereotypes and anecdotal feedback from colleagues in the profession associated with being a trainee clinical psychologist. It is important to consider the influences of stereotypes, as it could be assumed that identities are to some extent constructed by them (Lie, 2012) and which also may have influenced the findings.

Another key point is how the process of identification of trainee clinical psychologist participants towards other trainees and EBQ better fit models a three-dimensional construct, encompassing cognitive, affective and evaluative types of identification. This lies in contrast to how trainees identified with EBE and Carer that were shown to better fit two-dimensional models of cognitive and affective identification. Trainee identification towards trainees and EBQs might have occurred three dimensionally because of the strength of the connection between them, that was able to more sensitively detect the Evaluative component. This might be because this is their predominant social identity and trainees may be more likely to be affected by the concept of a shared fate when considering other trainees and EBQs (Campbell, 2007) thereby resulting in an evaluative type of identification.

Trainee clinical psychologists' identification towards EBEs and carers may not have occurred in an evaluative way in order to protect the trainee from the emotional burden of their lived experiences through a dissonance between these groups. This might also be explained through compassion fatigue that results from burnout in a healthcare professional role that negatively impacts the compassion and empathy they have towards patients (Figley, 2002) Although the reverse was true in newly qualified clinical psychologists, where the evaluative component was detected in identification towards EBEs and Carers, suggesting the newly qualified and trainee clinical psychologist differ in their types of identification towards their trainers. This might be because trainees are still establishing their relationships with their trainers, and newly qualified psychologists may have better formed relationships with them. Alternatively, they may better understand how to manage their own emotional responses towards others and be better equipped to manage the emotions of others, having completed their clinical psychology training. This might account for the differences in findings between how these two populations identify with their trainers.

6.7.1. Strengths and Limitations

This pilot study was the first to develop an in-group identification measure in UK clinical psychology training, and to develop single-item measures of mental health and professional identities (see Appendix K). However, the sample of N = 108 trainee clinical psychologist participants was a relatively small sample and only participants from across 14 different clinical psychology courses participated out of a possible 38 courses across the UK, and so it was more difficult to observe effects in the data. This impacts its generalisability, with most of the sample being female and white and a lack of lived experience amongst participants, in service user or carer roles. The development and validation of this identification measure is specific to trainee clinical psychologists and may not be applicable to other populations. The items within each identification scale were also not randomised and this may have resulted in order effects and biased the responses (Strack, 1992) but their presentation was consistent across each participant. Short measures of the Dark Triad (Dirty dozen tool, Jonason & Webster, 2010) and Big Five personality (Ten item inventory, Gosling et al., 2003) were used that may have limited its measurement of variation. Social desirability (Edwards, 1953) may have also impacted the way trainee clinical psychologists responded to items, that may have been influenced by their perception of what is socially acceptable as a trainee clinical psychologist.

6.7.2. Further research

The findings of the studies reported in this chapter has several implications for future research. The identification measure developed for this research could be used and applied in other contexts. For example, applying the tool to lived experience researchers could aid in understanding their identification towards research populations they work with and may support them in navigating their identities in this research. Further research into the different effects cognitive, affective and evaluative identification have in understanding relationships with certain constructs or participant groups might be useful, for example, whether participants feel proud to be associated with the group or research population. The findings regarding the three-dimensional nature of identification can be used to support trainee clinical psychologists to work more effectively with groups within clinical psychology training, through tapping into and enhancing the affective, cognitive and evaluative connections they have towards their trainers. This could potentially be achieved through using illustrative examples within their training to ask trainees to reflect on how they connect with their trainers. Additionally, measuring the process of identification between trainees and their trainers and its influence on the learning and clinical skills of trainee psychologists would help contribute to the evidence base for EBE and EBQ involvement in training in exploring the different skills they teach trainee clinical psychologists.

There is no measure of mental health identity and further research to develop a tool or to validate the single item used within this study may be beneficial and useful in mental health settings. The research reported in this chapter also adds validity to the key findings from the focus group research in Chapter 5, in relation to carers and trainee clincial psychologists feeling disconnected from each other, suggesting that clinical psychology training needs to do more to embed Expert Carers and Experts by Experience within training and facilitate better connections with them. Additionally, further measurement of variables related to the process of social identity, for example, a sense of belonging, loneliness, feelings of difference between them and others, self-esteem, the health and wellbeing of the group and the process of identification could be explored in the future within the context of clinical psychology training. This would support a more cohesive application of the Social Identity Approach to the context of UK Clinical Psychology training.

The EMERGES framework identified in previous chapters are motivating factors leading to identity development so future research could explore whether the process of empowerment, motivation, empathy, recovery model and medical model (power dynamics), growth and transformation, exclusion and historical experiences of being a survivor lead to processes of identification differently between trainee clinical psychologists and their trainers.

6.8. Conclusions

This pilot study reported in this chapter has led to the development of a valid and reliable three-dimensional social identification measure of cognitive, affective and evaluative identification for use with trainee clinical psychologists. The research found that personality type predicts type of identification differentially. It also found that type of identification influences mental health and professional identities and this is influenced through a cognitive process. The psychometric measure can be used for further research within clinical psychology training and beyond and support research into how identification influences the learning process of trainee clinical psychologists from their trainers.

CHAPTER SEVEN

A PRELIMINARY Q-SORT STUDY

IDENTIFYING THE PRIORITIES FOR SUPERVISION BY LIVED EXPERIENCE RESEARCHERS

“*Knowing that you can relate to the research topic and the participants because you know you have shared similar experiences is one thing - but knowing how to use this relatability during your work, I find, is a skill I don't know how to use naturally.*”

~ Lived experience researcher

7.1. Introduction

In Chapter 4, a systematic narrative review, the impact of lived experience researcher roles on identity was explored, highlighting the difficulty and complexity of these roles. However, provision of support to lived experience researchers based on their identity and needs as a researcher is relatively unexplored. Faulkner & Thompson, (2021) identify practical ways to provide support to lived experience researchers to navigate their roles and consider the value of supervision for them. Limited guidance exists on how supervision can be most appropriately implemented.

This preliminary study aimed to explore the experiences and perceptions of lived experience researchers using Q methodology to identify their support needs from supervision. The study draws and builds on the themes and findings found from the systematic narrative review of the positions of identity: Professional, Service user, Integrated, Unintegrated and Liminal and related themes through the EMERGES framework: Enablers and Empowerment, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and Transformation, Exclusion and Survivor roots (Chapter 4). It also draws on findings from the focus group qualitative study on identities in clinical psychology training, that adds further nuance regarding the identities of experts by experience and experts by qualification with lived experience (Chapter 5) and quantitative study identifying cognitive, affective, and evaluative factors that lead to social identification (Chapter 6). Additionally, it identifies key themes from personal reflections of the lead lived experience researcher's experiences working in the field (Chapter 1) and reflections of the service user advisor to the thesis (Chapter 8). The key themes and ideas found in these chapters, that specifically related to the lived experience researcher identity and the issues they navigate in their roles, informed the development of the statements used within this study. The cumulative knowledge from across these chapters identifies the breadth and complexity of the lived experience researcher experience through a multiple methods approach. The purpose of this preliminary study is to shed further insight on the support needs of lived experience researchers and systematically examine the importance of these issues according to their perspective. This may help to synthesise the findings and provide useful insights for supervisors to better understand and meet the individual support needs of lived experience researchers they work with. This will be achieved through Q methodology to identify specific profiles of lived experience researchers and their priorities for supervision.

Q methodology allows an understanding of the subjective experiences of individuals (Watts & Stenner, 2012). Typically, the methodology asks participants to arrange a set of statements related to a subject and rank them according to how much they agree or disagree with them. In this case, lived experience researchers were asked to rank statements according to how useful they would find each discussion topic in supervision. The statements were gathered from themes and findings from across the thesis and ranked by participants on a pre-defined grid according to their usefulness. A type of inverted factor analysis was applied to the responses to understand how different lived experience researchers similarly or differently ranked the items. The findings were interpreted both quantitatively and qualitatively through contextual information provided by participants. This preliminary research fills a gap in the literature as a Q methodology study aiming to understand the subjective viewpoints of priority topics for supervision by lived experience researchers has not been carried out previously.

7.1.1. Aims and objectives

To understand the subjective needs of lived experience researchers from supervision using Q methodology.

7.2. Methodology

7.2.1. Design

Q methodology was used in a cross-sectional preliminary study, purposively sampling lived experience researchers to understand their subjective views on priorities for supervision. Q methodology enables identification of the subjective experiences of participants (Watts & Stenner, 2012) and can be effectively applied to understand the different experiences of lived experience researchers and their priorities for discussion in supervision. The research methodology will first help identify useful topics to discuss in supervision based on the wider literature and empirical findings from previous chapters in the thesis and following analysis, will then group lived experience researchers with similar needs into factors, by identifying how similarly they sort the statements in the Q sort task.

7.2.2. Recruitment and ethics

A total sample of 18 lived experienced researchers were recruited to participate in the study. Within a Q sort study, the number of participants should not exceed the number of items within the task. To be eligible, they had to first self-define as either service user researchers, peer researchers, survivor researchers, disability researchers or lived experience researchers and were working in an equivalent role. These are defined as roles where the individual is drawing on their own lived experiences of physical or mental disabilities and using it to inform the research they are undertaking, or alternatively researching a topic related to their own lived experiences, either independently, at an institution such as a university, charity, third sector organisation or NHS. Participants were recruited through purposive sampling via these organisations, who employ or engage lived experience researchers, who were contacted via email to request participants from their organisations to take part. Individuals were contacted through these organisations via email with the recruitment advert, including the researcher's email address. Individuals who contacted the lead researcher to participate in the research were sent the information sheet and consent form. Participants were given the opportunity to discuss the research further and ask any questions to clarify its purpose and what was required of them. If participants were eligible to participate and provided informed consent, they were asked how they would like to complete the research, either online, in person or via post. Those that decided to participate online were sent the link to participate in the online Q sort study. Those who took part via post were sent materials to complete the study and a stamped addressed envelope to return their completed materials. Following the completion of the study participants were provided with the debriefing form to explain the study aims in more detail and which detailed the complaints procedure, contact emails of the research team, and organisations they could contact should they need support following the study. All participants were offered a £10 love2shop voucher to value their participation in the study. Ethical approval was granted by University of Liverpool, (Ref 10138).

7.2.3. Procedure

7.2.3.1. Step 1 Item development

The Q set is a set of statements on a topic, and in this preliminary study the Q set was developed through gathering statements from several sources. Statements were identified under themes and key areas related to identity and experiences of lived experience researchers. These themes emerged from the systematic review in Chapter 4 and the two empirical studies Chapters 5 and 6 and the lead researcher's personal reflections of working in the field, in Chapter 1 and the reflections of the service user advisor to the thesis reported in Chapter 8. The Q set aimed to represent a wide range of issues that lived experience researchers may encounter in their roles. Forty to eighty item statements are thought to be ideal for Q methodology (Shinebourne, 2009). The items represented perceptions of identity positions and experiences of lived experience researchers including for example, professional experiences, lived experiences, and the multiple identities they must navigate including unintegrated and integrated identities and other themes outlined in Chapter 4 of the systematic review in the EMERGES framework. The Q set items were reviewed by the supervisory team and a service user advisor to ensure clarity and comprehensibility. The items were then revised based on this feedback. The research team aimed for the Q set to represent a wide range of identity issues lived experience researchers may encounter in their research work. However due to the nature and cognitive demand of the task and the research population, whom we did not want to harm through the research, it was thought appropriate to have fewer items, so the task was less cognitively demanding. This meant the team focussed on items specific to the lived experience researcher role as opposed to the needs of a researcher more generally. Therefore, the items were reduced from an initial 80 items to 65 items and then further reduced to 54 items by excluding similar items and making other items represent broader themes.

7.2.3.2. Step 2 How the Q-sort was conducted

A pilot study was conducted with 5 participants who completed the Q-sort. Based on feedback from this pilot the protocol was refined and adjusted to enhance readability and clarity of instructions and statements. In the main study, participants were given the option of doing the Q sort task in person with the researcher present, in a University of Liverpool suitable and accessible room. Alternatively, they had the option to complete the Q-sort on an online platform (i.e. using a laptop or computer) or via post (i.e. completing the task in paper format and sending this data to the researcher). These different ways to participate in the study were added due to the impact of COVID-19 and the lockdown restrictions. Within the study 27 people agreed to take part in the study, but 7 did not complete the task and 2 had missing data, which left the overall sample size of 18, no participants took part in person, 6 participants took part online and 12 participants via post. The instruction given to participants was: “Please arrange the items related to supervisory topics according to how useful they are to you to discuss in your supervision as a lived experience researcher”. Participants were first asked to arrange the 54 statements into three categories of most useful, neutral, and least useful to them. Participants were then asked to use this initial sorting of the statements to support them to arrange these same statements on a pre-defined Q sort grid on an 11-point Likert scale based on their perceived usefulness to them in supervision using a Likert scale of – 5 least useful to +5 most useful (see figure 7). Participants were able to move these statements around on the grid until they were happy with the way they had ranked them.

If participants took part online the platform recorded the data entries of the participants but did not record any identifiable data or personal IP addresses of the participants to ensure privacy and confidentiality. The item statements were presented in a random order for all participants, and not structured under any themes or factors. There was also acknowledgement that there may be more items they find useful than the options available to them on the pre-defined grid, but participants were given the opportunity to discuss their decision making and any statements they would have placed higher or lower on the grid when they left their free text responses and feedback. Participants were advised to take breaks whilst undertaking the task (as it was cognitively demanding) and participants took approximately 40 to 60 minutes to complete it. Participants were reminded that they could stop the study at any point and withdraw their participation, without any negative repercussions to them.

7.2.3.3. Follow up feedback

Participants were asked to leave written feedback after they had performed the Q-sort, to understand their decision making and why they had selected their top 3 and bottom 3 topics for supervision. Participants could also provide general feedback on the Q-Sort task and suggest further topics to explore in supervision.

7.2.4. Data analysis

The data was analysed using KenQ software (Banasick, 2019) by uploading an excel document with the data entries in. A principal component analysis was used with a varimax rotation, and the number of factors extracted was determined based on the distinctive factor loadings, scree plot, eigenvalues, and cumulative variance each participant contributed to the factors, and these judgements were based on the expertise of the researchers (Brown, 1980).

Factors that have an eigenvalue of more than 1.00 are extracted by the software. Kline, (1994) identifies how the bigger the eigenvalue, the greater it explains the variance within the data. Q methodology typically extracts 7 or 8 factors, but it is acknowledged that the latent variables in the data are typically limited to 3 or 4 factors according to Kline, (1994).

Table 7.1. Participant Characteristics (N=18)

Lived experience/Disability
Autistic spectrum disorder
Depression
Schizophrenia
Bipolar disorder
Complex PTSD
General Anxiety disorder
Body dysmorphic disorder
Dissociative identity disorder
Self-harm
Suicide attempt
Ankylosing Spondylitis,
Fibromyalgia,
Obsessive compulsive disorder
Chronic pain syndrome
Pervasive developmental disorder
Disordered eating
Personality disorder
Trauma
Burnout
Voice box paralysis

Gender
Female (15)
Female/non-binary (1)
Male (1)
Did not disclose (1)

Age range
23-61 years old

Ethnicity
White British (6)
White European (2)
White Scottish (1)
White Irish (1)
White (other) (1)
White (1)
Mixed White British and Black (1)
Mixed Asian and White (1)
Indian (1)
Asian Bangladeshi (1)
Chinese (1)
African Caribbean (1)

Figure 7.1. Forced Q sort distribution grid

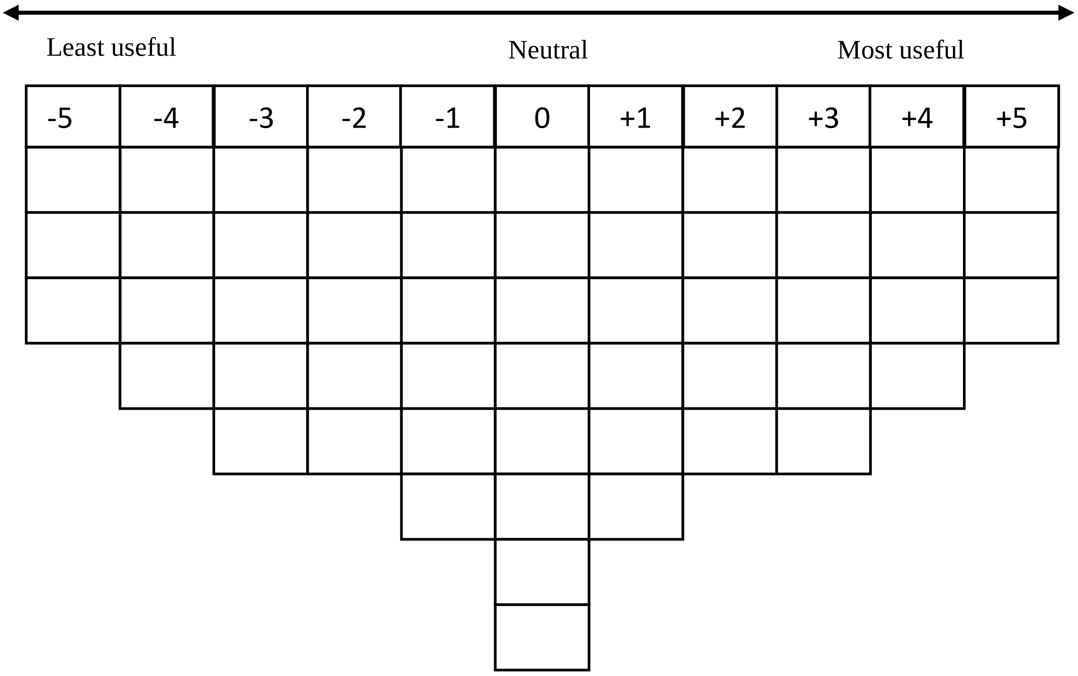


Table 7.1 details the participant demographics including the type of lived experience of mental or physical disabilities participants within the sample experience. These are not linked to the participant identities to ensure confidentiality and anonymity. Ethnicity, gender and age are also detailed.

Table 7.2 details the participants in the data and the duration they've been a lived experience researcher, and their broad experiences of lived experience work, their identities have been pseudo-anonymised.

Table 7.3 shows the composite factor arrays, ranging from -5 least useful to + 5 most useful to participants as topics to explore in supervision. The scores provided are the composite scores of each of the 18 participants in the sample in relation to the 3 factors identified and the extent to which they prioritise each of the statements in the Q set.

Table 7.4 shows the loading of the participants on each factor and there are clear differences in the loadings between the different factors. The factor loading value varies from -1 (negatively endorsed i.e. disagree with Factor) to 0 (neutral) to +1 (positively endorsed, i.e. agree with Factor) which are the correlational loadings participants have to each factor. For example, Rosena loads strongly on Factor 1 (0.7623) but only very weakly on Factors 2 (0.1616) and Factor 3 (0.058).

Table 7.2. Participants.

Elanor – has had "Positive" experiences of Lived experience research and is involved in this work "to aid my recovery." She has been working in the field for 10 years.	**Jenny** says, "I feel valued, have a voice and feel a part of the team." She has been working in the lived experience field for 11 years.
Kate – has been working for 5 years in her role "I was most interested in areas in which I had lived experience - both mental distress and LGBTQ+ wellbeing. To me it makes sense and is vital that research in these and other marginalised areas are led by people who've experienced what they are investigating."	**Tom** – has had a "difficult mental health journey" and is involved as a lived experience researcher to "Inform research and policy making." Has been working in the field for 5 years.
Rosena – has been a lived experience researcher for 3 years and is engaged in work on advanced directives because she "wants a voice should I become unwell."	**Emily** has been working in lived experience for 5 months. She has experienced coercive control and researches restorative healing for survivors of coercive control.
Alice - has been working as a lived experience researcher for 3 years. When referring to lived experience work says, "I'd never heard this concept before but thought it was really great that I could use my negative experiences to help improve these experiences for others."	**Alex** – Works as both a patient and public involvement consultant but now also as a research assistant outside of this field but is still engaged in lived experience work. They have been in the field for 6 years and "Just fell into it! But wanted to help others."
Sarah – has been a lived experience researcher for 5 years. She finds the role rewarding but at times challenging. She has experiences of being racially bullied and researches this experience in children. She says, "Sometimes being so involved with the data can be very difficult but knowing that I am helping others with similar experiences can make this feel worth it/easier."	**Judy** – has been working as a lived experience researcher for 9 years. She finds that being disabled and having the stigma of a mental health condition is a detraction from your status as a researcher. "It's a travesty that I'm expected to pretend that everything is ok – even though I'm marginalised because of my race, gender, and the impact of my mental health. I don't intend to be quiet anymore!"
Jin – has been a lived experience researcher for 4 years. He says, "I want to help better services and interactions between clinicians and patients to equalise these roles so there isn't a power difference."	**Julie** – finds the lived experience researcher role "Interesting, varied and enjoyable." She has been in the role for 12 years and says, "I feel connected to the research I do when I am a service user researcher."
Jane – "Generally positive" experiences of being a lived experience researcher.	**Meena**- has been working in lived experience roles for 2 years. She says, "I needed a job, a supportive role and a route into academic research."
Rani – has been working as a lived experience researcher for 9 months and says, "Using my lived experiences has been empowering."	**Emma** – 4 months into PhD, she says due to her personal connection to the research "I understand that I have personal bias and I need to be objective in my research."
Lina – Says her work as a lived experience researcher was "Accidental! I just happen to research a topic that affects me."	**Caroline** – has 4 years of experience working in lived experience work. She had poor mental health during her PhD. She wants to "Try and make a contribution so no one, or less people, go through what I did."

Table 7.3. Factor Arrays and Composite Loadings Statement	Factor 1	Factor 2	Factor 3
1. Discussing how to use the skills and abilities I already have and apply them in my role	+ 4	+ 2	-3
2. Identifying my training and learning needs relevant to the research	+ 4	+ 1	- 1
3. Supporting me with issues around payment for my work by my employer	- 1	-5	+ 4
4. Discussing whether my professional experiences impact the research	-4	- 2	- 2
5. Exploring what it means to be a lived experience researcher and enabling me to better understand the role	0	0	+ 3
6. Managing the expectations that I and others have of me in this role	+ 2	-4	+5
7. Co-creating appropriate labels/job titles for my role	- 1	-5	-5
8. Supporting me with queries over my fitness to do my role	-5	-5	- 2
9. Having regular opportunities to discuss personal difficulties that may impact my role	+ 5	+ 1	+ 2
10. Discussing queries relating to my competence as a researcher due to my personal connection to the subject	-5	-3	-4
11. Talking about my subjectivity and objectivity in relation to the research area	+ 2	+ 1	-4
12. Enabling a better understanding of the boundaries and remit of my role	0	- 2	+ 1
13. Helping me to set boundaries between my personal life and professional role	-3	0	0
14. Helping me to know when to separate my personal and professional experiences	- 2	- 2	- 1
15. Exploring how I relate to the research topic	0	+ 4	-4
16. Exploring how I relate to the participants in the research	- 2	+ 4	-3
17. Exploring how to navigate lived experience and professional aspects of the work at the same time	- 1	- 2	+ 3
18. Exploring how to actively integrate learning from my lived experience and apply it to the research	+ 1	0	- 2
19. Strengthening my identity as a lived experience researcher	+ 4	- 1	0
20. Helping me to feel part of the team	+ 1	0	+ 3
21. Discussing aspects of myself that are known to others and how this may impact my work	0	0	+ 3
22. Enabling me to disclose aspects of myself that are unknown to others and discussing how this may impact my work	+ 1	- 1	+ 2
23. Helping me to reflect on how I feel when assumptions are made of me due to my lived experience	-3	+ 4	- 1
24. Helping me to increase my confidence in my role as a lived experience researcher	+ 2	- 1	- 1
25. Helping me to feel valued and validated through supervision	+ 5	+ 5	0
26. Helping me to be heard as a lived experience researcher in the team	+ 3	+ 3	+5
27. Helping me to identify the positive experiences I have in my role	+ 3	- 2	-3

28. Helping me to identify sources of empowerment in relation to my role	+ 3	-3	+ 1
29. Enabling discussion on experiences of disempowerment in my role	+ 2	0	+ 2
30. Enabling discussion about the emotional burden the role may have on me	+ 1	+ 3	+ 3
31. Discussing the political motivations that underlie my work	-3	-3	0
32. Enabling me to reflect on what motivates and enables me to do my role	+ 4	+ 2	0
33. Providing space to discuss the impact on me when seeing people like me suffer through the data	-3	+ 5	- 1
34. Providing space to discuss the impact on me when seeing people like me recover through the data	-4	+ 2	+ 2
35. Helping me to reflect on how I feel when research findings are similar to my own experiences	-5	+ 2	0
36. Helping me to reflect on how I feel when research findings are different to my own experiences	- 2	+ 2	- 2
37. Providing space to discuss the social groups I am a part of and whether this impacts the research	-4	-4	0
38. Providing space to discuss the social relationships I have within the team I work in	0	-4	-5
39. Providing opportunities to share and learn through others experiences within the research	+ 1	+ 3	0
40. Reflecting on working with individuals that understand their experiences differently to me	- 1	- 1	-3
41. Reflecting on working with individuals that understand their experiences similarly to me	-4	0	-4
42. Reflecting on power differences I experience in my role with those I work with	+ 1	-3	-5
43. Having conversations in which there is recognition of my growth in my role	+ 3	- 1	- 2
44. Identifying when I am making a difference and to be praised and acknowledged for this	+5	+ 1	+5
45. Discussing the positive or negative impact I am having on the research	0	+ 1	-3
46. Enabling me to share my experiences of exclusion	- 1	- 4	- 1
47. Helping me to reflect on times when I am prevented from making meaningful change	- 1	0	+ 4
48. Helping me to reflect on barriers I come across in my role	0	+ 1	+ 4
49. Helping me to reflect on the stigma or discrimination that I personally experience	- 2	-3	+ 1
50. Helping me to reflect on the impact of witnessing others experience stigma or discrimination	-3	- 1	+ 1
51. Discussing additional support or reasonable adjustments I require to do my role	0	+ 3	+ 2
52. Providing space for me to share and reflect on my previous history of lived experience	- 2	+ 3	+ 4
53. Providing space for me to talk about my current lived experiences and how this may impact the research	+ 3	+ 5	+ 1
54. Regularly discussing and reviewing my wellbeing and support needs	+ 2	+ 4	+ 1

Table 7.4. Principal components analysis with varimax rotation

		Component loadings for each factor		
Outcome Priority Factor	**Participant**	**Factor 1**	**Factor 2**	**Factor 3**
Factor 1 **Strengthening my identity, skills, growth, and empowerment**	Rosena	**0.7623**	0.1616	0.058
	Rani	**0.7318**	0.0846	0.063
	Kate	**0.6504**	0.2638	-0.2198
	Jenny	**0.632**	0.1105	0.0748
	Meena	**0.5808**	0.3111	0.3674
	Julie	**0.4575**	-0.0448	-0.0318
	Emma	**0.3605**	0.163	0.2772
Factor 2 **Exploring the emotional and relational link I have with the research**	Sarah	-0.1633	**0.6744**	-0.2315
	Caroline	0.0569	**0.6735**	0.2336
	Alice	0.4122	**0.63**	0.1089
	Emily	0.3874	**0.6179**	0.0728
	Lina	0.0605	**0.5496**	0.4918
	Judy	0.0889	**0.4385**	0.0176
Factor 3 **Navigating my lived and professional experiences practically and emotionally**	Elanor	0.2396	0.0048	**-0.6139**
	Alex	-0.3423	0.2793	**-0.5895**
	Tom	0.0102	0.0009	**0.454**
	Jane	0.0404	0.1865	**0.4249**
	Jin	0.2773	0.1329	**0.4051**
Eigenvalues*		3.84	2.15	1.69
Variance explained		21%	12 %	9%

*Factors are extracted if the Eigenvalue is greater than 1.

7.5. Results

The KenQ analysis initially forced the data into 8 factors. Following a varimax rotation in a principal components analysis and a judgement of item loadings, scree plot, eigenvalues, cumulative variance and factor distinctiveness based on the expertise of the research team (Brown, 1980). 3 factors were found in the data: Factor 1: Strengthening my identity, skills, growth and empowerment; (7 participants loaded significantly (all positively) on this factor).

Factor 2: Exploring the emotional and relational link I have with the research (6 participants loaded significantly (all positively) on this factor).

Factor 3: Navigating my lived and professional experiences practically and emotionally (5 participants loaded significantly (3 positively and 2 negatively) on this factor). There were clear loadings for each participant across the factors extracted. The factors were independently labelled by the PhD researcher, methodology advisor and supervisory team and there was good agreement between them. The statement placement at the poles of each factor are presented in figures 7.5.1; 7.5.2; 7.5.3.

7.5.1. Factor 1: Strengthening my identity, skills, growth, and empowerment.

-5	-4	-3	+3	+4	+5
Discussing queries relating to my competence as a researcher due to my personal connection to the subject	Discussing whether my professional experiences impact the research	Helping me to reflect on how I feel when assumptions are made of me due to my lived experience	Helping me to be heard as a lived experience researcher in the team	Discussing how to use the skills and abilities I already have and apply them in my role	Identifying when I am making a difference and to be praised and acknowledged for this
Supporting me with queries over my fitness to do my role	Reflecting on working with individuals that understand their experiences similarly to me	Providing space to discuss the impact on me when seeing people like me suffer through the data	Providing space for me to talk about my current lived experiences and how this may impact the research	Strengthening my identity as a lived experience researcher	Having regular opportunities to discuss personal difficulties that may impact my role
Helping me to reflect on how I feel when research findings are similar to my own experiences	Providing space to discuss the impact on me when seeing people like me recover through the data	Helping me to set boundaries between my personal life and professional role	Helping me to identify sources of empowerment in relation to my role	Identifying my training and learning needs relevant to the research	Helping me to feel valued and validated through supervision
	Providing space to discuss the social groups I am a part of and whether this impacts the research	Discussing the political motivations that underlie my work	Helping me to identify the positive experiences I have in my role	Enabling me to reflect on what motivates and enables me to do my role	
		Helping me to reflect on the impact of witnessing others experience stigma or discrimination	Having conversations in which there is recognition of my growth in my role		

Figure 7.5.1. Poles of Factor 1

Table 7.5.1. Distinguishing statements for Factor 1

Distinguishing statements	**F1**	F2	F3
Discussing how to use the skills and abilities I already have and apply them in my role*	**+4**	+2	-3
Strengthening my identity as a lived experience researcher*	**+4**	-1	0
Identifying my training and learning needs relevant to the research*	**+4**	+1	-1
Enabling me to reflect on what motivates and enables me to do my role*	**+4**	+2	0
Helping me to identify the positive experiences I have in my role*	**+3**	-2	-3
Having conversations in which there is recognition of my growth in my role*	**+3**	-1	-2
Helping me to increase my confidence in my role as a lived experience researcher*	**+2**	-1	-1
Managing the expectations that I and others have of me in this role*	**+2**	-4	+5

*Significant at p <0.01

This first factor array of lived experience researchers was the most prominent factor array and had an eigenvalue of 3.84 and explained 21% of the variance in the data with 7 participants loading positively on to this factor. The factor described lived experience researcher's needs from supervision to strengthen their identity, motivations to enable their development through skills and training, a need for supervisors to recognise their growth and work in ways that helps increase their confidence in their roles (See Table 7.5.1). Participants that loaded onto this factor had an age range of 23 years old to 61 years old and each of the 7 participants were female. 1 of these participants was Asian Bangladeshi, 1 Indian, 3 White British, 1 Mixed Asian/White, and 1 White other. The range of duration in lived experience work spanned 4 months to 12 years. This factor represented more individuals from ethnic minority backgrounds and those who experienced severe mental illnesses including Schizophrenia and Bipolar disorder, which may have contributed to the manifestation of this factor centred around growth and empowerment.

Kate, said, "*identifying my training and learning needs, helping me to feel valued and validated & having regular opportunities to discuss my personal difficulties are the answers that most match what I consider professional non-clinical supervision to be for…I'd expect in any supervision….*" Kate highlights how the process of skills development should be the standard expected in any supervision.

Meena, summarises the needs of this lived experience researcher, "*I think empowerment and recognition of growth are more of a priority,*"

In contrast items that were negatively endorsed on this factor were centred around discussing experiences that were disempowering and that alluded to a sense of inadequacy that their lived experiences might bring to the role such as: "Discussing queries relating to my competence as a researcher due to my personal connection to the subject, -5,” “Supporting me with queries over my fitness to do my role, -5.” Participants in this factor were also not concerned with relational experiences or exploring similarities between themselves and the participants in the data. The item, “providing space for me to share and reflect on my previous history of lived experience,” was also rated lower in this factor in comparison to Factors 2 and 3. This might be because discussion of past experiences might detract from a focus on growth and progression of the lived experience researcher from their past lived experiences.

7.5.2. Factor 2: Exploring the emotional and relational link I have with the research.

-5	-4	-3	+3	+4	+5
Co-creating appropriate labels/job titles for my role	Providing space to discuss the social groups I am a part of and whether this impacts the research	Reflecting on power differences I experience in my role with those I work with	Enabling discussion about the emotional burden the role may have on me	Regularly discussing and reviewing my wellbeing and support needs	Providing space to discuss the impact on me when seeing people like me suffer through the data
Supporting me with queries over my fitness to do my role	Providing space to discuss the social relationships I have within the team I work in	Discussing queries relating to my competence as a researcher due to my personal connection to the subject	Providing opportunities to share and learn through others’ experiences within the research	Exploring how I relate to the participants in the research	Helping me to feel valued and validated through supervision
Supporting me with issues around payment for my work by my employer	Managing the expectations that I and others have of me in this role	Discussing the political motivations that underlie my work	Helping me to be heard as a lived experience researcher in the team	Exploring how I relate to the research topic	Providing space for me to talk about my current lived experiences and how this may impact the research
	Enabling me to share my experiences of exclusion	Helping me to identify sources of empowerment in relation to my role	Providing space for me to share and reflect on my previous history of lived experience	Helping me to reflect on how I feel when assumptions are made of me due to my lived experience	
		Helping me to reflect on the stigma or discrimination that I personally experience	Discussing additional support or reasonable adjustments I require to do my role		

Figure 7.5.2. Poles of Factor 2

Table 7.5.2. Distinguishing statements for Factor 2

Distinguishing statements	F1	**F2**	F3
Providing space to discuss the impact on me when seeing people like me suffer through the data	-3	**+5**	-1
Providing space for me to talk about my current lived experiences and how this may impact the research*	+3	**+5**	+1
Regularly discussing and reviewing my wellbeing and support needs*	+2	**+4**	+1
Exploring how I relate to the participants in the research*	-2	**+4**	-3
Exploring how I relate to the research topic*	0	**+4**	-4
Helping me to reflect on how I feel when assumptions are made of me due to my lived experience*	-3	**+4**	-1
Helping me to reflect on how I feel when research findings are similar to my own experiences*	-5	**+2**	0
Helping me to reflect on how I feel when research findings are different to my own experiences*	-2	**+2**	-2
Discussing how to use the skills and abilities I already have and apply them in my role*	+4	**+2**	-3

*Significant at $p < 0.01$

This second factor array had an eigenvalue of 2.157, adding 12% to the variance with a cumulative variance of 33%. 6 participants loaded onto this factor. This second factor array of lived experience researcher’s priorities from supervision were related to ideas of reflexivity and the need to explore their personal connection to the research and participants in the data, discuss the emotional burden of the role, their wellbeing needs and how to use their lived experiences in their roles in a meaningful way (See Table 7.5.2). The 6 participants that loaded onto this factor had an age range of 24 years old to 61 years old and all were female, with 1 participant Mixed White British and Black, 1 White Irish, 1 White, 1 White British, 1 White European and 1 African Caribbean. The range of duration in lived experience work spanned 5 months to 9 years. The participants that loaded onto this factor appeared to have multiple comorbidities and some with experiences of mental illnesses such as Body Dysmorphic disorder and Disordered eating, which might be considered conditions focussed on relational experiences which may have influenced the manifestation of this relationally centred factor. The participants in this factor were also engaged in work that was directly related to their own lived experiences.

Alice, who loaded onto this factor said, “*Knowing that you can relate to the research topic and the participants because you know you have shared similar experiences is one thing - but knowing how to use this relatability during your work I find is a skill I don't know how to use naturally.*” This identifies the need of lived experience researchers to be supported by the supervisor to explore their personal closeness to the work and to develop skills to be able to integrate personal experience in their work more meaningfully.

Sarah, explained how she wanted support to understand her relation to the data and its impact on her, "*Providing space to discuss the impact on me when seeing people like me suffer through the data - can be quite triggering to hear about/read about participant's experiences. I think it's really important to talk to supervisors on a personal level (peer to peer), exploring how I relate to the research topic - It's really important to understand how my own experiences may impact/influence my interpretations of participant data, and to reflect on this if necessary*."

Participants that loaded onto this factor were least concerned with items related to social relationships such as "Providing space to discuss the social groups I am a part of and whether this impacts the research, - 4," and "Providing space to discuss the social relationships I have within the team I work, - 4," which may mean this lived experience researcher is more focussed on their individual relation to the research as opposed to their social needs. "Enabling me to share my experiences of exclusion, - 4." was also negatively loaded on to this factor in contrast to Factors 1 and 3 which might be because Factor 2 is about integrating lived experience into their work rather than discussing unintegrated experiences such as that of exclusion.

7.5.3. Factor 3: Navigating my lived and professional experiences practically and emotionally.

-5	-4	-3	+3	+4	+5
Co-creating appropriate labels/job titles for my role	Reflecting on working with individuals that understand their experiences similarly to me	Discussing the positive or negative impact I am having on the research	Exploring how to navigate lived experience and professional aspects to the work at the same time	Helping me to reflect on times when I am prevented from making meaningful change	Identifying when I am making a difference and to be praised and acknowledged for this
Reflecting on power differences I experience in my role with those I work with	Discussing queries relating to my competence as a researcher due to my personal connection to the subject	Exploring how I relate to the participants in the research	Helping me to feel part of the team	Supporting me with issues around payment for my work by my employer	Helping me to be heard as a lived experience researcher in the team
Providing space to discuss the social relationships I have within the team I work in	Talking about my subjectivity and objectivity in relation to the research area	Reflecting on working with individuals that understand their experiences differently to me	Exploring what it means to be a lived experience researcher and enabling me to better understand the role	Providing space for me to share and reflect on my previous history of lived experience	Managing the expectations that I and others have of me in this role
	Exploring how I relate to the research topic	Discussing how to use the skills and abilities I already have and apply them in my role	Discussing aspects of myself that are known to others and how this may impact my work	Helping me to reflect on barriers I come across in my role	
		Helping me to identify the positive experiences I have in my role	Enabling discussion about the emotional burden the role may have on me		

Figure 7.5.3. Poles of Factor 3

Table 7.5.3. Distinguishing statements Factor 3

Distinguishing statements	F1	F2	F3
Managing the expectations that I and others have of me in this role*	+2	-4	+5
Helping me to reflect on times when I am prevented from making meaningful change*	-1	0	+4
Supporting me with issues around payment for my work by my employer*	-1	-5	+4
Helping me to reflect on barriers I come across in my role*	0	+1	+4
Exploring how to navigate lived experience and professional aspects of the work at the same time*	-1	-2	+3
Exploring what it means to be a lived experience researcher and enabling me to better understand the role*	0	0	+3
Discussing aspects of myself that are known to others and how this may impact my work*	0	0	+3

*Significant at p <0.01

This third factor array had an eigenvalue of 1.689 and added 9% variance resulting in the factors explaining a cumulative variance of 42%. 5 participants loaded onto this factor; three positively and two negatively. This factor array was related to exploring, understanding, and navigating lived and professional aspects of the lived experience researcher role with a desire to be supported both in practical and emotional ways to deal with conflicts and barriers they experience in their roles. There was a need to be supported to overcome these issues (See Table 7.5.3). The 5 participants that loaded onto this factor had an age range of 34 years old to 50 years old, with 3 participants being female and 1 participant male and 1 participant did not disclose. The ethnicity of these participants was White British (2), White Scottish (1), White European (1), and Chinese (1). The range of duration in lived experience work spanned 4 years to 10 years. The majority of participants that loaded onto this factor were white, and so may not to the same extent have experienced the same types of exclusion as those from ethnic minorities. They were more concerned with identifying ways to navigate their roles more effectively and to be enabled and supported to overcome barriers.

Participants identified how they wanted to be supported to carry out their roles better and enable a negotiation and navigation of both personal and professional experiences. Rosena, who did not load onto this factor but identifies its importance, says, "*I do not want too much of my personal lived experience to get in the way of being able to do the role…As other employees are probably not asked these to determine whether they can do their job role, so it may feel unfair. I have a personal life, but still need support to actually do the role in practical terms, yet with my supervisor providing emotional support when needed*." This suggests they do not want to be defined by their lived experience but want to be supported specific to their needs at a given time.

Jin identifies how payment is a supportive factor, enabling them to perform their roles and supports them to move on from being just a service user, "*Recognition in pay because that is how I will be able to "escape" the mental health system, to leave the benefit system and be free… to do this, I need support and help as I continue to suffer from my condition*."

Elanor and Alex, each loaded negatively onto this factor and each had been working in lived experience work for a significant number of years and both had positive experiences in their roles, which might have meant they had gained a level of expertise in their roles and were not concerned with practical or emotional support from supervisors.

Negatively endorsed items related to self-inefficacy as a researcher due to lived experiences, such as "Discussing queries relating to my competence as a researcher due to my personal connection to the subject, - 4," and "Talking about my subjectivity and objectivity in relation to the research area, - 4." As shown in the factor arrays, the item, "Discussing how to use the skills and abilities I already have and apply them in my role" was rated lower in comparison to Factors 1 and 2. This might have been due to a belief that existing skills may not be sufficient in managing the barriers they come across in their roles, necessitating the need for additional and tailored support from supervisors. Elanor and Alex, in contrast to those that positively loaded onto the factor instead, prioritised discussing social relationships, including experience of power imbalances, and their subjectivity and objectivity, amongst other things. This spectrum of needs identified reinforces the emphasis of this factor being a representation of holistic needs of the lived experience researcher, both personally and professionally, that explains this diversity in need of those that fit under this factor.

7.5.4. Comments on the Factor arrays

None of the lived experience researchers prioritised the need to explore the political motivations behind their work, which was surprising to the research team, but Alex said, "*I think things like politics are important… and might be good to discuss in places beyond supervision*." Co-creating labels and titles for the role were also not prioritised, which may be because this is a short-term activity that does not need to be regularly revisited. Being emotionally validated was commonly scored as most prioritised across the factor arrays, suggesting that this should be a fundamental component in supervisory sessions for all lived experience researchers. Exploring when findings were like one's own experience was also not prioritised, which may mean there is an expectation of a closeness to experiences, but that difference in experience is something that needs to be explored.

7.5.5. Additional topics to explore in supervision

Participants were also asked about additional topics they felt were important to consider and which add further nuance to the findings into understanding the priorities for supervision by lived experience researchers. These suggestions were grouped into three themes that directly map onto the findings of the main data: 1) Academic and methodological knowledge. 2) Relational experiences and 3) Providing practical and emotional support.

7.5.5.1. Academic and methodological knowledge

Rani and Kate identified the value of supervisors who could advise on multiple methodologies. Kate states how, "*It would also have been useful to have had a supervisor who is more aware of methodological issues, as it would have been great to explore and frame our research within specifically anti-oppressive or decolonising approaches*." Caroline, who is also a supervisor explained that what, "*a student struggles with was writing academically rather than emotionally and justifying arguments based on literature rather than personal experience*." This highlights that perspectives of supervisee and supervisor might also differ. These examples also demonstrate how supervisors bring their own expertise to the research. This theme aligns with Factor 1, in terms of skills development.

7.5.5.2. Relational experiences

Tom identified the importance of exploring, "*power relations within institutions*." Emma said "*feeling welcome in the workplace*" was important to her. Jane also stated the importance of learning skills in, "*managing conflict or difficult relationships*." Sarah felt that supervisors should do more to facilitate "*connecting people...and facilitating friendships*." These examples illustrate the need for lived experience researchers to feel like they belong in their teams. Kate, identified the need to talk about experiences of discrimination that were vicariously experienced, "*One thing I've found really useful in my current role is the ability to offload to my supervisor when I do come across discriminatory attitudes or assumptions about people with lived experience...*". This example highlights how lived experience researchers may have a shared fate with other lived experience researchers. Explorations of these topics relate to findings from Factor 2 but emphasise more social rather than individual needs.

7.5.5.3. Providing practical and emotional support

Jin, identified a need to explore "*whether the work is detrimental to my health or whether I've taken too much on and need to resign. This is different from "fitness to work"* *because I am fit to work but the work is "hurting me" if I continue*," suggesting the researcher requires emotional and practical support. Three participants, Sarah, Emily, and Judy, identified the importance of being signposted to support services. Sarah said it would be, "*useful for supervisors to signpost PhD students to relevant support services e.g., university counselling. This can enable you to focus more on your actual project/research during supervision meetings without personal life taking over*" reinforcing the importance of navigating and negotiating personal and professional experiences. Judy identified the need for encouraging "*Self-care and compassion*" as the work can be painful. Lina identified the importance of, "*Explicit discussion of what is just researcher experience and when external clinical supervision is needed…clinical supervision is vital arguably especially for lived experience researchers*," suggesting tailored support based on needs. These ideas coalesce with ideas found in Factor 3.

7.5.5.4. Additional comments and feedback by participants

Kate provided feedback on the process of identifying the supervisory needs of lived experience researchers, "*I think it's a really tricky balance…working in a field where you have lived experience can be a very emotional and triggering experience, and to avoid statements which could sound patronising, like suggesting lived experience researchers might need help with their boundaries (any more than anyone else!)*." This quote highlights the problems in assuming the needs of lived experience researchers when they want to be considered as researchers in general. Elanor found the exercise "*very meaningful*" and Emily said, "*I wish the outcome of this research was already implemented! Not many of these statements have been presented in my supervision, thus far*," suggesting the novel nature of the research and the importance of discussing these topics and the need for greater guidance on supervision for lived experience researchers.

7.6. Discussion

This preliminary research study aimed to understand the subjective needs of lived experience researchers and their priorities for discussion in supervision through Q methodology. The findings of the research discovered three factors of lived experience researchers: Factor 1; Strengthening my identity, skills, growth, and empowerment. Factor 2; Exploring the emotional and relational link I have with the research. Factor 3; Navigating my lived and professional experiences practically and emotionally. The following discussion will explore how these factors fit with the wider literature, and how the supervisory process can better support lived experience researchers. Each of the factors identify the importance of emotional support from supervision.

7.6.1. Factor 1; Strengthening my identity, skills, growth, and empowerment.

This factor accounted for the highest proportion of variation in the data and identifies a motivation to increase the skills of the lived experience researcher so they can effectively carry out their role. This relates to the EMERGES framework and the theme of empowerment which is centred around combining existing skills with new learning through training, consequently promoting professional development. This fits with research by Moss et al., (2014, p. 3) that suggests professional identity is the “integration of the personal and professional self.” Dunlop et al., (2022, p10) identify in their sharing lived experience framework that “training, support or professional grounding” is often not provided to those in lived experience roles such as the peer support worker, justifying a greater focus on their professional development.

This theme may have manifested as the lived experience researcher is often someone who belongs to multiple intersections. For example, participants in this factor, were female, had multiple comorbidities, and from ethnic minorities, who are shown to more likely doubt their professional legitimacy and experience imposter syndrome (Bravata et al., 2020). Maxwell, (2020) identifies how peer support training helped counter the experience of imposter syndrome in peer support workers. Similarly, Simpson et al., (2018) found professional identities of peer workers were enhanced through training. Additionally, Kirrane et al., (2019) found engagement and retention of researchers was associated with empowering supervisory relationships. The lived experience researcher in this factor wanted to distance themselves from sources of disempowerment. This necessitates support strategies that are empowering and strengthening of identity for those who fit under this factor. This aligns with a strengths-based approach to supervision as outlined by (Wade & Jones, 2015).

7.6.2. Factor 2; Exploring the emotional and relational link I have with the research.

This factor accounted for the second highest variation in the data and identified the lived experience researcher’s need to explore their lived experiences, bias, subjectivity, and reflexivity in relation to their research. It was essential to understand the impact of the lived experience researcher on the research and vice versa the impact of the research on the lived experience researcher. This is particularly important in qualitative research (Dodgson, 2019) and some researchers have recognised its importance in quantitative research (Jamieson et al., 2022). Poremski et al., (2022) found the process of reflexivity was important to the peer support worker if they were more inclined to be introspective. This factor was also more relevant to the lived experience researcher whose field of work was closely linked to their personal experiences. Therefore, discussion of the emotional labour of the work and greater support with this element was considered essential (Faulkner & Thompson, 2021).

Participants are likely to be impacted by interactions between the data and their own lived experiences, as illustrated in an anonymous blog by a peer researcher (McPin Foundation, 2018). This suggests that the lived experience researcher may compare and evaluate the validity of their own distress with the people in the research data and those they work with, justifying the need to be reflexive. Peer supervision can support the learning of the supervisee by understanding their own experiences in relation to the experiences of peers (Borders, 1991; Faulkner & Thompson, 2021). As there is an interaction between the lived experience researchers' personal and professional experiences a more clinical dimension to supervision, such as for example, taking a psychoanalytic approach to supervision may be beneficial (Lane, 2013) or a trauma informed approach (McChesney, 2022). Clinical supervision is mandatory to all healthcare professionals (Care Quality Commission (CQC), 2022), but does not apply to lived experience researchers, although this factor suggests a clinical need for it.

7.6.3. Factor 3; Navigating my lived and professional experiences practically and emotionally.

This factor was more difficult to label, due to the spectrum of topics prioritised, but the research team agreed that the lived experience researcher in this factor was focussed on understanding how to negotiate and navigate both their lived and professional experiences in their roles through supervisory support. They were also concerned with discussing barriers in their work and identifying practical and emotional ways to overcome them. The lived experience researcher in this factor was less likely to be from an ethnic minority and were not focussed on growth or empowerment or introspective needs. This theme parallels the positions of identity found in Chapter 4, that lived experience researchers need to negotiate and move between service user and professional identities when they are integrated or unintegrated. The lived experience researcher therefore requires the supervisor to be responsive to their changing needs and identities, that fits with Bernard's discrimination model of supervision (Bernard, 1979) and a person-centred approach (Rogers, 1959). Research suggests that those with mental health or physical disabilities are likely to have additional problems, including financial difficulties (Mental Health Foundation, 2022). This factor identifies the role of the supervisor in addressing different types of support for the lived experience researcher that spans practical, emotional, and financial needs (Faulkner, 2004). This suggests a more holistic supervisory support is necessary for those that fit under this factor.

7.6.4. How the findings relate to other frameworks

The findings across this preliminary study coalesce with extant models of supervision that come through Proctor's, (2001) model of clinical supervision of formative (developing skills and abilities) restorative (supportive of the burden and relational aspects of clinical work) and normative (administrative and managerial support), factors of supervision. Similarly, the Social Care Institute for Excellence, (2022) identifies that, "effective supervisors are those who have the required clinical and expert knowledge to assist supervisees in their work, provide emotional support, and who have the qualities to develop positive working relationships." These examples of existing frameworks of supervision map onto the three factors found in this study based on skills and identity development, relational experiences to the research and moving between professional and lived experiences through practical and emotional support.

7.6.5. Strengths and Limitations

This is the first preliminary research to the authors' knowledge aiming to understand the subjective needs of lived experience researchers from supervision. Each of the participants within the sample loaded onto one of the three factors, suggesting distinctiveness to their preferences from supervision that can support supervisors to better identify their needs. The factors found were independently labelled by the PhD researcher, supervisors, and methodology advisor, who were in agreement, reinforcing the validity of the findings. Three unique factors were found of lived experience researchers, emphasising the importance of tailored supervisory support for them.

The sample consisted of predominantly white females and so the findings may not be generalisable to all lived experience researchers. The participants in the research however tell us that exploration of stigma and discrimination was important to them and advocated for better representation of ethnic minorities. This challenges ideas by Kalathil & Jones, (2016) that suggest for 'diversity' to be acknowledged it relies on people that embody that minority. Although for lived experience researchers from minority backgrounds, the role may require navigating multiple intersections and so may also benefit from a trauma informed approach to supervision (Berger et al., 2018).

The research was cross-sectional, measuring the subjective experience of lived experience researchers at one point in time and so their support needs may differ in the future.

The exercise can therefore be repeated between lived experience researchers and supervisors regularly to identify their current needs.

Some participants failed to complete the task correctly which might have been because the instructions may have lacked clarity or there may not have been enough access to guidance from the researcher, when taking part online or via post. Some participants reported they did not like the requirement to allocate each statement to a position on the pre-defined grid and identified how more options on the grid would have been useful to them. The variation in participation across online, and via postal participation may have also contributed to different experiences of taking part in the study. This variation may have been ameliorated if undertaken in person, where the researcher could be present to guide participants through the process. Although all participants had access to the researcher via online zoom conferencing services, but not all participants took up this offer.

The concourse also may not have been exhaustive of the issues that lived experience researchers experience. However, the research identified additional topics to explore in supervision that mapped onto the factors found in the data, reinforcing the validity of the findings. Participants identified how the topics within the concourse were not typical of their supervisory support, but some said they felt they would all be beneficial to them, depending on their relevance to them at the time, evidencing the novelty and importance of the research findings. The findings also suggest and necessitate the need for a hybrid supervision, spanning clinical and academic supervision as there is an emotional dimension to the work that manifests in each type of lived experience researcher. These findings offer a novel contribution to the field of lived experience work, and the supervisory literature.

7.7. Conclusions

The research identifies the subjective needs of lived experience researchers and their priorities for supervision. The findings can support supervisors to work with lived experience researchers more effectively by providing specific support relevant to their needs. There were motivations to develop their skills and growth as a lived experience researcher (exemplified by Factor 1), motivations to explore their personal relation to the research (exemplified by Factor 2) and the need for practical and emotional support to help them navigate their lived and professional experiences in their roles (exemplified by Factor 3). This research identifies the subjective needs of lived experience researchers and is a steppingstone towards developing the evidence base for mandatory research and clinical supervision to lived experience researchers in each context they work in going forward.

CHAPTER EIGHT

REFLECTIONS OF IDENTITY

“We do not learn from experience we learn from reflecting on experience.”

~ John Dewey

8. Reflections of Identity

This chapter contains reflective and reflexive accounts by myself, the PhD researcher, Veenu Gupta and also from the service user advisor to the project, Alison Bryant. The chapter begins with reflections on the focus groups conducted by myself, to immerse myself in the experience and familiarise myself with the data. Alison also provides an account of how her identity has evolved through the process of being an expert by experience through to identifying as a lived experience researcher. We both reflect on our relation and perspectives towards the findings in the empirical chapters.

8.1. Reflections on the Focus Groups in Chapter 5 – Veenu Gupta

The groups in clinical psychology training, EBEs, carers, trainee clinical psychologists and EBQs took part in separate focus groups to understand how they construct their identities. The following reflections detail my experience of conducting the focus groups, the interactions between the participants and myself, as well as the interactions between participants. The reflections will explore the power dynamics of the encounters as well as initial thoughts regarding the process and content of the conversations. The purpose of the reflections is to immerse myself in the data, familiarise myself with it and reflect on the impact of myself as a researcher on the process. This will help support and inform the generation of the themes found in Chapter 5 and support the trustworthiness of the findings. To some extent, I saw my own experiences mirrored back at me when understanding the experiences of others. At other times, there were different perspectives from the different groups in clinical psychology training and how they viewed the profession, and I was able to understand their experiences through the different lenses they saw themselves through, how they viewed their roles in the field and how others viewed them, in some cases changing my perspectives on them.

8.1.1. Trainee clinical psychologist focus group

The trainee clinical psychologist focus group was the only focus group held in person. It was difficult to organise as each trainee from different universities had to be available at the same time to attend the focus group taking place at University of Liverpool. However, there was good attendance with eight trainees in this focus group.

I was initially nervous, having had to organise the arrival of participants and being prepared regarding the interview schedule and interview questions. When I explained the technicalities of how the data would be recorded and how it would go into archives with controlled access through the principal investigator, I was nervous because the focus group had gone from introductions that were very informal to a more formal experience. The researcher said they were nervous and apologised for this. The need to apologise came from a place where I felt the process should be professional, to some extent. Although, revealing my anxieties and my vulnerability helped to restore the power balance being held by me to being more equal across the groups. This potentially may have encouraged the trainee clinical psychologist participants to reveal their thoughts relating to the research question in an honest way with each other and enable them to share their own vulnerabilities and experiences.

On initial reflections of the discussion there seemed to be differences in trainees' experiences of mental health and professional experiences, and this led some to talk about their lived experience identities and exploring the acceptability of these within the profession. Others spoke of their distance from being qualified and their need to develop more of a professional identity. There was also discussion about a lack of belonging within the profession relating to representation in terms of class, lived experiences and ethnic diversity. There was also discussion into how clinical psychology seeps into their personal lives and how some felt a need to separate both personal and professional lives. Others with a lived experience spoke of how to be a cohesive person within clinical psychology and being able to hold their lived experience and professional identities at the same time. The communication seemed to be constructed of ideas of equally competing ideas of both separation and cohesion of their identities in their personal and professional lives. These were some experiences that I identified with and understood, having trained as a mental health nurse previously and the conflicts and challenges I experienced in wanting to integrate my own lived experiences into my work.

8.1.2. Expert by Experience focus group

This focus group was carried out virtually, by myself, through Zoom conferencing software and enabled EBEs from across different universities to participate, with six EBEs participating. In terms of this focus group, it is important to acknowledge that I am also an EBE and in theory have similar experiences and understand the role the other members within the focus group perform. In a way this causes the power dynamics to be problematic. For example, I hold an element of power through the idea that I have some insight into the identities of this group of people which biases the level of enquiry.

In contrast I feel as though also being an EBEs suggests that through my identification with the members within the focus group created a power balance between me and members of the group. However, I felt a pull to contribute to the conversation and participate in the conversation which was something I had to battle with. I also had an idea and pre-conceived understanding of the nature by which these group members construct their identities, and this may have influenced the questioning, coming from a place of experience. However, I also needed to balance the needs of the group with the aims and purpose of the research, so I felt there was a lot of re-direction in terms of the line of enquiry and ensuring each participant had enough time to share their own experiences. My line of inquiry may have been biased by my own knowledge of the role.

The members within this focus group both agreed with each other and disagreed based on their unique experiences of their roles and this interaction between the group captured differences in identity that emerged across the group that competed for validity across the conversation. There seemed to be a breadth of differences in how individuals understood themselves and this seemed to occur as EBEs, despite having the role in common with each other. They held differences in their personal experience of mental health that resulted in them being EBEs. These differences tended to divide the group as their experiential expertise lies in a diverse set of experiences. However, there was agreement between the group and they spoke of their need to make a difference through their roles and the need to be heard to achieve this.

There was dissatisfaction in the roles as they felt the mental health system and the context of clinical psychology training that they worked in did not want to move with their thoughts and be influenced by EBE involvement in a meaningful way. I also, to some extent agreed with their frustrations of services taking a long time in actioning the suggestions I contribute and realised that this was a common experience to others. This again suggests that EBE involvement is limited by the power imbalances that exist within the structures they work in, that limit and reduce the EBE voice. My own experiences reflect the general experiences and identity constructions of this group, suggesting validity of this focus group in representing the wider EBE identity.

8.1.3. Carer focus group

This Carer focus group was also run via Zoom conferencing and carried out online. This enabled Carers who otherwise wouldn’t have been able to attend in person due to their caring commitments to be able to participate. Seven Carers attended from different universities. Initially as a researcher, I had the Carer identity in mind when inquiring about how individuals within this group thought about themselves. This meant that my line of inquiry was being influenced by my own understandings of how Carers construct their identities. The first question asked was about whether they identified with the label of Carer which was the first question in a line of questions. The answer surprised me when the group collectively rejected the Carer label and its identity based on the stigma attached to it. This gave me the knowledge that I would have to adjust my line of inquiry to unpick how this group thought of themselves as individuals and as a group. This initially felt challenging to me, which meant I had to be flexible and enable the discussion to be directed by the group. The power lay in the group and their answers that directed the construction of knowledge. I was also aware of the fact that I had no experience of being a Carer and therefore I should be led by the conversation that occurred within the focus group.

The group, despite not identifying with the label of Carer seemed to agree and have a consensus in their experiences of the roles and the challenges and stigma associated with it and this meant the focus group, to me, felt like a community coming together that had shared values, experiences, and knowledge of each other. The Carers within the focus group engaged in conversation with one another, rather than being led by me, the researcher. This felt like a social identity of people with similar experiences coming together and educating an outsider about themselves. The power that lay between them as a group was empowering and encouraging of each other and their perspectives and the conversation continued after the recording ended. It changed my understanding of their identities and made me realise how stigmatised the label of Carer was, and how disempowering it could be. This was so different to the sense of empowerment I felt witnessing the strength that lay in the connection of members within the group and the power of a shared group identity they belonged to.

8.1.4. Expert by Qualification focus group

This was the last focus group in this study, and it took a long time to organise and get people available at the same time. The label given to the identities in this group, EBQs, was very powerful and made me feel more nervous in my role as the interviewer as these participants were Experts in the field of Clinical Psychology and somehow this took the power and control away from me as the researcher. The label carried certain meanings associated with it. However, as the research was my PhD work and I was an expert in the research, I was able to take back some of this control by being able to facilitate and steer the conversation to the point of the research question. The EBQ members felt uncomfortable about the label that had been assigned to this focus group, explaining Clinical Psychology and Research Psychologist staff as EBQs. This relates to similar feelings of being out of control that service users and Carers experience, having labels assigned to them without their control. The members in the focus group had both positive and mixed feelings of the label of EBQs. They found it useful in representing the diversity of staff they have on their programs such as both Clinical Psychologists and Research Psychologists, but they had never heard the term before, and it intrigued them. They felt that it gave them a lot of power and expertise, but this also made them uncomfortable. However, they reflected that they often label service users and Carers as EBEs and how this dynamic then restores the power imbalance, making them more equal. There was also discussion on visible and invisible identities and how sometimes choice regarding sharing and disclosing parts of who you are is dependent on its visibility through the label used to describe you. There was also motivation for some to integrate their lived experience into the research they do as researchers, but with competing motivations of Clinical Psychologists in the group wanting to separate the personal from their professional lives. This aligned with my own experiences of the research and clinical field, where lived experience feels much more welcoming in the research process, whereas it is perceived to be problematic in a clinical context.

8.2. Reflections of a Service user Advisor – by Alison Bryant

I am writing this reflective piece to consider how my involvement with Liverpool Experts by Experience (LExE) clinical psychology doctorate group, has influenced my identity and to see where in this process the EMERGES framework relates and helps me to understand my involvement. My knowledge of service user providers was negligible prior to becoming a member of LExE, that support and act as a critical friend to the Doctorate of Clinical Psychology at the University of Liverpool. I knew how it felt to be a service user within mental health or physical health settings, but not that the knowledge that the experience afforded me could be perceived as valuable to others. I had been conscious at times that I had experiences that were detrimental to my recovery, or conversely beneficial, but I had never encountered a forum in which these matters could be held up to illustrate a service user perspective, by voicing experiences which could shape understanding, empathy, and insight in informing health professionals and to offer that perspective to those in training.

My route to LExE involvement came about as a result of my clinical psychologist’s intervention contacting the LExE team on my behalf. At that time I socialised little, lacked confidence, was isolated and my interest in life was diminished. My introduction to becoming a service user provider and developing this aspect of my identity with LExE has been transformative over the 3 years of my involvement. This involvement has given me so many rewarding experiences, shaping my identity and awareness in the process of exploring each new opportunity to engage with clinical psychology trainees. My negative perspective and feelings about my lived experience and the consequences of having lived with a range of mental health issues for a lifetime have been reframed as a result. Involvement provides a route by which the negative becomes a positive, in that other service users on their journey may benefit through sharing knowledge with the clinical psychologists of tomorrow. The hard edges of the pain of lived experience have eroded as I have shared my story and perspective with these trainees, evolving my identity further and shaping a solidarity and shared identity as we work towards a common goal together. The academic team responsible for assisting and developing the service user input for the Doctorate of Clinical Psychology are fully invested in the process and involvement of those with lived experience, and are open to exploring meaningful ways in which participation can be further developed. There is nothing tokenistic about this participation, and that validates me as a service user provider to feel valued as a co-producer in the activities which are deeply embedded throughout every aspect of training.

The EMERGES framework developed by Veenu Gupta has offered me both insight into the construction of my own service user identity and also insight through investigating and considering the structures of the framework by which others and I can evaluate, understand and develop our own identities as service user providers and to thrive in that identity. There has been a marked growth for me as an individual resulting from my involvement, enhancing my understanding of overlapping identities and concurrently as a stabilising factor in my continued recovery, with better insight, knowledge and understanding of myself when reflecting on the work I have participated in and found so rewarding. My sadness is that there are other service users who have not had this rich and valuable experience. All service users have so much to share derived from their specific identity and experiences and, if given the opportunity to do so, this would be the catalyst for change for themselves, for services, for policy, for training and for others that they come into contact with in their lives.

The benefits of greater understanding and empathy are like ripples on a pond, encompassing coping with mental health in all forms, supporting carer roles, assisting to promote mental health awareness, and reducing societal and self-stigma. This is about empowerment in every sense, through facilitating and encouraging service users to take on the mantle of service user provider identities. Utilising the EMERGES framework in practice allows service user providers better insight into their identity/identities when considering and assessing at each stage Empowerment, Motivation, Empathy, Recovery, Growth, Exclusion and Survivor Roots as specific aspects of their individual and unique journey as a service user or service user provider. Use within the therapeutic alliance by clinical psychologists would help to open up discussions with service users about how these issues impact the individual, to promote engagement with the benefits that come with involvement as a service user provider to increase self-esteem and promote recovery. Within training, the EMERGES framework for those with lived experience or trainees with no lived experience can facilitate sharing and solidarity in co-production with service user providers to the benefit of each, particularly when striving to ensure power imbalances are reduced.

My understanding and ability to reflect on the work that I do as a service user provider with LExE has been enhanced via applying the EMERGES framework to myself and my involvement. This is a powerful tool for understanding and insight into what identity/identities are, how these identities arrived and formed and how they intersect with my role as a LExE member, and what it means to my identity and mental health stability to have participated in shaping the next generation of clinical psychologists in training through my involvement.

8.3. Reflecting on the results of Chapter 6 by Alison Bryant

As an EBE and advisor on this research, I have been eager to explore the findings of the studies in relation to the hypotheses and subsequent analysis of the data. I was interested in the in-group identification measure on one hand but also to explore the data relating to the identification of trainees to EBQs, EBEs, Carers and trainees, the results were intriguing and enlightening. As an EBE deeply involved in every aspect of the Doctorate of Clinical Psychology programme, using my lived physical and mental health perspective to add richness and detail to training, teaching and research, I want and hope to make a difference. Therefore, it was not easy to consider that from the research findings that both Carers, and to a lesser extent EBEs, are not identified with by trainees in the same way they identify with EBQs and other trainees. It shows that there is some way to go in establishing the value of Carers within training and reinforcing the value of EBEs. Of course, this data directly relates to the participants and the courses they have attended who have been involved in the research. Some courses still have scant EBE/Carer involvement, or the involvement is not true co-production, where EBEs/Carer's are not viewed as valued partners but as a tick in a box to satisfy course requirements.

Carers, have a smaller representation on courses than EBEs, so may have struggled to have their identity acknowledged and their voices heard. Establishing the validity and value of Carer perspectives is clearly a challenge to overcome. Once qualified, trainees spend the bulk of their professional lives building therapeutic alliances with service users where the input of the Carer or family is vital in the success of that process, so their voice needs to be heard in training to reinforce their status and value to tip the balance to support healthcare professionals in identifying with this population. Having the opportunity to work alongside Carers and EBEs enriches training/trainee knowledge helping them to become better Clinical Psychologists. If these studies are repeated in the future, I hypothesise there will be evidence of a shift in the way trainees identify with Carers, as well as a greater identification with EBEs as courses/trainers make ongoing efforts to maximise inclusion of EBE/Carers as being central to training.

It is I suspect inevitable that Trainees are disposed to relate to other Trainees/Psychologists at a cognitive level as they share a profession/career path and a similar route through higher education to achieve and undertake training and positions within their profession. Also, through their training, Trainees gain insight, knowledge and a common language which affords them a shared professional perspective (together with qualified Psychologists) on society, systems, services and EBEs and Carers.

Trainees are compassionate people who have entered a profession that cares for some of the most vulnerable people in society – those with mental/physical health issues. Cognitively and affectively however, as illustrated by the research findings, there is a significant barrier to identification. Potentially, through affectively connecting by sharing narratives in the context of training will enhance Trainees' understanding of Carers and EBEs who are not clients in therapy but educators sharing their lived experiences. This population can add huge value and insight to training and though they may be respected by trainees, currently from the findings there is a "credibility deficit" where they are not viewed or identified as colleagues. The barriers that are so necessary for clinical psychologists to maintain the therapeutic alliance with service users need to be modified in training settings. Retaining professional boundaries is not essential and may be detrimental in forming valuable connections in training settings. Perhaps taking a different stance and seeing EBEs/Carers as having their own 'qualifications' to contribute to training might elevate their identity. The EBE qualification is not academic but their life experience is.

I enjoy my contact with Trainees. I identify with them, with their commitment to training and their goal to practice as a clinical psychologist. My own identity as a service user has been shaped by my experience of receiving clinical psychology and I am passionate about offering my experience and insight to enhance their training. I enjoy being part of Trainees' lives during the three years of their course and contributing to their research. I believe I can make a strong connection which is valued by Trainees and I know is valued by myself.

I am an EBE and not a Trainee or EBQ, however, I empathise and identify with all the groups and their identities. My life experiences and what I have to share places me in the group of EBEs, even though we as a group may not share the same background or mental/physical health issues. I also identify with Carers through my own lived experience and my knowledge of the role of others as Carers etc. In regard to identity, I personally don't feel any barrier to engagement with Trainees or EBQs despite not sharing their training or academic background. My perspective when considering the groups and their separate and shared identity is to see this through the lens of considering our shared humanity, shared goals, and our joint experience of wishing to contribute to and enrich training.

8.4. Reflections on Chapter 7 by Veenu Gupta

Factor 1; Strengthening my identity, skills, growth, and empowerment.

As a lived experience researcher and PhD researcher, I have often experienced great distress and stigma and discrimination due to my mental disabilities that has resulted in a diminished self-concept, self-belief, and lack of confidence. The lived experience researcher role, specifically, means a navigation of both service user and researcher identities that is often unclear and ambiguous, and so it necessitates a strengthening of identity and an understanding of the role and its many facets. As a lived experience researcher, I have appreciated when I have been supported to develop my skills and ability to effectively carry out my role as well as when supervisors have been emotionally validating, and acknowledging the difficulties I have experienced both personally and professionally, which have on occasions been empowering and enabling. This experience of supportive relationships in the supervisory process has the potential to counter relationships and experiences that have been disempowering in people's personal life.

Factor 2; Exploring the emotional and relational link I have with the research.

Lived experience research is intrinsically linked to a personal connection to the research, participants, and the data. Often this has led to a questioning of the objectivity of the lived experience researcher due to their intense and close relation to the research. This is sometimes considered a strength and a useful insight and expertise into the subject matter and subsequently an asset to the research. The nature of quantitative research is built on establishing objectivity, and the ownership of subjectivity is explored through reflexivity and reflection in qualitative work and supervision. Despite the strengths and limitations of having a closeness to the research, there are times when the research can be triggering and remind me of my own lived experiences. This means my supervisory needs may be different to researchers without lived experience and warrant additional support through a type of clinical supervision that can support me with self-care and compassion or strategies to support me with the emotional impact of the work by signposting to support when the research is particularly triggering and explore these experiences in supervision. A need to explore connection to the research is something that is also validating and recognises the complexity of the lived experience researcher role and their relation to the research process. I think from a personal perspective I identify most with this particular factor and this might be because I am more introspective in my nature.

Factor 3; Navigating my lived and professional experiences practically and emotionally.

Any effective supervision strives to provide support strategies for lived experience researchers to effectively carry out their roles. Practical ways are the typical sources of support, such as methodological and academic. However, as a lived experience researcher I have found I have needed to navigate times when I have required both emotional and practical support to carry out my role. I have found support to navigate both lived and professional experiences is essential as I have moved between different positions of identity, I am drawing on depending on who I am talking to, or the context I am working in which might require further support from supervisors to negotiate this movement between identities. I have also often wanted to disclose my lived experiences but due to stigma and feeling as though I will be asked to take time off work, I have not disclosed this in supervision. I also acknowledge that I do not want the entire supervision to be about my lived experiences but about instead to focus on the research. Normalising discussion of both lived experience and professional needs can lead to provisions of support relevant to the lived experience researcher and for them to be supported in the way they need to be. This requires the supervisor to also move between their own positions of identity to provide tailored practical and emotional support.

8.5. Reflections on Chapter 7 by Alison Bryant

As a service user and an EBE Research Adviser aligned to the Doctorate in Clinical Psychology programme and specifically involved in this research project, I know my own boundaries and what I am comfortable with regarding my identity and involvement. However, reflecting on this chapter and aware of how I relate to it with that lens, I am so fortunate to have the support of the lead researcher with regard to my lived experience when contributing to this research.

I am also aware that for the lead researcher (and this really resonated deeply with me) that supervision appropriately provided is required for all lived experience researchers, not only within the research process itself but particularly in the need for the safe space of supervision to support and share their lived experience perspective and identity as lived experience researchers in research. The lead researcher is keenly attuned to her own perspective and identity in this context and brings that reflection to bare throughout her research, checking for bias and double-checking for unconscious bias as I have discovered in our many conversations.

I reflected too on how rewarding reading the data in this chapter was for me in exploring and analysing the research findings which address existing gaps in the literature concerning lived experience researchers and supervision. I also relished and related to the depth and richness captured via the anonymised feedback, and insights shared by participants on their experiences and lived identity working in lived experience researcher roles.

Hopefully, supervision will become mandatory with the publication of this research underscoring the need to bridge and address the gaps that exist in supervision, particularly in emotional validation, for lived experience researchers which needs prioritising. Supervision must be a tailored blend of research and clinical support for the lived experience researcher, conducted with sensitivity and awareness by the supervisor around the harm that may be caused in bringing that lived experience to an area of research so directly connected to their lived experience identity. It is important all lived experience researchers and supervisors reflect on this and develop a framework structure or tool which can be used, to encourage best practice in supervision in the future when currently targeted supervision for lived experience researchers is not commonplace.

I know how much I benefit in sharing my concerns and perspective on this research with the lead researcher, to examine my own identity and bias unconscious or otherwise as a result of my lived experience. My familiarity and identification with the EMERGES framework allows me to further explore and better understand how my identities are integrated and connected to my role in research as an EBE Research Adviser. It is intriguing to acknowledge that I have that intersectionality with separate aspects and identities that converge and merge in that context. Having been involved in this research throughout its lifespan has empowered me, giving me new insights and expertise as an EBE Research Adviser.

8.6. Reflection on becoming a Lived Experience Researcher– by Alison Bryant

Before accepting the role to become the service user/EBE adviser on the PhD, I was aware of the subject of the research and of the lived experience of the researcher. I considered my own identity at the outset and how any bias I may have had would impact through my involvement. The process of reflection has been continuous for me throughout the lifespan of the research, which was partly instigated by myself because of my concerns, but also encouraged by the researcher to be able to discuss and share my perspective through the research process and journey. At the outset I had preconceived notions about boundaries and the limitations of my own involvement and a wish not to ‘tread on any toes’ of supervisors or of the lead researcher and indeed of participants through my input because of my lived experience identity and not being an EBQ. I did not then acknowledge that my lived experience, my life experiences, and my knowledge of research at that point put me at the intersection of holding a variety of identities and positions. Effectively, throughout the research process I have become more and more deeply embedded within my identity and able freely to share my perspective and input to participate fully and meaningfully. My involvement has been valued and my opinion sought throughout which has empowered me in feeling confident that my contribution is worthwhile and that I have also grown with the support of the lead researcher. She has given me time to explore my thoughts at every turn and with a safe space, that I would term supervision, to consider myself as a lived experience researcher rather than how, at the outset, I would have considered myself as an EBE adviser. The research process has taken me to new places in my thinking about identity and how my identity and those of others are constructed and navigated and built and change.

The EMERGES framework, has allowed me to explore my identity/identities and how I can benefit through using this as a tool for understanding myself in relation to others as well as in better understanding myself. The research findings have opened up conversations on every role and identity held in training/research and beyond. The EMERGES framework is also a portal in supervision to safely navigate the links between the individual and their identity/identities and their research, particularly where lived experience and research subjects coincide. The lead researcher said to me, “I think we’ve both grown in our roles over time and through learning from each other”. I would say I know I have grown and feel comfortable and confident now in my lived experience researcher skin and that I can contribute to research adding a different but equally valid perspective and knowledge and have grown in my overall knowledge of the research process which has upskilled and empowered me further. I know too that the research journey has taken the lead researcher on her own parallel journey to the one I have taken and I would like to state how much I value the expertise, skills and knowledge which she has shared freely and openly throughout this process. I know as the research is published and disseminated it will have real impact in training and supervision and wider clinical practice. I look forward to seeing this next stage of the research journey come to fruition with pride in my own involvement and gratitude to the lead researcher in inviting me to share her research journey and I wish her well now and in the future.

CHAPTER NINE

GENERAL DISCUSSION
&
CONCLUSIONS

9.1. A reorientation back to the aims of the thesis

- To understand the identity of lived experience researchers and groups in clinical psychology training through multiple methods.

- To identify recommendations to support groups in clinical psychology training to work together more effectively and reduce them and us divisions.

- To identify the needs of those with lived experience working in mental health, education, and research settings and how to support them.

9.1.1. An Overview

The thesis began with Chapter 1, an exploration of my identity as a PhD researcher, as someone working in lived experience work, to gain an understanding of the many facets of identity I hold and the factors that contribute to identity formation. The purpose of Chapter 1 was to provide a reflective and reflexive account of my positionality at the beginning of the research. Chapter 2 went on to situate this field of work through outlining the history of service user involvement and its progress to date, to contextualise the research in the context of what is already known about lived experience work. Chapter 3, provided a brief overview of the theoretical basis of identity, considering Social Identity Theory, Identity Theory, Liminality, Intersectionality, and Hermeneutical and Testimonial Injustice to provide a basis from which to understand identity constructions and which is knowledge that can be drawn upon when understanding proceeding empirical chapters. Although it was found that these theories relating to identity were not robust enough to explain the identities of those who span oppositional identities, such as the experts by experience role. This role spans service user and professional identities at the same time, which are often construed as binary in the way they are understood. This meant there was space to better develop and understand the identities of those in lived experience roles and to contribute conceptually and theoretically to develop the evidence base to understand these identities better. Therefore, the PhD attempted to better understand the identities in the field of mental health, education, and research through a mixed methods approach with a motivation to identify their support needs.

The following section details a summary of the empirical studies within the thesis and how the main aim of understanding identity constructions across lived experience researchers and providers and also groups in the context of clinical psychology training were measured through different approaches such as qualitative, quantitative and multiple methods. This is followed by an additional section synthesising these findings in consideration of the EMERGES framework developed in the thesis, and how the findings relate to the wider research. This will be followed by a consideration of the strengths and limitations of the thesis, ideas for future directions and applications of the research to move the field forward and recommendations for practical applications and utility of the findings to reduce 'Them & Us' divisions and identify support needs for those in this sector.

9.1.2. Chapter 4 Understanding the Identity of Lived Experience Researchers and Providers

Chapter 4 identified and synthesised 13 qualitative empirical studies on lived experience researchers and providers that explored their identities in a systematic way. A search strategy and inclusion and exclusion criteria were identified, including lived experience researchers and providers who were either service user researchers, experts by experience, peer support workers or mental health professionals with lived experience who were treated as a homogenous group. The synthesis applied a modified version of Popay et al. (2006) method of conducting narrative reviews through 3 stages: 1) A preliminary summary of findings of the studies; 2) Assessing the relationships within the data and 3) Testing the robustness of the synthesis with key stakeholders. The review identified a conceptual framework to understand the identities of lived experience researchers and providers through positions of professional, service user, integrated, unintegrated and liminal identities that they often moved between dependent on context and triggers. These positions of identity were influenced by the EMERGES framework, through themes of Enablers and Empowerment, Motivation to Integrate, Empathy of the Self and Others, Recovery model and Medical Model, Growth and Transformation, Exclusion and Survivor roots. The systematic review highlighted that the studies had methodological flaws and bias and limited research from the field of clinical psychology training. The framework can support those in the sector to better understand the identities of lived experience researchers and providers and provide ways to support them in reflecting on their identities through applying the framework in their reflective practice. It can also support team members to better understand them and work with them more effectively.

9.1.3. Chapter 5 A Social Construction of Identities in Clinical Psychology Training in the UK

Chapter 5 was focused on creating and measuring a social construction of identities in Clinical Psychology training in the UK, through focus group methodology. Four separate focus groups with a total sample of N = 25, with 6 experts by experience, 7 expert carers, 8 trainee clinical psychologists and 4 experts by qualification were conducted with key stakeholders in clinical psychology training. The research explored and analysed these identities through their discourse and interactions via a thematic analysis with a social constructionist epistemology and critical realist ontology, deductively interpreted through the EMERGES framework from Chapter 4. The research found further nuance to their identities, which were structured similarly to the positions of identity found in Chapter 4. Additional themes identified how each group belonged to multiple identities of professional and personal identities and the different groups were motivated to integrate, separate, permeate or make visible or make invisible these different identities dependent on context. Each group also constructed Learner and Expert identities in relation to their ability to effectively engage in lived experience work. The study found that labels carried expectations and weight and thereby impacted the power, status, and stigma these groups experienced. There were motivations across groups to rebalance the power between them. There were also fixed impermeable identities, reminiscent of social identities that constructed barriers between these groups, but which could be bridged through emotional connections, communication, and redistribution of power. It was also found that groups in clinical psychology training functioned in a way that was consistent with the meanings attached to their labels, suggesting the importance of developing labels that were representative of their roles and their purpose in the context of clinical psychology training so they could work more effectively in their organisation. Recommendations to support these groups to work more effectively together, and additionally recommendations for label constructions to rebalance the power between groups and to accurately reflect individual role identities were developed.

9.1.4. Chapter 6: Developing an In-Group Identification Measure in Clinical Psychology Training

Chapter 6 was a pilot study aimed to develop a reliable and valid in-group identification measure for trainee clinical psychologists and then apply the measure to understand trainee clinical psychologists' identification towards their trainers. Items for the measure adapted and adopted the cognitive and affective identification scale developed by Johnson et al., (2012) and tested its reliability and validity in newly qualified clinical psychologists in a pilot study with a sample of N = 32, where items were reviewed for comprehensibility and clarity. The measure was then administered to a sample of N = 108 trainee clinical psychologists to understand their identification towards Experts by Experience, Carers, Trainee Clinical Psychologists and Experts by Qualification. In this phase of the study participants were also administered personality measures and measures of mental health, professional identities, and other related variables. The data was entered into an exploratory factor analysis, and the factor structure was verified through confirmatory factor analysis. The findings revealed the 2-factor measure manifested 3 dimensionally resulting in cognitive, affective, and evaluative types of identification. This third component explained items of identification that encompassed items relating to when the participant was personally impacted by a negative outcome that affected the person they were identifying with, hence labelled Evaluative due to the personal ties element of the factor. The research found that trainee psychologists did not affectively identify with experts by experience or expert carers. They did however cognitively identify with trainee clinical psychologists and experts by qualification suggesting identity formation occurs cognitively with a dominant identity. There were few trainees with lived experience of mental health or of being a Carer that may have impacted a lack of detection of emotional factors influencing connections between them and EBEs and Carers. It is theorised that this disconnection between trainee clinical psychologists and EBEs and Carers may perform a function in reducing the emotional burden that comes from connecting with those with lived experience. It was also theorised that EBEs may come across as professionalised, and thereby they may not invoke emotional responses. The findings illustrate that identification towards different trainers occurs differently and is influenced by individual differences in personality, mental health, and professional identities.

9.1.5. Chapter 7: Identifying Priorities of Lived Experience Researchers for Supervision

The final study in Chapter 7 was preliminary research involving a Q sort study that aimed to understand the priorities of lived experience researchers for discussion in supervision. The study brought together learning from across each empirical and reflective chapters to identify the breadth and complexity of the experience and needs of lived experience researchers. The study found three factors of lived experience researchers. Factor 1: Strengthening identity, skills, growth, and empowerment; Factor 2: Support to navigate personal and relational link to the research, and Factor 3: Support to navigate personal and professional identities emotionally and practically, This study identifies key topics important to lived experience researchers to explore in supervision but also identifies three types of lived experience researchers and their individual support needs that can help their supervisors to effectively provide tailored support to them. Each of the factors encompass the importance of emotionally validating responses from supervisors. In contrast to the expected findings, there were limited motivations between lived experience researchers to co-create labels and job titles that reflected their roles which may have been because this task does not require ongoing support and may be useful at one point in time and its importance in supervision may be less relevant. This motivation may be more relevant in social settings where individuals are interacting with others based on their roles and the labels used to describe them, as opposed to in a supervisory session. The three factors also span different areas of the EMERGES framework that can help inform the way supervisors support lived experience researchers by referring to the specific themes identified within the EMERGES framework relevant to each of the three factors, to identify more personalised ways to better support lived experience researchers. The findings of this study also identify the support needs of lived experience researchers as spanning both research and clinical supervision, that could be developed in the future.

9.2. The EMERGES Framework

The systematic narrative review found themes that are related to identity development and to some extent influence the positions of identity found of Professional, Service user, Integrated, Unintegrated and Liminal identities. The positions of identity found through a synthesis of 13 empirical studies, closely resemble findings of the identity constructions of mental health professionals with lived experience in a previous study (Richards et al., 2016) but additionally incorporates Liminal identities that were also found to occur in lived experience researchers and providers, described as liminal or ambivalent identities (Faulkner & Thompson, 2021; Simpson et al., 2018). The EMERGES framework, however, is a novel and original conception of this thesis. It is an acronym that identifies themes of Enablers and Empowerment, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and Transformation, Exclusion/Stigma and Discrimination and Survivor roots that influence identity positions. The following discussion will assimilate findings from the three empirical studies and observe how they relate to the framework, to reinforce its robust nature. The framework also identifies similar themes to CHIME-D framework identifying themes related to recovery in mental health patients of Connectedness, Hope, Identity, Meaning, Empowerment (Leamy et al., 2011) and recommendations from later researchers to include the idea of Difficulties. The PROSPER framework also identifies factors related to post-traumatic growth in patients with psychosis specifically (Ng et al., 2021) which has some overlap with the idea of growth and transformation in the EMERGES framework. However, the EMERGES framework provides an accessible way to understand the themes that impact lived experience researchers and providers and is more pragmatic and highlights both the positive and negative experiences of lived experience researchers and providers.

9.2.1. Enablers and Empowerment

The findings from the systematic narrative review revealed that when lived experience researchers were able to combine their existing skills from their personal lives into their professional roles was an empowering and enabling experience. The empowerment of peer workers was facilitated by the process of training, which Simpson et al., (2018) found promoted their professional development.

Findings from the qualitative study, Chapter 5, identified how Carers felt the Carer label was stigmatising and were motivated to develop alternative labels to describe themselves, which increased their value in society. This fits with research that suggests labels can be empowering or disempowering (Ashford et al., 2018). Experts by Experience and Trainee clinical psychologists were also motivated to redistribute power between them and others in clinical psychology training by flattening the hierarchy and rebalancing the power, which aligns with the process of democratic and emancipatory lived experience work. This involves service users and survivors taking power from service providers (Beresford, 2021). Being associated with the social identity of clinical psychology training, may also have the impact of empowering those working within it as it is an identity that is associated with greater power and status. This might influence the maintenance of service users and survivors remaining in EBE roles despite them being emotionally laboursome. Being associated with this helping profession, may consequently have an influence on the health and wellbeing of those associated with it.

Chapter 6 found that dominant social identities were formed through cognitive connections, that lead to a stronger sense of social identity. Research suggests that social identities can have an impact on the health and wellbeing of the group, and potentially be empowering, through the idea of the social cure identified by Jetten et al., (2012) and have a positive influence on wellbeing.

The process of empowerment manifested itself in Chapter 7, a Q methodology study into identifying priorities for supervision by lived experience researchers where Factor 1: Strengthening the identity, skills, growth, and empowerment of lived experience researchers was identified. Research suggests that when the supervisory relationship is empowering it leads to greater engagement and retention of researchers (Kirrane et al., 2019) and may reduce the emotional burden on those in lived experience work. A strengths-based approach towards lived experience work and working in ways that are empowering is essential in sectors that integrate lived experience.

In the supervisory relationship, typically the supervisor is the expert and the supervisee the learner. However, the lived experience researcher begins as an expert in their field, and so the typical supervisory relationship that is premised on the supervisor being the expert and the lived experience researcher the learner (Hair & O'Donoghue, 2009) may not be relevant to the needs of the lived experience researcher and may consequently be disempowering. Chapter 5 found that individuals could be both learner or expert, but not everyone could be an expert. For the lived experience researchers to work as experts in their field they may need to be empowered to inhabit the expert role. Research suggests that supervisors should tailor supervision relevant to the developmental needs of the supervisee specific to their expert or novice status (Littrell et al., 1976). Foglesong et al., (2022) recognises how mental health practitioners are typically supervised by other mental health practitioners. However, they make the observation that peer support workers are not necessarily supervised by other peer support workers, consequently meaning supervisors may lack the expertise in lived experience work. This may be replicated in the supervision of lived experience researchers. This means greater guidance for supervisors of those with lived experience in the field is necessary and so the learning from Chapter 7 can be empowering to both lived experience researchers and supervisors. This suggests that empowering relationships may come through connecting with peers, as opposed to those who are more expert. This suggests that expert knowledge of how to integrate lived experiences into professional domains may come from peers in the field and highlights the benefits of peer supervision as suggested by Faulkner & Thomposon (2021).

9.2.2. Motivation to integrate

The findings of the systematic review identified lived experience researchers and providers had a motivation to integrate lived experiences into their work and this was especially significant for peer researchers and experts by experience. Some research also indicated that when others demonstrated and modelled disclosure, supported them to understand how to disclose lived experienced themselves (Newcomb et al, 2017).

Chapter 5, the qualitative chapter, identified how experts by experience were more concerned with this motivation. Although trainee clinical psychologists also had this motivation but felt they did not have the skills to be able to integrate their lived experiences in the context of clinical psychology training and felt that they did not have opportunities to disclose their personal experiences in their training, or training on how to do this effectively in clinical practice. This also reproduced the learner nature of trainees and the expert nature of experts by experience regarding this motivation to be able to effectively integrate lived experience into their work. This may have resulted from the effect of inhabiting labels used to describe them as experts and labels such as trainees that acted as self-fulfilling prophecies, resulting in individuals acting in accordance with the meanings of the labels used to describe them. Although, there is now guidance for valuing lived experience for trainee clinical psychologists in the context of clinical psychology training (BPS, 2020) that may go some way in providing trainee clinical psychologists with more skills in how to integrate their lived experience. The research also identifies how lived experience is emotional work and is laboursome in roles where lived experience is more visible, such as the expert by experience role. Whereas trainees and EBQs have the choice in determining if, when and how they disclose their lived experiences into their work.

Chapter 6, into understanding trainee clinical psychologists’ identification to their trainers only had a few trainee clinical psychologists with service user or carer experience. This resulted in a lack of detection of lived experience in the population which may occurred due to stigma of lived experience in the profession. The lack of integration of lived experience and identification with EBEs and Expert Carers by the trainee clinical psychologists in this study may be explained by the motivation of the trainees to develop their professional and expert knowledge as clinicians, despite clinical psychology training advocating for and valuing lived experience, as this is not the purpose of their role. The thesis found the purpose of particular roles in clinical psychology training determined the extent to which integration of lived experiences occurred. However, Richards et al., (2016) identify that mental health spaces may not be safe for disclosures, which may have also influenced this lack of disclosure amongst trainees in the sample.

Chapter 7 identified methods to support integration of lived experience into lived experience researcher roles resulting in the manifestation of Factor 2: Support to navigate personal and relational link to the research as a lived experience researcher. Poremski et al., (2022) found the process of reflexivity was more important to the peer support worker, particularly if they were more inclined to be introspective. Calvert et al., (2016) identified how the process of reflection and reflexivity in supervision could be transformational. Discussion of the emotional labour of lived experience work necessitates greater support, outlined by Faulkner & Thompson, (2021). The research finds that lived experience researchers are also likely to be impacted by the interactions between the data and their own lived experiences. In an anonymous blog for McPin Foundation, a peer researcher talks about how she experienced imposter syndrome as she felt her own lived experiences may not have been as distressing as the experiences of those she worked with (McPin Foundation, 2018). This suggests that the lived experience researcher when engaging in work that requires integration of lived experience, may compare, and evaluate the validity of their own distress with the people in the research data and those they work with, justifying the need to be reflexive and to be adequately supported.

It might therefore be beneficial to draw on learning from clinical supervision that is integrative in nature and is centred on the dynamics between the supervisor, supervisee and the third party, the patient, amongst other things (Holloway, 1995). A greater exploration of the reciprocal relation to the research process between the lived experience researcher, the participants in the data, the supervisor, and additionally the population may be worth exploring in supervision. Faulkner and Thompson (2021) identify how lived experience researchers might benefit from peer supervision. Alternative methods might be to employ dyads or triads between multiple lived experience researchers and the supervisor. This can support the learning of the supervisee by understanding their own experiences in relation to the experiences of peers (Borders, 1991). As there is an emotional labour to lived experience work (Faulkner & Thompson, 2021) it may be justified to incorporate a clinical dimension to supervision or for example consider psychoanalytic approaches to supervision (Ogden, 2005) or trauma informed approaches (Berger et al., 2018). Chapter 7 also suggested there is an idea that lived experience researchers might not be as effective researchers due to their closeness to the research and often there is a questioning of their objectivity by supervisors. This is an idea that needs to be challenged and explored. Due to a personal and professional dimension to lived experience work, a combination of research and clinical supervision is recommended. Clinical supervision is mandatory to all healthcare professionals (CQC, 2022) although this does not apply to lived experience researchers. This thesis, however, suggests a clinical need for it.

9.2.3. Empathy of the self and others

The systematic review in Chapter 4, found that sharing of lived experiences and social connections and reciprocity enabled empathetic responses and a greater understanding of their lived experiences and needs. There was also learning and understanding through hearing about others' experiences which helped them understand their own. Lived experience work resulted in feelings of 'group survivorship' (Hill, 2021) and of 'personhood,' (Richards et al., 2016) which are ideas that allude to the development of shared social identities.

Chapter 5 also builds on the idea of empathy that comes through belonging to the same social identity. The focus group methodology evidenced stronger social identities of members in each focus group that resulted in supportive and empathetic relationships and a sense of shared experiences. The theme of empathy manifested differently among Experts by Experience who each had unique lived experiences, but they connected through a common shared experience of their roles, general experiences of distress and common goals in wanting to make a difference to the mental health system due to their own experiences. The Carer focus group revealed a stronger social identity and supportive interactions. The trainee clinical psychologist identity was motivated in better connecting with their cohort and other trainee clinical psychologists, and experts by qualification on the courses, but they did not feel completely connected to experts by experience. This was due to limited timetabled involvement and the perceived formality of relationships that did not occur fluidly. The expert by experience was also motivated in building better connections with trainee clinical psychologists. The focus group methodology may have resulted in individuals operating in a way that was consistent with their social identity that was further reinforced through highlighting the perceived barriers and differences between them and other groups, that further exacerbated the strength of their own group, which is consistent with how social identities are formed (Tajfel & Turner, 1979). The focus group methodology also enabled the members in the group to function as a whole through the idea of in-group homogeneity. There was an empathy towards those in one's own in-group which relates to previous research (Szanto & Krueger, 2019). However, if the research methodology explored identity constructions through for example individual interviews or mixed group focus groups, their identity constructions may have manifested differently.

Identification with their own group members in Chapter 5, showed solidarity, satisfaction and centrality towards their own in-groups following in-group identification that enabled them to identify with the group and behave as one. This is explained by the factors found by Leach et al., (2008) regarding the components that influence in-group identification. Additionally, this could be understood through the process of applying the findings from Chapter 6, of affective, evaluative, and cognitive factors of identification and further research to determine whether these different types of identification influence the process of empathy differently may be important. A three-factor model aligns with measures of identification identified (Cameron, 2004; Obst & White, 2005). The process of Evaluative identification with others occurs in a way that better reflects the process of empathy, in that the individual identifying with another is personally affected by a negative impact to the social identity they strongly identify with, suggesting an empathetic response. This suggests the process of identification may also occur through empathetic responses (Szanto & Krueger, 2019). This Evaluative component may mean a sense of shared group identity and shared fate that results from belonging to a social identity and the extent to which members identify with and empathise with a group is illustrated in research by Walters et al., (2020) based on research on LGBT and Muslim identities. Rogers, (1959) suggests empathy is key in a therapeutic relationship between service providers and service users. This might also apply to connecting groups within clinical psychology training and between lived experience researchers and their supervisors. The process of empathy can reduce barriers between groups, and support trainee clinical psychologists to better learn from their trainers, through this process of identification and empathy. The idea that Experts by Experience and lived experience researchers and providers across the studies have been shown to be empathetic, suggests that they can be effective service providers in the context of mental health, education, and research, reinforcing their values as experts by experience, lived experience practitioners or mental health professionals with lived experience.

Chapter 7 identified how lived experience researchers had an empathy towards their research participants and therefore the importance of Factor 2: Support to navigate personal and relational link to the research as a lived experience researcher. This highlighted the necessity of reflection and reflexivity in lived experience work, due to their personal connection to the work. There were strong themes of a need to be supported in emotional and validating ways in lived experience work and to feel a sense of belonging in their roles. This might come from connecting with peers, shared goals, shared lived experiences, shared belief in conceptual models in the mental health and disability fields. It was also found there was a sense of shared fate across lived experience researchers, suggesting greater empathy to others like themselves.

9.2.4. Recovery model and medical model

Models in healthcare and service user and carer involvement are found to be predominantly based on the recovery model, medical model, social disability model and trauma informed models. This theme encompasses the idea of each of these models that are differently identified with by both service users and service providers. They also differently impact attitudes towards mental illness and disability and stigma, as well as the power dynamics held between experts by experience and experts by qualification. They all also, influence the extent to which a lived experience role is professionalised, or the extent to which the individual maintains authenticity as a service user or survivor. Chapter 5 found that there was a motivation to rebalance the power dynamics by trainee clinical psychologists who recognised they held power, and experts by experience and carers that wanted to claim back power from service providers. The expert by experience role and label was a way to gain expert status and transfer the power back to service users. Models influence the extent to which lived experience is stigmatised. Chapter 6 identified trainees' identification between experts by experience, carers, trainees, and experts by qualification but could have provided greater insight into how individual differences between identification with different conceptual and philosophical models of care trainee clinical psychologists believe in influenced their identification with experts by experience that feel the same or differently about these models. However, chapter 7 found that philosophical models and differences working with people that understand their experiences differently or similarly were not subject matters that lived experience researchers prioritised as things they wanted to discuss. However, the importance of these models of healthcare and disability may be more relevant in clinical settings where service users and survivors are directly impacted by service providers. Although this research also finds that even in service user and carer involvement work models such as the medical model can be re-enacted, and the types of relationships found in healthcare between service users, carers and service providers is replicated in lived experience work. Going forward service providers should help understand the perspective and frame of model the service user provider wants to understand their experiences through and work with them in this person-centred way.

9.2.5. Growth and Transformation

The systematic review in Chapter 4, suggests that lived experience researchers grow and transform due to the impact of their roles, gaining additional skills and confidence (Hutchinson & Lovell, 2013). The theme also relates to research on posttraumatic growth (Ng et al., 2021). Chapter 5 identifies how each group in clinical psychology training, Trainee Clinical Psychologists, Experts by Experience, Carers and Experts by qualification are both constructed as learner and expert as they progress and develop greater skills and knowledge of how to integrate lived experience into their professional work. Chapter 6 identified three factors which were found to influence the process of identification between individuals and their social identities and therefore these are influencing factors that can support and foster a sense of belonging that may lead in turn to growth in developing connections and relationships with others and stronger social identities, resulting in greater wellbeing. This can be explained by the social cure phenomenon highlighted by Jetten et al., (2012). The learning from Chapter 6 can support people to facilitate and trigger their affective, evaluative, and cognitive identification towards those they work with and thereby support growth and encourage the effects of a social cure. Chapter 7 also encompasses the idea of growth and development for the lived experience researcher through Factor 1: Strengthening the identity, skills, growth, and empowerment of lived experience researchers which was the biggest factor. It appears to be important across the literature and studies that those in lived experience roles move beyond the service user identity, and lived experience roles can enable growth and transformation.

9.2.6. Exclusion/Stigma and Discrimination

The systematic review in Chapter 4 found the theme of exclusion and stigma and discrimination across the literature. There were them & us divisions within and between experts by experience and mental health professionals with lived experience (Adame, 2011) and exclusion of those from minorities in the mental health sector. It was also identified how the sector was unsafe for disclosures of lived experience that stopped some disclosures (Richards et al., 2016). Chapter 5 found there were Them & Us divisions between groups, and barriers to lived experience work by service providers. There was also stigma within the profession of clinical psychology that stopped disclosures and integration of lived experience by trainees and experts by qualification. These findings relate to the ideas of institutional, relational, and self-stigma and so these individuals experience multiple levels of discrimination. This disconnection between trainee clinical psychologists and EBEs and Expert Carers may be influenced through the process of epistemic and hermeneutical injustice (Fricker, 2017) that impacts the knowledge gained from those in these roles, as they have lower status based on where they are placed in the hierarchy such as within the context of clinical psychology training. It was also found that Trainee clinical psychologists from minoritized backgrounds were not expected in the stereotypes associated with roles in clinical psychology training which thereby unconsciously excluded minorities and their place within clinical psychology training. This suggests a greater need to establish greater diversity in the profession and encourage the changing identity of clinical psychology training going forward.

Chapter 6 identified that trainee clinical psychologists did not strongly identify with experts by experience and expert carers, which may have been due to stigma and fear of lived experience or due to dissonance and not wanting to be emotionally burdened by lived experience. It may have also been because they wanted to be associated with social identities that had increased status and held more power such as the expert by qualification. However, there was a difference between trainees relationship towards experts by experience and the relation of newly qualified clinical psychologists and their increased identification towards experts by experience. This might be because as psychologists become more experienced in their roles, it becomes easier to tolerate and work with lived experience, and not have to work in ways that puts a barrier up to it. Chapter 7 also identified a sample that was illustrative of the lack of diversity in lived experience work. Participants acknowledged the importance of more diversity and representation in lived experience work despite not embodying that intersection of identity. However, the value of lived experience work comes through individual’s personal connection and so it is increasingly important to have those from each intersection in the field so it can result in meaningful research that benefits marginalised and minoritized identities. This is shown to make the process of research much more meaningful in addressing the needs of the population.

9.2.7. Survivor roots

Chapter 4 identified how the roots of service user and survivor led work started from lived experience of disability or trauma (Toikko, 2016). Service users and Survivors and mental health professionals with lived experience might have different experiences of services and this might influence whether or why they engage in lived experience work, in order to improve the system or to stay away from it. The chronology of the lived experience worker usually begins with lived experience and this pattern and trajectory is paralleled in the wider literature. Chapter 5 however identifies that lived experience work can also be a source of burden that fits with the idea of emotional labour talked about by Faulkner & Thompson (2021). Although the experience of suffering is something that motivates those in lived experience roles to endure this due to the importance of the work and wanting to make a difference for others like themselves. Chapter 5 also highlights the diversity of thought across those in lived experience roles that fits with previous research (Wallcraft & Nettle, 2009).

Chapter 6 identifies how the evaluative identification factor also manifested, suggesting identification can be influenced through the process of suffering and lived experience. However, trainees' identification to EBEs and Carers was not affective, and there was a disconnect in terms of an emotional connection to them. This dissonance may have been a protective factor and acted as a buffer against the emotional burden of lived experience. Chapter 5 and 7 identified that those in lived experience work continued in their roles even if they were suffering from the emotional burden and pain of the work because of the importance of the work, or potentially because their threshold for suffering was so high, they maybe could not recognise when they needed to look after themselves. The idea of wellbeing intelligence may have been demonstrated by trainees and EBQs in Chapters 5 and 6 and less so from EBEs and Expert Carers, that were more likely to be closer to the experience of suffering. Although Carers did identify the importance of separation from lived experiences alongside Trainees and EBQs, but this motivation to separate lived experiences and professional experiences did not apply to the motives of EBEs. This might reinforce the distinct roles and purpose of the EBE and EBQ.

Chapter 7 identifies the importance of support found through Factor 3: Support to navigate personal and professional identities in emotional and practical ways. This suggests support should be specific to the needs of the individual at a given time and acknowledges the wide variation in needs of those engaged in lived experience work, which might be because their backgrounds and lived experiences are so diverse and varied. This coalesces with the person-centred approach to healthcare identified by (Rogers, 1959).

9.3. Strengths and Limitations

The order of studies including systematic review (Chapter 4) and empirical papers (Chapter 5 and 6) occurred in parallel to one another, but may have benefitted from a sequential progression, building on each other. Although, the final empirical paper (Chapter 7) enables a synthesis of learning from across each chapter.

The qualitative chapters 4, 5, and 7 have an element of subjectivity in relation to how findings could have been interpreted, but they were informed through a multidisciplinary team of lived experience researchers, service user advisors, clinical psychologists and research psychologists that were expert in the field and participants were also experts and so there is validity and data saturation in the studies. Chapter 4 is the first systematic narrative review to provide a conceptual framework to understand the process of identity development in lived experience researchers and offers a novel synthesis that has utility as a reflective tool for lived experience researchers and providers to reflect on their experiences. However, the conceptual framework and its comprehensive nature may have meant that other findings were interpreted through its lens and assimilated into the identified themes. If the conceptual framework was not identified for example, the interpretation of findings may have been different. However, the triangulation of each empirical study and its observation of identity through different methods results in a comprehensive exploration of identities in this field. The fact that the findings from across the thesis can be assimilated into the framework evidences its robustness. The systematic review, however, did not account for the grey literature or research on identity in other fields such as survivor and service user blogs, literature on gender, LGBT and Ethnicity, which may have contributed additional insight into the process of identity formation.

Chapter 5 is the first qualitative paper to use focus group methodology to measure the collective group identity of key stakeholders in clinical psychology training and identifies recommendations to reduce power imbalances, them & us divisions and advises on label use for groups in clinical psychology training. Although the sample was small and lacked diversity. Although, the research team and those sampled were experts in their fields in clinical psychology training and so there was assumed to be data saturation. There was also a recommendation to increase diversity across these groups, so the field is better representative of the population and its needs.

Chapter 6 is the first psychometric development of an in-group identification measure for use with trainee clinical psychologists. Although, Chapter 6 and its quantitative component had a relatively small sample of N = 108 trainee clinical psychologists from across a limited number of clinical psychology courses in the UK and was cross sectional in design. This means the findings need to be treated with caution and may not be generalisable. The field of lived experience work in clinical psychology training is ever changing and evolving and so replication of these studies would be important to understand the changing identity of members within clinical psychology training going forward.

Chapter 7 is the first attempt to understand the subjective needs of lived experience researchers through supervision and identifies a collection of issues they may need support with. A focus was to identify from lived experience researchers what their priorities for discussion in supervision were, based on their individual needs. It also reduces the complexity of the EMERGES framework and positions of identity and identifies relevant support strategies for lived experience researchers in a more personalised way. The three factors found also coalesce with the extant supervisory literature on normative, restorative, and formative, factors integral to supervision found by Proctor (1987).

As the PhD researcher, I had to navigate multiple identities in this research and how to work with those in different roles such as experts by qualification and service user advisors whilst negotiating their different identities. I had great difficulty in navigating my user-led motivations for the research whilst relinquishing some control over the research through the participation and involvement of a service user advisor. However, it is acknowledged that this type of involvement from the service user advisor may have been more participatory rather than perceived as coproduction, and this may have been influenced by the complex identities having to be navigated and the idea that as the PhD researcher, I should have control and autonomy over the research process, evidencing the multiple levels of complexity and difficulty of lived experience work. The lived experience and personal connection that I brought to the PhD thesis helped support the robustness of the research which was designed through this subjective perspective and then objectively measured through empirical studies in the real world, to see how the identities of others in lived experience work are constructed. The rigour by which the empirical studies were designed and informed through lived experience, has consequently resulted in meaningful outcomes to the field. The application and utility of the findings can better support lived experience work and those that work in the field.

9.4. Implications and clinical significance

The thesis helps to better understand the identities of those in mental health, education and research settings and identifies some support strategies to better support those in this sector to engage in lived experience work. The research offers novel findings both conceptually and theoretically, to the evidence base, that help elucidate the identities of those in the sector. The EMERGES framework offers a robust conceptual framework from which to understand those in this field. The focus group research provides an original and novel understanding of the organisational identity of clinical psychology training and provides recommendations to support each group within the organisation to work together more effectively. A reliable and valid In-group identification measure is also established. The measure is the first in-group identification measure adapted and adopted for use with trainee clinical psychologists. The three factors of affective, cognitive, and evaluative identification can be used as ways to better connect groups within clinical psychology training. The thesis also provides an understanding of the support needs of lived experience researchers and how each can be understood as belonging to one of three factors that can be used to understand them and their individual support needs. The thesis, therefore, provides a range of methods to support identity consciousness and ways to support lived experience work. The three factors found of lived experience researchers is linked back to key components in the EMERGES framework specific to their needs as demonstrated in Figure 9.1, offering an evidence-based way to personalise support to lived experience researchers.

9.5. Future research

The EMERGES framework can be further tested for external validity through asking lived experience research organisations to adopt the framework and support lived experience researchers to reflect on their experiences in relation to the framework. It would also be important to understand whether an understanding of identities supports effective team working and reduces them and us divisions between those in lived experience roles and those specifically in professional roles. The effect of ascribing expert status to both service users and carers in the context of mental health, education and research should also be studied to see whether it has the desired and assumed effect of increasing status, value and respect and reduce stigmatised identities. As the context of clinical psychology and the mental health and research field expands and grows through increased motivations to integrate lived experience, it would be important to replicate these studies to understand whether identity constructions change in the field going forward.

9.6.1. Recommendations for using the EMERGES framework

Enablers and Empowerment

- Understand existing competencies and provide additional opportunities for learning and training.
- Meaningful involvement and integration of lived experience that is not tokenistic and feeling valued and listened to.
- Providing a functional and effective payment method for lived experience researchers and providers.
- Providing reasonable adjustments for involvement.

Motivation

- Understand motivations behind lived experience researchers and providers' work.
- Find ways of integrating lived experience into work.
- Demonstrating disclosure and learning effective methods of disclosure through others.

Empathy of the self and others

- Provide a social domain to work within to share ideas and experiences to encourage mutual understanding of distress.
- Understand how our own experiences might impact how we understand the experiences of others, both negatively and positively.

Recovery model and medical model

- Respect and understand the models from which lived experience researchers and providers understand their experiences.
- Reflecting on power differences in the team
- Find ways to rebalance the power dynamics and redistribute power

Growth and transformation

- Provide lived experience researchers and providers opportunities to integrate their lived experience as this can lead to growth and benefits.
- Measure the impact of integration of lived experience on the lived experience researchers and providers and whether this is positive or negative on them and the service.
- Opportunities and time to develop in expertise through talking with other experts.

Exclusion/Stigma and Discrimination

- Provide lived experience researchers and providers with opportunities to understand their experiences of stigma and discrimination.
- Understand the them and us divisions between distinct groups in mental health services and find ways of reducing this gap and developing ways to be more inclusive.
- Create safer spaces for diverse communities within lived experience roles

Survivor roots

- Understand the complexity and nuance in experience of each lived experience researcher and provider and their positionality as for example either survivors of the mental health system or service users.
- Ensure that negative experiences of the mental health system are not reproduced in lived experience researchers and providers work contexts. Provide service providers with opportunities to learn from service users and survivors and their experiences.

9.6.2. How to support lived experience researchers in supervision

- Factor 1; Strengthening the identity, skills, growth, and empowerment of the lived experience researcher.

- Factor 2; Exploring the emotional and relational link the lived experience researcher has with the research.

- Factor 3; Supporting the lived experience researcher to navigating their lived and professional experiences practically and emotionally.

- Provide both research and clinical supervision to lived experience researchers.

- Ask lived experience researchers to complete the Q sort study regularly to review their requirements and needs from supervision.

- Refer to the particular elements of the EMERGES framework specific to the factor that the lived experience researcher falls under.

9.6.3. Recommendations for clinical psychology training

- Open communication between trainee clinical psychologists and experts by experience in both informal and formal settings to promote fluid connections and relationships and an open culture embedding and integrating lived experience in clinical psychology training.

- Rebalancing power dynamics between groups through ascribing expert status to experts by experience and expert carers and avoiding referring to trainers as experts by qualification.

- Establishing a more effective payment method and considering integrating experts by experience and expert carers onto the payroll system to enable them to feel like genuine staff members and embedded in clinical psychology training.

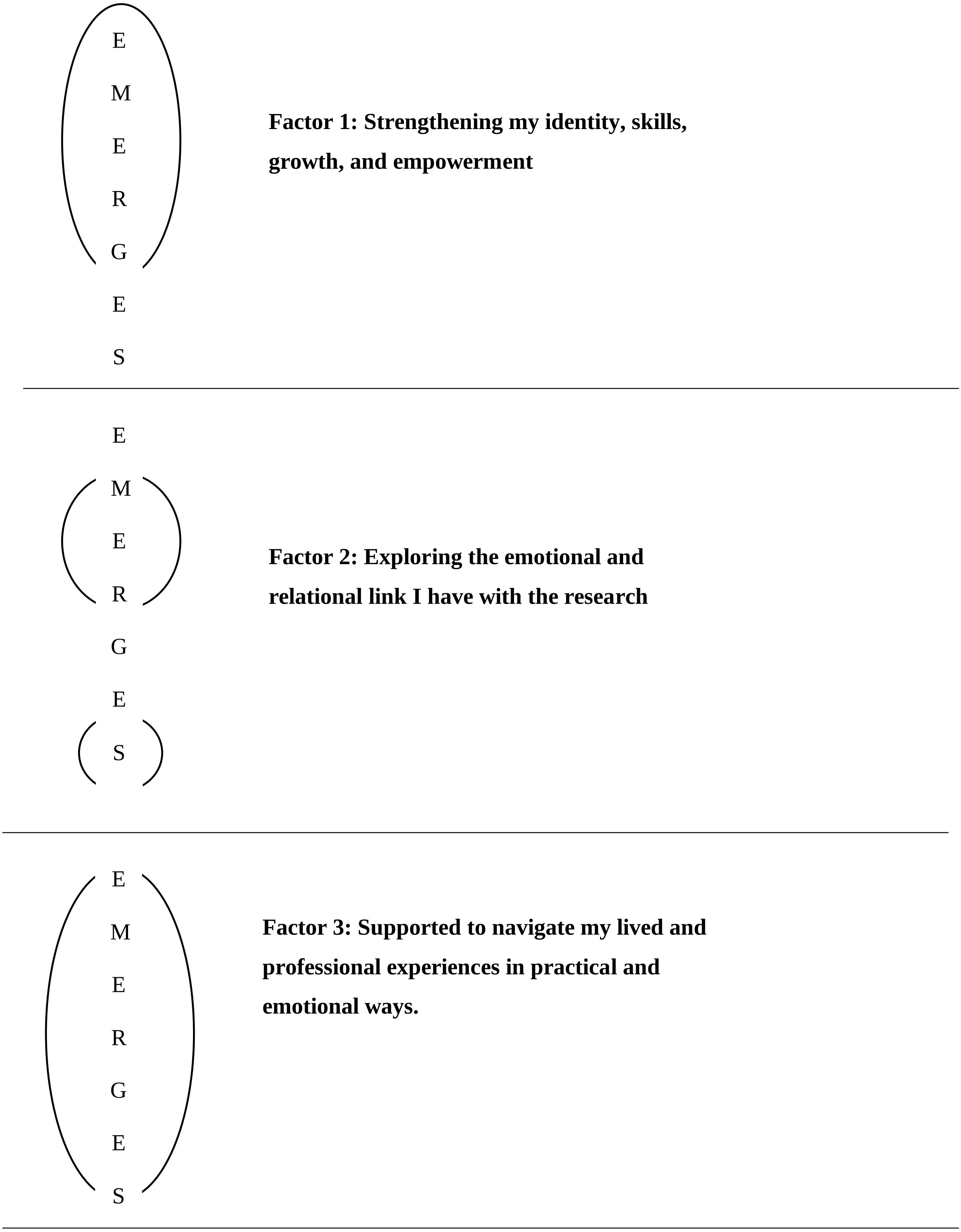
- Co-creating labels for groups in clinical psychology training and identify ways to know what diversity in schools of thought relating to philosophical and conceptual understandings of lived experience they each belong to, to help reinforce their identities and how they can be better understood by the people they work with.

- Development of guidelines to support experts by experience and expert carers to support them with issues relating to disclosure and the impact of this.

- Support trainee clinical psychologists to reflect on their affective, evaluative, and cognitive connections they have with experts by experience and experts by qualification that train them using items from the psychometric tool, to help facilitate identification between them.

- Ask trainee clinical psychologists and lived experience researchers to explore their relation to their research and participants in the data by using the reliable and valid in-group identification measure.

Figure 9.1. Mapping the factors onto the EMERGES framework (Empowerment and Enablers, Motivation to integrate, Empathy of the self and others, Recovery model and medical model, Growth and transformation, Exclusion and Survivor roots).



9.7. Final Reflections: A Continuing Development of my Identity

As I have come through the process of doing my PhD, I have learned more about those in the field of mental health education and research and specifically about the nature of roles that encompass both professional and lived experience identities. I have also learned about how to conduct qualitative research both through the narrative systematic review and the focus group interviews. I have enhanced my quantitative research skills by learning about confirmatory factor analysis and learning new skills in Q methodology. I have also managed to navigate and negotiate the many challenges of being a lived experience researcher, and the pull to integrate and embed my own lived experiences, whilst also learning about the experiences of others that are equally valid experiences. The research findings have been rich in quality and validate the complexity of lived experience work in this field and the difficulties and challenges that need to be navigated. I have, through this process, learned to better navigate my different identities, and the research findings can help support others to also navigate their lived experience roles. I have developed my skills as a mixed methods researcher and gained confidence in learning new research methodologies that I can add to my skill set. This fits with the idea of Empowerment in the EMERGES framework, the final stage in the framework.

Early on, I went through the struggles of being a service user and survivor roots that have been a strong part of my identity, but this is not a linear model and I have continuously moved between the stages of the framework throughout the PhD. Through engaging in lived experience work made me think I could be more than just a service user. I have experienced tokenism and experiences of exclusion and understand how those experiences can negatively impact the lived experience researcher, but also how when we are listened to and our feedback implemented, can make us and the service grow and develop. I have learned that people in this work can sometimes be individuals in groups, sometimes working independently and sometimes working for the collective. There is also wide variation regarding the models in which they identify and come to understand their experiences of distress. The field can result in many different types of power dynamics that need to be navigated, with a view to rebalancing these power dynamics across groups. Through the process of the focus group research and reflecting on this experience I grew a greater understanding of my own experiences in relation to others and grew a greater empathy for others in this role, as well as identities that I was not familiar with, such as the Carer identity. I also realised the impact of labels and social identities, and how they influence the construction of identities and influence individuals to operate in ways that are consistent with them. The more I engage in this type of work, the more expert I get at it and learn new ways of integrating lived experiences, without necessarily telling my story, but through embedding theoretical models and channelling this in my research and lived experience work. Having come through my PhD as a learner and become an expert by experience and also an expert by qualification, I understand that these identities can coexist and there can be overlap between them. I hope the research can go some way in mental health, education, and research to better support the motivations of those with lived experience in the field to integrate their experiences in the way they want to. Overall, the process has been empowering, and I have reached the top of the EMERGES framework. I hope to continue my development and embed the learning from this PhD into lived experience work going forward and apply what I have learned in my new role as Research Associate in the EXTEND early intervention in psychosis study, working closely with the EXTEND-InG, involvement group, with Experts by Experience, service users and carers. I hope to support their growth, identity, skills, and empowerment, helping them navigate their multiple identities and their relational and personal links to the research. As Mahatma Gandhi said, "*The best way to find yourself is to lose yourself in the service of others.*" I better understand my own identity now through the process of this research and hope the research can go some way in being of service to others. I hope to continue to work in the field and continue to promote the development of emerging identities in mental health, education, and research.

9.8. Final Conclusions

To conclude, the PhD thesis has been an exploration of emerging identities in mental health, education, and research. It has been a multiple methods approach to understanding identity and its formation in a collection of different ways. It has gone some way in providing ways to raise identity consciousness in this field and has resulted in multiple methods for those in the field to reflect on their identities and identifies support for those that integrate lived experience in professional spheres and mechanisms to do this more effectively.

References

Abes, E. S., Jones, S. R., & McEwen, M. K. (2007). Reconceptualizing the Model of Multiple Dimensions of Identity: The Role of Meaning-Making Capacity in the Construction of Multiple Identities. *Journal of College Student Development*, *48*(1), 1–22. https://doi.org/10.1353/csd.2007.0000

Academy of Medical Royal Colleges. (2020). *Developing professional identity in multi-professional teams*.

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

Allen, M. S., Iliescu, D., & Greiff, S. (2022). Single Item Measures in Psychological Science. *European Journal of Psychological Assessment*, *38*(1), 1–5. https://doi.org/10.1027/1015-5759/a000699

Andrasson, F., Andreasson, J., & Hanson, E. J. (2017). Developing A Carer Identity and Negotiating Everyday Life Through Social Networking Sites. *Innovation in Aging*, *1*(suppl_1), 465–466. https://doi.org/10.1093/geroni/igx004.1659

Andreassen, T. A., Breit, E., & Legard, S. (2014). The making of 'professional amateurs.' *Acta Sociologica*, *57*(4), 325–340. https://doi.org/10.1177/0001699314552736

Armenta, C. N., Fritz, M. M., & Lyubomirsky, S. (2017). Functions of Positive Emotions: Gratitude as a Motivator of Self-Improvement and Positive Change. *Emotion Review*, *9*(3), 183–190. https://doi.org/10.1177/1754073916669596

Arnstein, S. R. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*, *35*(4), 216–224. https://doi.org/10.1080/01944366908977225

Arroll, B., & Allen, E.-C. F. (2015). To self-disclose or not self-disclose? A systematic review of clinical self-disclosure in primary care. *British Journal of General Practice*, *65*(638), e609–e616. https://doi.org/10.3399/bjgp15X686533

Ashby, S. E., Adler, J., & Herbert, L. (2016). An exploratory international study into occupational therapy students' perceptions of professional identity. *Australian Occupational Therapy Journal*, *63*(4), 233–243. https://doi.org/10.1111/1440-1630.12271

Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug and Alcohol Dependence*, *189*, 131–138. https://doi.org/10.1016/j.drugalcdep.2018.05.005

Ashforth, B. E., & Mael, F. (1989). Social Identity Theory and the Organization. *The Academy of Management Review*, *14*(1), 20. https://doi.org/10.2307/258189

Association for Clinical Psychologists (ACP-UK). (2019). *Racism in the Profession of Clinical Psychology*. Https://Acpuk.Org.Uk/Acp-Uk_statement_on_trainers_conference/.

Banasick, S. (2019). KADE: A desktop application for Q methodology. *Journal of Open Source Software*, *4*(36), 1360. https://doi.org/10.21105/joss.01360

Beames, J. R., Kikas, K., O'Gradey-Lee, M., Gale, N., Werner-Seidler, A., Boydell, K. M., & Hudson, J. L. (2021). A New Normal: Integrating Lived Experience Into Scientific Data Syntheses. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.763005

Becker, H. (1963). *Outsiders: studies in the sociology of deviance*. Free Press.

Bee, P., Price, O., Baker, J., & Lovell, K. (2015). Systematic synthesis of barriers and facilitators to service user-led care planning. *British Journal of Psychiatry*, *207*(2), 104–114. https://doi.org/10.1192/bjp.bp.114.152447

Beech, N. (2011). Liminality and the practices of identity reconstruction. *Human Relations*, *64*(2), 285–302. https://doi.org/10.1177/0018726710371235

Ben-Zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. *Journal of Mental Health*, *19*(4), 318–327. https://doi.org/10.3109/09638237.2010.492484

Beresford, & Campbell. (2004). *Participation and protest: mental health service users/survivors'. in M.J. Todd and G Taylor (eds), Democracy and Participation: Popular Protest and New Social Movements*. Merlin Press.

Beresford, P. (2002). User Involvement in Research and Evaluation: Liberation or Regulation? *Social Policy and Society*, *1*(2), 95–105. https://doi.org/10.1017/S1474746402000222

Beresford, P. (2021). *Participatory Ideology: From Exclusion to Involvement.* Bristol University Press.

Beresford, P., & Campbell, J. (1994). Disabled People, Service Users, User Involvement and Representation. *Disability & Society*, *9*(3), 315–325. https://doi.org/10.1080/09687599466780361

Beresford, P., Nettle, M., & Perring, R. (2010). *Towards a social model of madness and distress? Exploring what service users say*.

Berger, & Luckmann. (1991). *The Social Construction of Reality*. Penguin books.

Berger, R., Quiros, L., & Benavidez-Hatzis, J. R. (2018). The intersection of identities in supervision for trauma-informed practice: Challenges and strategies. *The Clinical Supervisor*, *37*(1), 122–141. https://doi.org/10.1080/07325223.2017.1376299

Bernard, J. (1979). Supervisor Training: A Discrimination Model. *Counselor Education and Supervision*, *19*(1), 60–68. https://doi.org/10.1002/j.1556-6978.1979.tb00906.x

Bleakley, A., Bligh, J., & Browne, J. (2011). *Medical Education for the Future: Identity, Power and Location* (Vol. 1). Springer.

Blee, K. M., & Taylor, V. (2002). Semi-structured interviewing in social movement research. In B. Klandermans & S. Staggenborg (Eds.) *Methods of social movement research* (pp. 92–117). University of Minnesota Press.

Boisvert, C. M., & Faust, D. (2002). Iatrogenic symptoms in psychotherapy: A theoretical exploration of the potential impact of labels, language and belief systems. *American Journal of Psychotherapy*, *56*(2), 244–259.

Borders, L. D. (1991). A Systematic Approach to Peer Group Supervision. *Journal of Counseling & Development*, *69*(3), 248–252. https://doi.org/10.1002/j.1556-6676.1991.tb01497.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., Clarke, V., & Weate, P. (2016). Using Thematic Analysis in Sport and Exercise Research. In B. Smith & A. C. Sparkes (Eds.), *Routledge Handbook of Qualitative Research in Sport and Exercise* (pp. 191–205). Routledge.

Bravata, D. M., Watts, S. A., Keefer, A. L., Madhusudhan, D. K., Taylor, K. T., Clark, D. M., Nelson, R. S., Cokley, K. O., & Hagg, H. K. (2020). Prevalence, Predictors, and Treatment of Impostor Syndrome: a Systematic Review. *Journal of General Internal Medicine*, *35*(4), 1252–1275. https://doi.org/10.1007/s11606-019-05364-1

Bray. (2019). *Counselor self-disclosure: Encouragement or impediment to client growth?* . Counselling Today. Https://Ct.Counseling.Org/2019/01/Counselor-Self- Disclosure-Encouragement-or-Impediment-to-Client-Growth/ .

British Psychological Society. (2020a). Racial and social inequalities: Taking the conversations forward. *Division of Clinical Psychology*.

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

Broady, T. R. (2015). The carer persona: Masking individual identities. *Persona Studies, 1*(1). https://doi.org/10.21153/ps2015vol1no1art392

Brown, R., & Williams, J. (1984). Group Identification: The Same Thing to All People? *Human Relations*, *37*(7), 547–564. https://doi.org/10.1177/001872678403700704

Brown, S. (1980). *Political subjectivity: Applications of Q Methodology in political science.* Yale University Press.

Brown, W. J., & Basil, M. D. (2010). Parasocial Interaction and Identification: Social Change Processes for Effective Health Interventions. *Health Communication, 25*(6–7), 601–602. https://doi.org/10.1080/10410236.2010.496830

Buckley-Walker, K., Crowe, T., & Caputi, P. (2010). Exploring identity within the recovery process of people with serious mental illnesses. *Psychiatric Rehabilitation Journal*, *33*(3), 219–227.

Burke, P. J., & Stets, J. E. (2009). *Identity Theory*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195388275.001.0001

Burnham, J. (1993). Systemic supervision: The evolution of reflexivity in the context of the supervisory relationship. *Human Systems*, *4*, 349–381.

Burr, V. (2003). *Social Constructionism* (2nd Edition). Routledge.

Byrne, L., Happell, B., & Reid-Searl, K. (2017). Risky business: Lived experience mental health practice, nurses as potential allies. *International Journal of Mental Health Nursing*, *26*(3), 285–292. https://doi.org/10.1111/inm.12245

Byrne, L., Roennfeldt, H., Davidson, L., Miller, R., & Bellamy, C. (2022). To disclose or not to disclose? Peer workers impact on a culture of safe disclosure for mental health professionals with lived experience. *Psychological Services, 19*(1), 9–18. https://doi.org/10.1037/ser0000555

Bytheway, B., & Johnson, J. (1998). The Social Construction of Carers'. In A. Symonds & A. Kelly (Eds.), *'The Social Construction of Community Care*. Macmillan.

Calvert, F. L., Crowe, T. P., & Grenyer, B. F. S. (2016). Dialogical reflexivity in supervision: An experiential learning process for enhancing reflective and relational competencies. *The Clinical Supervisor*, *35*(1), 1–21. https://doi.org/10.1080/07325223.2015.1135840

Cameron, C., Moore, M., Nutt, A., & Chambers, E. (2019). Improving understanding of service-user involvement and identity: collaborative research traversing disability, activism and the academy. *Disability & Society*, *34*(7–8), 1312–1331. https://doi.org/10.1080/09687599.2019.1632693

Cameron, J. E. (2004). A Three-Factor Model of Social Identity. *Self and Identity, 3*(3), 239–262. https://doi.org/10.1080/13576500444000047

Cameron, J. E., & Lalonde, R. N. (2001). Social identification and gender-related ideology in women and men. *British Journal of Social Psychology*, *40*(1), 59–77. https://doi.org/10.1348/014466601164696

Campbell, D. T. (2007). Common fate, similarity, and other indices of the status of aggregates of persons as social entities. *Behavioral Science*, *3*(1), 14–25. https://doi.org/10.1002/bs.3830030103

Care Quality Commission (CQC). (2022). *Regulation 18: Staffing: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18*. Https://Www.Cqc.Org.Uk/Guidance-Providers/Regulations-Enforcement/Regulation-18-Staffing.

Carr, S. (2019). 'I am not your nutter': a personal reflection on commodification and comradeship in service user and survivor research. *Disability & Society, 34*(7–8), 1140–1153. https://doi.org/10.1080/09687599.2019.1608424

Chamberlain J. (1990). The ex-patients movement: where have we been and where are we going? *The Journal of Mind and Behaviour, 111*, 323–336.

Chambers, M., & Hickey, G. (2012). *Service User Involvement in the Design and Delivery of Education and Training Programmes leading to Registration with the Health Professions Council*. .

Clair, J. A., Beatty, J. E., & Maclean, T. L. (2005). Out of Sight but Not Out of Mind: Managing Invisible Social Identities in the Workplace. *Academy of Management Review*, *30*(1), 78–95. https://doi.org/10.5465/amr.2005.15281431

Clark, C. J., Fox, E., & Long, C. G. (2015). Can teaching staff about the neurobiological underpinnings of borderline personality disorder instigate attitudinal change? *Journal of Psychiatric Intensive Care*, *11*(01), 43–51. https://doi.org/10.1017/S1742646414000132

Clarke, S. P., & Holttum, S. (2013). Staff Perspectives of Service User Involvement on Two Clinical Psychology Training Courses. *Psychology Learning & Teaching*, *12*(1), 32–43. https://doi.org/10.2304/plat.2013.12.1.32

Conneely, M., McNamee, P., Gupta, V., Richardson, J., Priebe, S., Jones, J. M., & Giacco, D. (2021). Understanding Identity Changes in Psychosis: A Systematic Review and Narrative Synthesis. *Schizophrenia Bulletin*, *47*(2), 309–322. https://doi.org/10.1093/schbul/sbaa124

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cooke, S., Daiches, A., & Hickey, E. (2015). Narratives of experts by experience: the impact of delivering training in partnership on the subject of personality disorder. *The Journal of Mental Health Training, Education and Practice*, *10*(4), 234–244. https://doi.org/10.1108/JMHTEP-03-2015-0012

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *1*(1), 16–20.

Coulter, A., & Collins, A. (2011). *Making Shared Decision Making a Reality: No decision about me, without me*.

Crane, L. (2012). Trust me, I'm an expert: identity construction and knowledge sharing. *Journal of Knowledge Management*, *16*(3), 448–460. https://doi.org/10.1108/13673271211238760

Crawford, P., Brown, B., & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies*, *45*(7), 1055–1063. https://doi.org/10.1016/j.ijnurstu.2007.05.005

Crenshaw, K. (1989). *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics.* University of Chicago Legal Forum.

Crenshaw, K. (2017). *On Intersectionality: Essential Writings"*. Faculty Books.

Croft, S., & Beresford, P. (1988). Being On The Receiving End: lessons for community development and user involvement. *Community Development Journal*, *23*(4), 273–279. https://doi.org/10.1093/cdj/23.4.273

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2015). A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents. *Academic Medicine*, *90*(6), 718–725. https://doi.org/10.1097/ACM.0000000000000700

Davidson L. (2016) The Recovery Movement: Implications For Mental Health Care And Enabling People To Participate Fully In Life. Health Affairs (Project Hope). Jun;35(6):1091-1097. DOI: 10.1377/hlthaff.2016.0153. PMID: 27269027.

Daya, I. (2021). *The participation ladder: A consumer/survivor lens*. Http://Www.Indigodaya.Com/Wpcf7_captcha/2020/10/Participation-Ladder_consumer_survivor-Lens-2.Pdf.

de Ruysscher, C., Tomlinson, P., Vanheule, S., & Vandevelde, S. (2019). Questioning the professionalization of recovery: a collaborative exploration of a recovery process. *Disability & Society*, *34*(5), 797–818. https://doi.org/10.1080/09687599.2019.1588708

Dobransky, K. (2011). *Labeling, Looping, and Social Control: Contextualizing Diagnosis in Mental Health Care* (pp. 111–131). https://doi.org/10.1108/S1057-6290(2011)0000012010

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Department of Health (DOH). (1999). *Patient and public involvement in the new NHS*. The Stationery Office.

Department of Health (DOH). (2000). *The NHS Plan.* . The Stationery office.

Department of Health (DOH). (2001). *The expert patient: A new approach to chronic disease management for the 21st century*. Department of Health.

Dunlop, B. J., Woods, B., Lovell, J., O'Connell, A., Rawcliffe-Foo, S., & Hinsby, K. (2022). Sharing Lived Experiences Framework (SLEF): a framework for mental health practitioners when making disclosure decisions. *Journal of Social Work Practice*, *36*(1), 25–39. https://doi.org/10.1080/02650533.2021.1922367

Edwards, A. L. (1953). The relationship between the judged desirability of a trait and the probability that the trait will be endorsed. *Journal of Applied Psychology*, *37*(2), 90–93. https://doi.org/10.1037/h0058073

Ellemers, N., Knippenberg, A., & Wilke, H. (1990). The influence of permeability of group boundaries and stability of group status on strategies of individual mobility and social change. *British Journal of Social Psychology*, *29*(3), 233–246. https://doi.org/10.1111/j.2044-8309.1990.tb00902.x

Emery, L. (2015). *Experiences of service user involvement and their influence on identity*. PhD Thesis Canterbury Christ Church University Salomons Centre for Applied Psychology.

Fairhurst, G. T., & Grant, D. (2010). The Social Construction of Leadership: A Sailing Guide. *Management Communication Quarterly*, *24*(2), 171–210. https://doi.org/10.1177/0893318909359697

Faulkner, A. (2004). *The ethics of survivor research Guidelines for the ethical conduct of research carried out by mental health service users and survivors*. The Policy Press.

Faulkner, A., & Thompson, R. (2021). Uncovering the emotional labour of involvement and co-production in mental health research. *Disability & Society*, 1–24. https://doi.org/10.1080/09687599.2021.1930519

Felton, A., & Stickley, T. (2004). Pedagogy, power and service user involvement. . *Journal of Psychiatric and Mental Health Nursing*, *11*(1), 89–98.

Figley, C. R. (2002). *Treating compassion fatigue.* Brunner-Routledge.

Foglesong, D., Spagnolo, A. B., Cronise, R., Forbes, J., Swarbrick, P., Edwards, J. P., & Pratt, C. (2022). Perceptions of Supervisors of Peer Support Workers (PSW) in Behavioral Health: Results from a National Survey. *Community Mental Health Journal*, *58*(3), 437–443. https://doi.org/10.1007/s10597-021-00837-2

Foucault, M. (1967). *Madness and Civilization: A History of Insanity in the Age of Reason* (R. Howard, Ed.). Tavistock.

Fox, J. (2011). 'The view from inside': understanding service user involvement in health and social care education. *Disability & Society*, *26*(2), 169–177. https://doi.org/10.1080/09687599.2011.544057

Fox, J. (2016). Being a service user and a social work academic: balancing expert identities. *Social Work Education*, *35*(8), 960–969. https://doi.org/10.1080/02615479.2016.1227315

Fricker, M. (2007). *Epistemic Injustice*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Fricker, M. (2017). *Evolving Concepts of Epistemic Injustice.* The Routledge Handbook of Epistemic Injustice (1st Edition). Routledge.

Gamson, W. (1992). 'The Social Psychology of Collective Action.' In A. Morris & C. McClurg Mueller (eds) (Eds.), *Frontiers in Social Movement Theory,* (pp. 53–76). Yale University Press.

Gardner, S. (2021). *The Intersection of Empathy, Social Identity, And Threat*. The Faculty of Humboldt State University.

Garfield, S. L. (1966). Clinical psychology and the search for identity. *American Psychologist*, *21*(4), 353–362. https://doi.org/10.1037/h0023529

Gazzola, N., de Stefano, J., Audet, C., & Theriault, A. (2011). Professional identity among counselling psychology doctoral students: A qualitative investigation. *Counselling Psychology Quarterly*, *24*(4), 257–275. https://doi.org/10.1080/09515070.2011.630572

Glorfield, L. W. (1995). An Improvement on Horn's Parallel Analysis Methodology for Selecting the Correct Number of Factors to Retain. *Educational and Psychological Measurement, 55*(3), 377–393.

Goldie, J. (2012). The formation of professional identity in medical students: Considerations for educators. *Medical Teacher*, *34*(9), e641–e648. https://doi.org/10.3109/0142159X.2012.687476

Gosling, S. D., Rentfrow, P. J., & Swann, W. B, Jr. (2003). A Very Brief Measure of the Big Five Personality Domains *Journal of Research in Personality*, *37*, 504–528.

Grapsas, S., Brummelman, E., Back, M. D., & Denissen, J. J. A. (2020). The "Why" and "How" of Narcissism: A Process Model of Narcissistic Status Pursuit. *Perspectives on Psychological Science*, *15*(1), 150–172. https://doi.org/10.1177/1745691619873350

Grijak, D. (2017). Authenticity as a Predictor of Mental Health. *Klinička Psihologija*, *10*(1–2), 23–34. https://doi.org/10.21465/2017-KP-1-2-0002

Hair, H. J., & O'Donoghue, K. (2009). Culturally Relevant, Socially Just Social Work Supervision: Becoming Visible Through a Social Constructionist Lens. *Journal of Ethnic And Cultural Diversity in Social Work, 18*(1–2), 70–88. https://doi.org/10.1080/15313200902874979

Hannan, R. (2013). The Triangle of Care: carers included. *Journal of Public Mental Health, 12*(3), 171–172. https://doi.org/10.1108/JPMH-06-2013-0042

Happell, B., Byrne, L., Platania-Phung, C., Harris, S., Bradshaw, J., & Davies, J. (2014). Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International Journal of Mental Health Nursing*, *23*(5), 427–434. https://doi.org/10.1111/inm.12077

Harper, D., Goodbody, L., & Steen, L. (2003). Involving users of services in clinical psychology training. Clinical Psychology. *Clinical Psychology*, *21*(14–19), 30.

Harper, D., & Speed, E. (2014). Uncovering Recovery. In *De-Medicalizing Misery II*. Palgrave Macmillan. https://doi.org/10.1057/9781137304667.0008

Haslam, A. (2014). Making good theory practical: Five lessons for an Applied Social Identity Approach to challenges of organizational, health, and clinical psychology. *British Journal of Social Psychology, 53*(1), 1–20. https://doi.org/10.1111/bjso.12061

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social Identity, Health and Well-Being: An Emerging Agenda for Applied Psychology. *Applied Psychology*, *58*(1), 1–23. https://doi.org/10.1111/j.1464-0597.2008.00379.x

Hawkins. (1999). *Reconstructing Illness: Studies in Pathography* (2nd ed.). Purdue University press.

Healthcare Professions Council (HCPC). (2018). *Service user and carer involvement*. Https://Www.Hcpc-Uk.Org/Education/Resources/Education-Standards/Service-User-and-Carer-Involvement/.

Higson, H., & Allan, S. (2019). *Professional and personal identities as clinical psychologists.* In W. Curvis (Ed.), Professional Issues in Clinical Psychology. Developing a professional identity through clinical psychology training and beyond (1st Edition). Routledge.

Hill, A. (2021). *Service user and carer representatives' experiences of the personal effects of involvement in clinical psychology training*.

Hills, P., & Argyle, M. (2001). Emotional stability as a major dimension of happiness. *Personality and Individual Differences*, *31*(8), 1357–1364. https://doi.org/10.1016/S0191-8869(00)00229-4

Hinkle, S., Taylor, L. A., Fox-Cardamone, D. L., & Crook, K. F. (1989). Intragroup identification and intergroup differentiation: A multicomponent approach. *British Journal of Social Psychology*, *28*(4), 305–317. https://doi.org/10.1111/j.2044-8309.1989.tb00874.x

Hodge, S. (2005). Competence, Identity and Intersubjectivity: Applying Habermas's Theory of Communicative Action to Service User Involvement in Mental Health Policy Making. *Social Theory & Health*, *3*(3), 165–182. https://doi.org/10.1057/palgrave.sth.8700055

Hogg, M. A. (2012). Uncertainty-Identity Theory. In *Handbook of Theories of Social Psychology* (pp. 62–80). SAGE Publications Ltd. https://doi.org/10.4135/9781446249222.n29

Hogg, M. A., & Abrams, D. (1988). *Social identifications: A social psychology of intergroup relations and group processes.* Taylor & Frances/Routledge.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Sage.

Hughes, N., Locock, L., & Ziebland, S. (2013). Personal identity and the role of "carer" among relatives and friends of people with multiple sclerosis. *Social Science & Medicine (1982)*, *96*, 78–85. https://doi.org/10.1016/j.socscimed.2013.07.023

Huse, L.-K. (2020). Fundamentals of Social Identity and Social Justice: Considering Social Identity Within CBPR With Marginalized Populations. *Frontiers in Communication*, *5*. https://doi.org/10.3389/fcomm.2020.00041

Hutchinson, A., & Lovell, A. (2013). Participatory action research: moving beyond the mental health 'service user' identity. *Journal of Psychiatric and Mental Health Nursing*, *20*(7), 641–649. https://doi.org/10.1111/jpm.12001

International Association for Public Participation (IAP2). (2018). *IAP2's public participation spectrum.* Https://Iap2.Org.Au/WpContent/Uploads/2020/01/2018_IAP2_Spectrum.Pdf

Jacob, K. S (2015) Recovery model of mental illness: a complementary approach to psychiatric care. Indian J Psychol Med. Apr-Jun;37(2):117-9. doi: 10.4103/0253-7176.155605. PMID: 25969592; PMCID: PMC4418239.

Jamieson, M., Govaart, G., & Pownall, M. (2022). Reflexivity in Quantitative Research: a Rationale and Beginner's Guide. *Https://Doi.Org/10.31234/Osf.Io/Xvrhm*.

Jetten, J., Haslam, C., & Haslam, A. (2012). *The social cure: Identity, health and well-being.* Psychology Press.

John, O. P., & Srivastava, S. (1999). The Big Five Trait taxonomy: History, measurement, and theoretical perspectives. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and research* (pp. 102–138). Guilford Press.

Johnson, M., Cowin, L. S., Wilson, I., & Young, H. (2012). Professional identity and nursing: contemporary theoretical developments and future research challenges. *International Nursing Review*, *59*(4), 562–569. https://doi.org/10.1111/j.1466-7657.2012.01013.x

Johnson, M. D., Morgeson, F. P., & Hekman, D. R. (2012). Cognitive and affective identification: Exploring the links between different forms of social identification and personality with work attitudes and behavior. *Journal of Organizational Behavior*, *33*(8), 1142–1167. https://doi.org/10.1002/job.1787

Jonason, P. K., & Webster, G. D. (2010). The dirty dozen: A concise measure of the dark triad. *Psychological Assessment*, *22*(2), 420–432. https://doi.org/10.1037/a0019265

Jones, M., & Pietilä, I. (2020). Personal perspectives on patient and public involvement – stories about becoming and being an expert by experience. *Sociology of Health & Illness*, *42*(4), 809–824. https://doi.org/10.1111/1467-9566.13064

Kachanoff, F. J., Ysseldyk, R., Taylor, D. M., de la Sablonnière, R., & Crush, J. (2016). The good, the bad and the central of group identification: Evidence of a U-shaped quadratic relation between in-group affect and identity centrality. *European Journal of Social Psychology*, *46*(5), 563–580. https://doi.org/10.1002/ejsp.2199

Kalathil, J., & Jones, N. (2016). Unsettling Disciplines: Madness, Identity, Research, Knowledge. *Philosophy, Psychiatry, & Psychology*, *23*(3–4), 183–188. https://doi.org/10.1353/ppp.2016.0016

Karasawa, M. (1991). Toward an assessment of social identity: The structure of group identification and its effects on in-group evaluations. *British Journal of Social Psychology*, *30*(4), 293–307. https://doi.org/10.1111/j.2044-8309.1991.tb00947.x

Kirrane, M., Kilroy, S., & O'Connor, C. (2019). The moderating effect of team psychological empowerment on the relationship between abusive supervision and engagement. *Leadership & Organization Development Journal*, *40*(1), 31–44. https://doi.org/10.1108/LODJ-07-2018-0252

Kline, P. (1994). *An easy guide to factor analysis*. Routledge.

la Barbera, F., & Capone, V. (2016). Five dimensions of European identity: A contribution to the Italian adaptation and validation of the In-Group Identification Scale. *Europe's Journal of Psychology*, *12*(2), 288–303. https://doi.org/10.5964/ejop.v12i2.1058

Leach, C. W., van Zomeren, M., Zebel, S., Vliek, M. L. W., Pennekamp, S. F., Doosje, B., Ouwerkerk, J. W., & Spears, R. (2008). Group-level self-definition and self-investment: A hierarchical (multicomponent) model of in-group identification. *Journal of Personality and Social Psychology*, *95*(1), 144–165. https://doi.org/10.1037/0022-3514.95.1.144

Leamy, M., Bird, V., Boutillier, C. le, Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Li, C.-T., Ran, Y.-P., & Kádár, D. (2018). Constructing self-expert identity via other-identity negation in Chinese televised debating discourse. *Text & Talk*, *38*(4), 435–455. https://doi.org/10.1515/text-2018-0009

Lie, N. (2012). "Stereotypes and Identity Construction: Concepts as Tools." *Interférences Littéraires/Literaire Interferenties*, *9*, 183–191.

Littrell, J. M., Lee-Borden, N., & Lorenz, J. (1976). A Developmental Framework for Counseling Supervision. *Counselor Education and Supervision*, *19*(2), 129–136. https://doi.org/10.1002/j.1556-6978.1976.tb02021.x

Llewelyn, S., & Gardner, D. (2009). Boundary issues in clinical psychology. . *Clinical Psychology Forum*.

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis. *International Journal of Evidence-Based Healthcare*, *13*(3), 179–187. https://doi.org/10.1097/XEB.0000000000000062

Lovakov, A. v., Agadullina, E. R., & Osin, E. N. (2015). A Hierarchical (Multicomponent) Model of In-Group Identification: Examining in Russian Samples. *The Spanish Journal of Psychology*, *18*, E32. https://doi.org/10.1017/sjp.2015.37

MacLean, T. L., & Webber, S. S. (2015). Navigating Multiple Identities Across Multiple Boundaries. *Journal of Management Inquiry*, *24*(2), 156–173. https://doi.org/10.1177/1056492614546222

Martin, J. M. (2010). Stigma and student mental health in higher education. *Higher Education Research & Development*, *29*(3), 259–274. https://doi.org/10.1080/07294360903470969

Martinez, A. G., Piff, P. K., Mendoza-Denton, R., & Hinshaw, S. P. (2011). The Power of a Label: Mental Illness Diagnoses, Ascribed Humanity, and Social Rejection. *Journal of Social and Clinical Psychology*, *30*(1), 1–23. https://doi.org/10.1521/jscp.2011.30.1.1

Martiny, S. E., & Rubin, M. (2016). *Towards a Clearer Understanding of Social Identity Theory's Self-Esteem Hypothesis* (pp. 19–32). https://doi.org/10.1007/978-3-319-29869-6_2

Maxwell, V. (2020). *How Peer Support Training Is Reducing My Imposter Syndrome*. Https://Www.Psychologytoday.Com/Gb/Blog/Crazy-Life/202011/How-Peer-Support-Training-Is-Reducing-My-Imposter-Syndrome.

Mayer, C., & McKenzie, K. (2017). '…it shows that there's no limits': the psychological impact of co-production for experts by experience working in youth mental health. *Health & Social Care in the Community*, *25*(3), 1181–1189. https://doi.org/10.1111/hsc.12418

Mayhew, M. G., Gardner, J., & Ashkanasy, N. M. (2010). Measuring individuals' need for identification: Scale development and validation. *Personality and Individual Differences*, *49*(5), 356–361. https://doi.org/10.1016/j.paid.2010.03.031

McChesney, K. (2022). A rationale for trauma-informed postgraduate supervision. *Teaching in Higher Education*, 1–23. https://doi.org/10.1080/13562517.2022.2145469

McCoy, M. L., & Aronoff, M. (1994). Against all odds: Revitalization of local self-help alternatives by longterm mental health consumers. *Qualitative Sociology*, *17*(4), 365–381. https://doi.org/10.1007/BF02393336

McCrae, N., Askey-Jones, S., & Laker, C. (2014). Merely a stepping stone? Professional identity and career prospects following postgraduate mental health nurse training. *Journal of Psychiatric and Mental Health Nursing*, *21*(9), 767–773. https://doi.org/10.1111/jpm.12131

McElhinney, R. (2008). *Professional Identity Development: A Grounded Theory Study of Clinical Psychology Trainees*. University of Edinburgh.

McIntosh, G. L. (2018). Exploration of the perceived impact of carer involvement in mental health nurse education: Values, attitudes and making a difference. *Nurse Education in Practice*, *29*, 172–178. https://doi.org/10.1016/j.nepr.2018.01.009

McLachlan, J. C., Finn, G., & Macnaughton, J. (2009). The Conscientiousness Index: A Novel Tool to Explore Students' Professionalism. *Academic Medicine*, *84*(5), 559–565. https://doi.org/10.1097/ACM.0b013e31819fb7ff

McLaughlin, H. (2009). What's in a Name: "Client", "Patient", "Customer", "Consumer", "Expert by Experience", 'Service User'--What's Next? *British Journal of Social Work*, *39*(6), 1101–1117. https://doi.org/10.1093/bjsw/bcm155

McPin Foundation. (2018). *Overcoming imposter syndrome as a peer researcher*. Https://Mcpin.Org/Wsbs-Impostersyndrome/.

Melucci, A. (1989). *Nomads of the Present: Social Movements and Individual Needs in Contemporary Society.* . Hutchinson Radius.

Mental Health Foundation. (2022). *Debt and Mental Health*. Https://Www.Mentalhealth.Org.Uk/Explore-Mental-Health/a-z-Topics/Debt-and-Mental-Health.

Millar, S. L., Chambers, M., & Giles, M. (2016). Service user involvement in mental health care: an evolutionary concept analysis. *Health Expectations*, *19*(2), 209–221. https://doi.org/10.1111/hex.12353

Minogue, V., Holt, B., Karban, K., Gelsthorpe, S., Firth, S., & Ramsay, T. (2009). "Involvement in mental health education, training and research: A literature review", . *Mental Health and Learning Disabilities Research and Practice*, *6*(2), 211–227.

Moorhead, B. (2019). Transition and Adjustment to Professional Identity as a Newly Qualified Social Worker. *Australian Social Work*, *72*(2), 206–218. https://doi.org/10.1080/0312407X.2018.1558271

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional Identity Development: A Grounded Theory of Transformational Tasks of Counselors. *Journal of Counseling & Development*, *92*(1), 3–12. https://doi.org/10.1002/j.1556-6676.2014.00124.x

Munday, J. (2006). Identity in Focus. *Sociology*, *40*(1), 89–105. https://doi.org/10.1177/0038038506058436

Nario-Redmond, M. R., Biernat, M., Eidelman, S., & Palenske, D. J. (2004). The Social and Personal Identities Scale: A Measure of the Differential Importance Ascribed to Social and Personal Self-Categorizations. *Self and Identity*, *3*(2), 143–175. https://doi.org/10.1080/13576500342000103

Näslund, H., Sjöström, S., & Markström, U. (2020). Service user entrepreneurs and claims to authority – a case study in the mental health area. *European Journal of Social Work*, *23*(4), 672–684. https://doi.org/10.1080/13691457.2019.1580249

National Institute for Health Research (NIHR). (2019). *PPI (Patient and Public Involvement) resources for applicants to NIHR research programmes*. Https://Www.Nihr.Ac.Uk/Documents/Ppi-Patient-and-Public-Involvement-Resources-for-Applicants-to-Nihr-Research-Programmes/23437#standards-for-Public-Involvement.

Newcomb, M., Burton, J., & Edwards, N. (2017). Service user or service provider? How social work and human services students integrate dual identities. *Social Work Education*, *36*(6), 678–689. https://doi.org/10.1080/02615479.2017.1327574

Ng, F., Ibrahim, N., Franklin, D., Jordan, G., Lewandowski, F., Fang, F., Roe, D., Rennick-Egglestone, S., Newby, C., Hare-Duke, L., Llewellyn-Beardsley, J., Yeo, C., & Slade, M. (2021). Post-traumatic growth in psychosis: a systematic review and narrative synthesis. *BMC Psychiatry*, *21*(1), 607. https://doi.org/10.1186/s12888-021-03614-3

Noorani, T. (2013). Service user involvement, authority and the 'expert-by-experience' in mental health. *Journal of Political Power*, *6*(1), 49–68. https://doi.org/10.1080/2158379X.2013.774979

Norwood, C., Tickle, A., de Boos, D., & Dewa, R. (2019). Tame clients: an evaluation of service users' and trainee clinical psychologists' perspective of service user involvement in teaching. *The Journal of Mental Health Training, Education and Practice*, *14*(5), 327–338. https://doi.org/10.1108/JMHTEP-11-2018-0068

Oates, J. (2017). Editorial: Being a mental health nurse. *Journal of Psychiatric and Mental Health Nursing*, *24*(7), 469–470. https://doi.org/10.1111/jpm.12397

Obst, P., & White, K. (2005). Three-Dimensional Strength of Identification Across Group Memberships: A Confirmatory Factor Analysis. *Self and Identity*, *4*(1), 69–80. https://doi.org/10.1080/13576500444000182

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Quality and Safety*, *25*, 626–632.

Ogden, T. H. (2005). On psychoanalytic supervision. *The International Journal of Psychoanalysis*, *86*(5), 1265–1280. https://doi.org/10.1516/BEE8-C9E7-J7Q7-24BF

Oliver, K., Kothari, A., & Mays, N. (2019). The dark side of coproduction: do the costs outweigh the benefits for health research? *Health Research Policy and Systems*, *17*(1), 33. https://doi.org/10.1186/s12961-019-0432-3

Omeni, E., Barnes, M., MacDonald, D., Crawford, M., & Rose, D. (2014). Service user involvement: impact and participation: a survey of service user and staff perspectives. *BMC Health Services Research*, *14*(1), 491. https://doi.org/10.1186/s12913-014-0491-7

Onken, S. J., & Slaten, E. (2000). Disability Identity Formation and Affirmation: The Experiences of Persons with Severe Mental Illness. *Sociological Practice*, *2*(2), 99–111. https://doi.org/10.1023/A:1010136801075

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Systematic Reviews*, *10*(1), 89. https://doi.org/10.1186/s13643-021-01626-4

Parsons, T. (1951). *The Social System*. The Free Press.

Paulhus, D. L., & Williams, K. M. (2002). The Dark Triad of personality: Narcissism, Machiavellianism and psychopathy. *Journal of Research in Personality*, *36*(6), 556–563. https://doi.org/10.1016/S0092-6566(02)00505-6

Persky, A. M., & Robinson, J. D. (2017). Moving from Novice to Expertise and Its Implications for Instruction. *American Journal of Pharmaceutical Education*, *81*(9), 6065. https://doi.org/10.5688/ajpe6065

Pilgrim, D., & Waldron, L. (1998). User involvement in mental health services: how far can it go? *Journal of Mental Health*, *7*(1), 95–104.

Pilling, M. D. (2012). Invisible Identity in the Workplace: Intersectional Madness and Processes of Disclosure at Work. *Disability Studies Quarterly*, *33*(1). https://doi.org/10.18061/dsq.v33i1.3424

Pinel, P. (1818). *Nosographie philosophique*.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rogers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme Version, 1(1), b92. *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews. A Product from the ESRC Methods Programme Version, 1(1), B92.*

Poremski, D., Kuek, J. H. L., Yuan, Q., Li, Z., Yow, K. L., Eu, P. W., & Chua, H. C. (2022). The impact of peer support work on the mental health of peer support specialists. *International Journal of Mental Health Systems*, *16*(1), 51. https://doi.org/10.1186/s13033-022-00561-8

Postmes, T., Haslam, S. A., & Jans, L. (2013). A single-item measure of social identification: Reliability, validity, and utility. *British Journal of Social Psychology*, *52*(4), 597–617. https://doi.org/10.1111/bjso.12006

Proctor, B. (2001). Training for the supervision alliance attitude, skills and intention. In J. R. Cutliffe, T. Butterworth, & B. Proctor (Eds.), *Fundamental Themes in Clinical Supervision,*. Routledge.

Repper, J., & Breeze, J. (2007). User and carer involvement in the training and education of health professionals: A review of the literature. *International Journal of Nursing Studies*, *44*(3), 511–519. https://doi.org/10.1016/j.ijnurstu.2006.05.013

Richards, J., Holttum, S., & Springham, N. (2016). How Do "Mental Health Professionals" Who Are Also or Have Been "Mental Health Service Users" Construct Their Identities? *SAGE Open*, *6*(1), 215824401562134. https://doi.org/10.1177/2158244015621348

Rogers, C. (1959). *A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework.* In S. Koch (Ed.), Psychology: A Study of a Science. Formulations of the Person and the Social Context (Vol. 3, pp. 184–256). McGraw Hill.

Roth, J., & Mazziotta, A. (2015). Adaptation and Validation of a German Multidimensional and Multicomponent Measure of Social Identification. *Social Psychology, 46*(5), 277–290. https://doi.org/10.1027/1864-9335/a000243

Rush, B. (1812). *Medical Inquiries and Observations Upon The Diseases Of The Mind, 2006 reprint:* Kessinger Publishing.

Rush, B. (2004). Mental health service user involvement in England: lessons from history. *Journal of Psychiatric and Mental Health Nursing, 11*(3), 313–318. https://doi.org/10.1111/j.1365-2850.2004.00728.x

Schmidt, M., & Hansson, E. (2018). Doctoral students' well-being: a literature review. *International Journal of Qualitative Studies on Health and Well-Being, 13*(1), 1508171. https://doi.org/10.1080/17482631.2018.1508171

Schneider, S., Rasul, R., Liu, B., Corry, D., Lieberman-Cribbin, W., Watson, A., Kerath, S. M., Taioli, E., & Schwartz, R. M. (2019). Examining posttraumatic growth and mental health difficulties in the aftermath of Hurricane Sandy. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(2), 127–136. https://doi.org/10.1037/tra0000400

Schreur, Fides, Lea, & Goodbody. (2015). Learning from service user and carer involvement in clinical psychology training. *Journal of Mental Health Training, Education and Practice*, *10*(3), 137–149.

Sheldon, K., & Harding, E. (2010). Good Practice Guidelines to support the involvement of Service Users and Carers in Clinical Psychology Services. *The British Psychological Society, Division of Clinical Psychology*.

Shinebourne, P. (2009). Using Q Method in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 93–97. https://doi.org/10.1177/160940690900800109

Shotter, J. (1993). *Cultural politics of everyday life: Social constructionism, rhetoric and knowing of the third kind.* University of Toronto Press.

Simpson, A., Oster, C., & Muir-Cochrane, E. (2018). Liminality in the occupational identity of mental health peer support workers: A qualitative study. *International Journal of Mental Health Nursing*, *27*(2), 662–671. https://doi.org/10.1111/inm.12351

Social Care Institute for Excellence (SCIE) (2022). *Effective supervision in a variety of settings The foundations of effective supervision practice*. Https://Www.Scie.Org.Uk/Publications/Guides/Guide50/Foundationsofeffectivesupervision/.

Stets, J., & Burke, P. (2014). Self-esteem and identities. *Sociological Perspectives*, *57*(4), 409–433.

Strack, F. (1992). "Order Effects" in Survey Research: Activation and Information Functions of Preceding Questions. In *Context Effects in Social and Psychological Research* (pp. 23–34). Springer New York. https://doi.org/10.1007/978-1-4612-2848-6_3

Stryker, S. (1980). *Symbolic interactionism: A social structural version.* Benjamin/Cummings Publishing Company.

Stuart, S. R., Tansey, L., & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, *26*(3), 291–304. https://doi.org/10.1080/09638237.2016.1222056

Szanto, T., & Krueger, J. (2019). Introduction: Empathy, Shared Emotions, and Social Identity. *Topoi*, *38*(1), 153–162. https://doi.org/10.1007/s11245-019-09641-w

Tajfel, H. (1978). *Differentiation between social groups: Studies in the Social Psychology of Intergroup Relations.* Academic Press.

Tajfel, H., & Turner, J. C. (1979). *An integrative theory of intergroup conflict.* In W.G. Austin, & S. Worchel (Eds.), The social psychology of intergroup relations. Brooks/Cole.

Tambuyzer, E., Pieters, G., & van Audenhove, C. (2014). Patient involvement in mental health care: one size does not fit all. *Health Expectations*, *17*(1), 138–150. https://doi.org/10.1111/j.1369-7625.2011.00743.x

Tambuyzer, E., & van Audenhove, C. (2013). Service User and Family Carer Involvement in Mental Health Care: Divergent Views. *Community Mental Health Journal*, *49*(6), 675–685. https://doi.org/10.1007/s10597-012-9574-2

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

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*(3), 455–471. https://doi.org/10.1002/jts.2490090305

Terry, J. (2012). Service user involvement in pre-registration mental health nurse education classroom settings: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *19*(9), 816–829. https://doi.org/10.1111/j.1365-2850.2011.01858.x

Tew, J., Holley, T., & Caplen, P. (2012). Dialogue and Challenge: Involving Service Users and Carers in Small Group Learning with Social Work and Nursing Students. *Social Work Education*, *31*(3), 316–330. https://doi.org/10.1080/02615479.2011.557429

Thoits, P. A., & Virshup, L. K. (1997). Me’s and we’s: Forms and functions of social identities. In R.D. Ashmore & L.J. Jussim (Eds). In *Self and identity: Fundamental issues* (pp. 106–133). Oxford University Press.

Thomas, P., & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10*(5), 361–370. https://doi.org/10.1192/apt.10.5.361

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O’Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, *387*(10023), 1123–1132. https://doi.org/10.1016/S0140-6736(15)00298-6

Toikko, T. (2016). Becoming an expert by experience: An analysis of service users’ learning process. *Social Work in Mental Health*, *14*(3), 292–312. https://doi.org/10.1080/15332985.2015.1038411

Touraine, A. (1981). *The Voice and The Eye: An Analysis of Social Movements*. Cambridge University Press.

Townend, M., Tew, J., Grant, A., & Repper, J. (2008). Involvement of service users in education and training: A review of the literature and exploration of the implications for the education and training of psychological therapists. *Journal of Mental Health*, *17*(1), 65–78. https://doi.org/10.1080/09638230701529715

Trepte, S., & Loy, L. S. (2017). Social Identity Theory and Self-Categorization Theory. In *The International Encyclopedia of Media Effects* (pp. 1–13). Wiley. https://doi.org/10.1002/9781118783764.wbieme0088

Tse, S., Cheung, E., Kan, A., Ng, R., & Yau, S. (2012). Recovery in Hong Kong: Service user participation in mental health services. *International Review of Psychiatry*, *24*(1), 40–47. https://doi.org/10.3109/09540261.2011.646244

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory.* Basil Blackwell.

Turner, J. C., & Onorato, R. S. (1999). Social identity, personality, and the self-concept: A self-categorizing perspective. In *In T. R. Tyler, R. M. Kramer, & O. P. John (Eds.), The psychology of the social self* (pp. 11–46). Lawrence Erlbaum Associates Publishers.

Turner, V., & Abrahams, R. (1969). Liminality and Communitas. In *The Ritual Process* (1st ed., p. 37).

Verplaetse, J. (2009). *Localising the moral sense: Neuroscience and the Search for the Cerebral Seat of Morality, 1800-1930*. Springer Science & Business Media.

Vierthaler, J. M., & Elliott, E. C. (2022). A shared lived experience of a psychologist battling a mental health crisis. *Psychological Services*, *19*(1), 46–48. https://doi.org/10.1037/ser0000489

Wade, J. C., & Jones, J. E. (2015). *Strength-based clinical supervision: A positive psychology approach to clinical training*. Springer Publishing Company.

Wallcraft, J., & Bryant, M. (2003). *The Mental Health Service User Movement in England.* Sainsbury Centre for Mental Health.

Wallcraft, J., & Nettle, M. (2009). History, Context and Language. In *Handbook of Service User Involvement in Mental Health Research* (pp. 1–11). John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470743157.ch1

Wallcraft, J., Read, J., & Sweeney, A. (2003). *On our own terms: Users and survivors of mental health services working together for support and change*. Sainsbury Centre for mental Health.

Wallcraft, J., Schrank, B., & Amering, M. (Eds.). (2009). *Handbook of Service User Involvement in Mental Health Research*. Wiley. https://doi.org/10.1002/9780470743157

Walters, M. A., Paterson, J. L., McDonnell, L., & Brown, R. (2020). Group identity, empathy and shared suffering: Understanding the ‘community’ impacts of anti-LGBT and Islamophobic hate crimes. *International Review of Victimology*, *26*(2), 143–162. https://doi.org/10.1177/0269758019833284

Warner, J., & Gabe, J. (2004). Risk and liminality in mental health social work. *Health, Risk & Society*, *6*(4), 387–399. https://doi.org/10.1080/13698570412331323261

Watts, S., & Stenner, P. (2012). *Doing Q Methodological Research: Theory, Method and Interpretation*. SAGE Publications Ltd. https://doi.org/10.4135/9781446251911

Wiles, F. (2017). Developing social work students’ professional identity: the role of England’s Professional Capabilities Framework. *European Journal of Social Work*, *20*(3), 349–360. https://doi.org/10.1080/13691457.2017.1314935

Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. *Burnout Research*, *6*, 18–29. https://doi.org/10.1016/j.burn.2017.06.003

Wilson, L., Vannice, S., Hacksel, C., & Leonard, L. (2018). Peer worker or client?: conflicting identities among peer workers engaged in harm reduction service delivery. *Addiction Research & Theory*, *26*(5), 361–368. https://doi.org/10.1080/16066359.2017.1410704

Woodward, N. (2014). *Experiences of Personal and Professional Identities during Clinical Psychology Training*. University of Hertfordshire.

Wu, S., Li, Y., Wood, E. H., Senaux, B., & Dai, G. (2020). Liminality and festivals—Insights from the East. *Annals of Tourism Research*, *80*, 102810. https://doi.org/10.1016/j.annals.2019.102810

Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The Impact of Illness Identity on Recovery from Severe Mental Illness. *American Journal of Psychiatric Rehabilitation*, *13*(2), 73–93. https://doi.org/10.1080/15487761003756860

Yu, G., & Wu, Y. (2021). Managing expert/novice identity with actions in conversation: Identity construction & negotiation. *Journal of Pragmatics*, *178*, 273–286. https://doi.org/10.1016/j.pragma.2021.03.021

APPENDICES

Appendix A

Chapter 5 Interview schedule

Firstly, thank you for coming to participate in this focus group – it's very difficult to get people free at the same time so thank you for taking time out of your day to do this. So, I'm Veenu a PhD Psychology researcher and I will be facilitating this discussion. This focus group will also be audio-recorded with your consent. The research data will contribute towards PhD thesis, journals and disseminated at conferences. Only the research team will have direct access to this data, but this will go into archives for other researchers to use with controlled access, if their question fits with the data. There will be two weeks after the focus group where you can ask for your data or parts of your data to be omitted from the transcript, should you wish and the data from that point onwards will be anonymised using pseudonyms.

So, I thought I'd give you some information about the study and its aims. We are hoping to see what identities exist within clinical psychology and how different groups within clinical psychology training think of themselves as well as how they think of others. It's also important to assess the individual unique identities that exist within each group. We are therefore looking to assess the social and personal identities of service users, carers, trainees and Expert by Qualifications that are involved in clinical psychology training and their relation to one another and move forward further down the line to see how we can encourage connections with one another through identity. A person's identity is not just about what makes an individual unique (which is what most people take identity to mean), but also what we share with others and the groups in which we feel we belong.

This focus group will be one of four and we are hoping to have separate focus groups for service users, carers, Expert by Qualifications and trainees. Similar questions will be asked within each focus group. The focus group will be more of a discussion and not everyone needs to answer each question if they do not wish to. These questions are semi-structured and will just provide a guide for the discussion within the focus group and I will use prompts to facilitate this.

So, this focus group will involve a discussion around certain questions, and this will hope to tap into some data that will hopefully provide answers to how those in clinical psychology construct their identities and see themselves and how they see others. To give a bit of clarity in terms of the meaning of identity, I think of it as something explaining a sense of who you are as a person as well as social identity that is drawn from the groups in which we belong through having shared values, beliefs and goals that connect us.

4 focus groups A separate focus group for each of these: 1) Expert by Experience 2) Carers 3) Experts by Qualification 4) trainee clinical psychologists.

Even though these groups are exclusive: either service users, carers, trainees or Expert by Qualifications – the individuals within these groups may personally feel they belong to another group in addition to this. So, it would be important to find out why they have chosen to participate in this specific focus group. (For example, a Expert by Qualification may also be a carer, or a Trainee may also be a service user).

(This may reflect that the focus group they have chosen to participate in will reflect a stronger identity for them). These groups however will not be purposely mixed.

Please only share what you feel comfortable with and be mindful not to identify other people if you discuss their answers outside of this group. Please therefore respect that this is a confidential space.

Social Identity mapping

Please think of and write down the different groups you are a part of and/or work with and identify how important these groups are to you, in what way you are connected to them and how these different groups are connected or not connected. I have provided an example for you.

Warm up question: Tell us a bit about which service user and carer group you belong to and how important it is to you.

Within this focus group we will think about your identity in relation to your role within clinical psychology. I guess to start us off it might be nice to see why you are involved as an (EBE, Carer, trainee or EBQ?).

Warm up question: So, I wondered what you all thought about the identity of this group and the label of it as either (EBE, carer, trainee & EBQ.) What do you think of the other labels (EBEs, carer, trainees & EBQs?).

Self-Categorisation

1. How would you describe yourself/identity in relation to your involvement in Clinical Psychology training? (Self-stereotyping) For example I am an EBE and PhD researcher.
2. Do you think of yourself as an (EBE, Carer, Trainee or EBQ?).
3. Has being a (EBE, Carer, Trainee, EBQ) had an impact on you/changed the way you think about yourself? What has it made you think about yourself? How does that make you feel?
4. How important is this identity to you? (Salience). Why is it so important to you?
5. Do you hold more than one identity? For example, are there multiple hats you wear?
6. Do you feel you belong to any of the other groups involved in clinical psychology training (EBE, Carer, Trainee, EBQ)? How important are these other identities to you?

Professional identity

7. Has being a (Trainee, EBE, Carer, EBQ) had an impact on the way you think about yourself?
8. Would you say you have a professional identity as a result of being a (EBE, Carer, Trainee, EBQ)? What is it about this role that encourages this identity? How does this affect you in your role? - Do you think of this identity outside of this context? (Salience) In what context do you think about this identity? (Salience) How important is this identity to you? (Centrality). How often do you think about this identity? How does that make you feel?
9. Do you think there is a conflict between your occupational role (EBE; Carer; trainee and EBQ) and your identity? In what ways does this occur?

Lived Experience Identity

10. Do you think your role encourages or discourages a lived experience identity (Service user identity)? What is it about this role that encourages/discourages this identity? How does this affect you in your role? – Do you think of this identity outside of this role? (Salience) In what context do you think about this identity? How important is this identity to you? (Centrality). How often do you think about this identity? How does that make you feel?
11. Do you think there is a conflict between your lived experience identity and your professional identity?

12. Do you think the other groups are able to talk about their own lived experience identities?

Intra-group identity/ In-groups

13. Do you feel connected to this group (EBE, Carer, Trainee, EBQ)? (Solidarity) What connects you?
14. Do you feel like you share the same experiences/values as others within this group identity? (In- group homogeneity) In what way? Are there similarities and differences within your group identity?
15. How does belonging to this group (EBE; Carer; Trainee; EBQ) make you feel? Do you have any positive or negative feelings attached to this group?
16. How content are you belonging to the group (EBE, Carer, Trainee, EBQ)? (Satisfaction)

Inter-group identity/ Out groups

17. What do you think about the other groups? (EBE; Carer; EBQ; trainee). Do you have any positive and negative feelings about the other groups? Do you think that the other groups see themselves in this way? Are there similarities and differences between your identity and their identity?
18. Do you feel connected to the other groups (EBEs, Carers, EBQs, trainees) involved in clinical psychology training? Do you feel disconnected from the other groups in any way?
19. What do you think the other groups think about you?
20. How do you think the other groups identify themselves?
21. How do you see your group within the wider clinical psychology programme? Do you think these groups function as a whole within clinical psychology training or do they have separate identities?

Appendix B

Chapter 6 Additional measures

I am cynical about the benefits of coproduction.
I believe that clinical psychology is not political
I am religious
I feel different to trainee clinical psychologists
I feel different to service users
I feel different to carers
I feel different to Experts by Qualification (Clinical Psychologists and Research staff)
I identify with people who think of mental health conditions as a result of a chemical imbalance
I identify with people who view mental health conditions as a result of trauma
I identify with people who view mental health conditions as a result of social inequalities
I am content with trainees in clinical psychology.
I am content with the level of service user involvement in clinical psychology
I am content with the level of carer involvement in clinical psychology
I am content with clinical psychology as a profession
I feel I belong within the world of clinical psychology
I see my ethnicity represented in clinical psychology
I see my social class represented in clinical psychology
I feel connected to service user and carer groups within clinical psychology
I feel disconnected from service user and carer groups in clinical psychology education as a result of COVID – 19
I think of my occupational role outside of the context of clinical psychology training
I hold negative attitudes towards those with mental health conditions
I hold appropriate boundaries
I think people will judge me badly if I disclose my mental health
I am interested in coproduction
I experience a Power imbalance in relation to my role within clinical psychology
I am Burnt out
I experience Imposter syndrome
I am empathetic
I have taught empathy to trainees
I am non- judgemental
I have taught trainees to be non-judgemental
I am genuine
I have taught trainees to be genuine
I believe trainees learn from other trainees
I believe trainees learn from service users (Experts by Experience)
I believe trainees learn from Carers (Experts by Experience)
I believe trainees learn from experts by qualification (Clinical Psychologists and Research staff)

Appendix C

Trainee identification to Experts by Experience (Service users)

Factor loadings based on a principal components analysis with oblique rotation of nine items measuring cognitive and affective identification of trainee clinical psychologists towards Experts by Experience (service users and survivors that train clinical psychologists).

Items in Social identification measure	Cognitive identification	Affective Identification
1. I feel happy to work with service users within a clinical psychology programme	-.119	**-.905**
2. I am proud to work with service users within a clinical psychology programme	.105	**-.871**
3. It feels good to work with service users within a clinical psychology programme	-.068	**-.896**
4. If any service user was asked to leave their role I would be very disappointed.	.209	**-.445**
5. My self-identity is based in part on membership/connection to expert by experience groups	**.725**	-.008
1. I think of myself as a member of an Expert by experience group and this is very important to my sense of who I am	**.763**	.217
2. My sense of self overlaps with the identity of service users	**.834**	-.033
8. If service users were criticised it would influence how I thought about myself.	**.607**	-.250
9. I identify with service users who are Experts by Experience	**.743**	-.118
Eigenvalues (Cumulative Variance) 3.692 (41.022%) 1.878 (61.86%)		

Appendix D

Trainee to Carer Identification

Factor loadings based on a principal components analysis with oblique rotation of nine items measuring cognitive and affective identification of trainee clinical psychologists towards Carers (that train clinical psychologists).

Items in Social identification measure	**Cognitive Identification**	**Affective Identification**
1. I feel happy to work with carers within a clinical psychology programme	-.077	**.925**
2. I am proud to work with carers within a clinical psychology programme	-.081	**.954**
3. It feels good to work with carers within a clinical psychology programme.	-.054	**.933**
4. If a Carer was asked to leave their role I would be very disappointed.	.222	**.595**
5. My self-identity is based in part on membership/connection to carer groups	**.790**	-.002
6. I think of myself as a member of a Carer group and this is very important to my sense of who I am	**.866**	-.167
7. My sense of self overlaps with the identity of carers	**.843**	.102
8. If carers were criticised it would influence how I thought about myself.	**.771**	.183
9. I identify with Carers.	**.778**	-.090
Eigenvalues (Cumulative variance) 3.518	39.090% 2.886	71.158%

Appendix E

Trainee to Trainee identification

Factor loadings based on a principal components analysis with oblique rotation of nine items measuring cognitive and affective identification of newly trainee clinical psychologists towards trainee clinical psychologists.

Items in Social identification measure	Affective Identification	Cognitive Identification
1. I feel happy to work with trainee clinical psychologists within a clinical psychology programme	**.940**	.008
2. I am proud to work with trainee clinical psychologists within a clinical psychology programme	**.844**	-.119
3. It feels good to work with trainee clinical psychologists	**.943**	.078
4. If a trainee clinical psychologist was asked to leave their role I would be very disappointed.	**.404**	.021
5. My self-identity is based in part on my membership/connection to trainee clinical psychologists.	-.084	**-.858**
6. I think of myself as a member of trainee clinical psychologist group and this is very important to my sense of who I am.	-.034	**-.912**
7. My sense of self overlaps with the identity of trainees.	-.045	**-.897**
8. If trainees were criticised it would influence how I thought about myself.	.349	**-.420**
9. I identify with trainee clinical psychologists	.366	**-.601**
Eigenvalues (Cumulative variance)	4.480 49.777%	1.559 69.098%

Appendix F

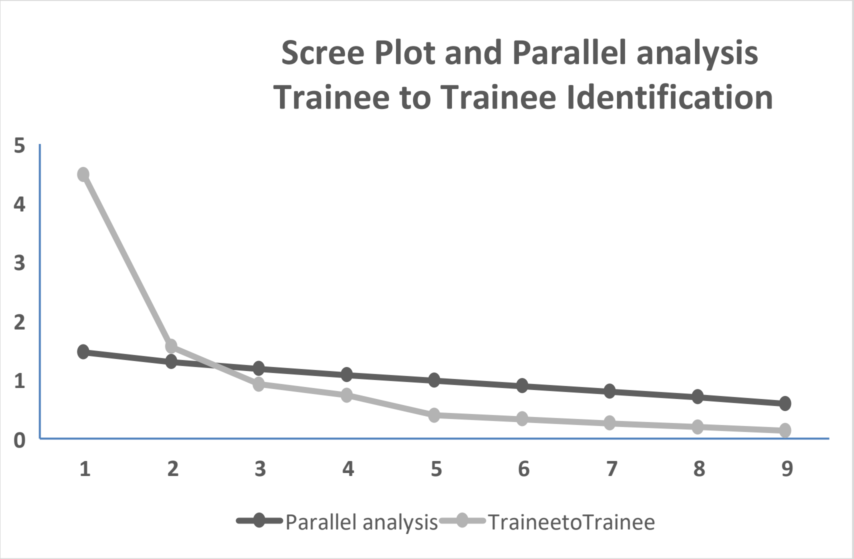
Trainee to Expert by Qualification

Factor loadings based on a principal components analysis with oblique rotation of nine items measuring cognitive and affective identification of trainee clinical psychologists towards Experts by Qualification (research and clinical psychologists and other academic staff that train clinical psychologists).

Items in Social identification measure	**Cognitive Identification**	**Affective Identification**
1. I feel happy to work with Experts by Qualification (Clinical Psychologists and Research staff)	-.011	**.898**
2. I am proud to work with Experts by Qualification within a clinical psychology programme.	.061	**.874**
3. It feels good to work with Experts by Qualification	-.072	**.906**
4. If an Expert by Qualification was asked to leave their role I would be very disappointed.	-.117	-.024
5. My self-identity is based in part on membership/connection to clinical psychology as a profession.	**.861**	.014
6. I think of myself as a member of Clinical Psychology as a profession and this is very important to my sense of who I am	**.882**	.102
7. My sense of self overlaps with the identity of Experts by Qualification.	**.862**	-.067
8. If the clinical psychology programme were criticised, it would influence how I thought about myself.	.275	.110
9. I identify with Experts by Qualification	**.747**	-.052
Eigenvalues (Cumulative variance)	3.508 38.981%	2.049 61.745%

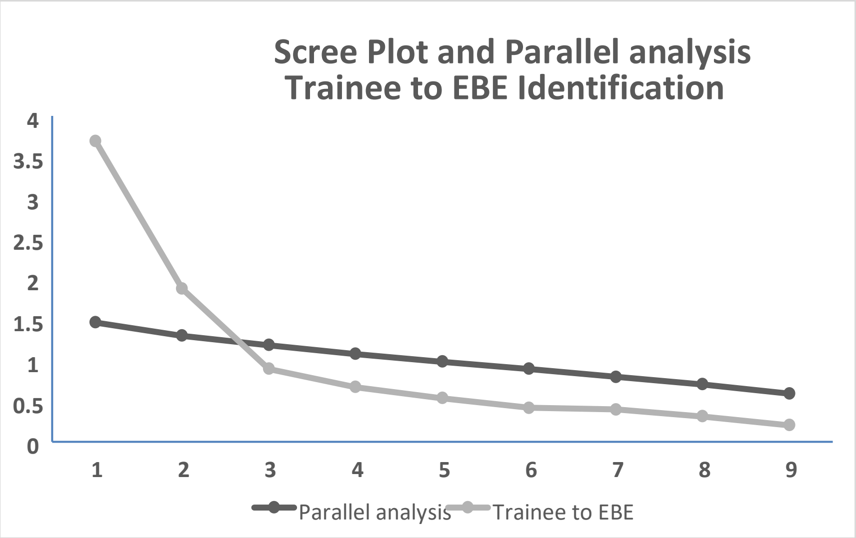
Appendix G

Trainee to Trainee scree plot and parallel analysis of items and eigenvalues



Appendix H

Trainee to EBE (service user and survivor) scree plot and parallel analysis of items and eigenvalues.



Appendix I

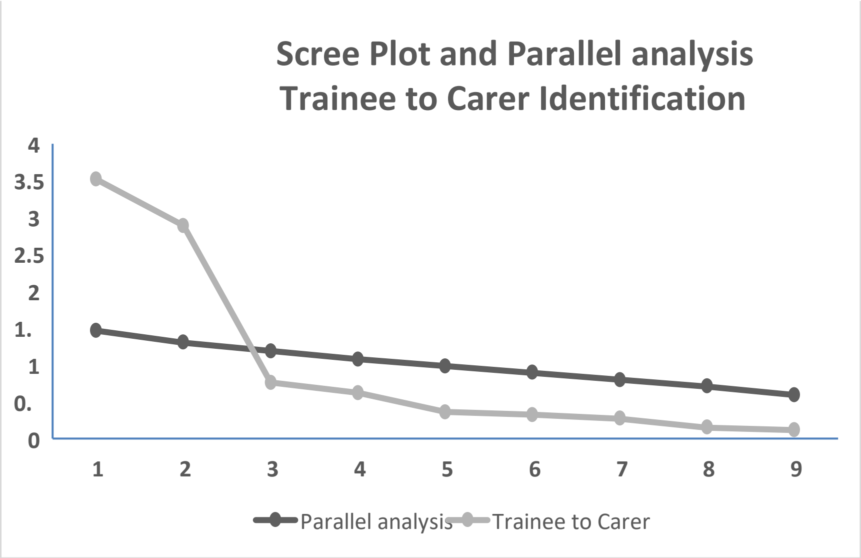
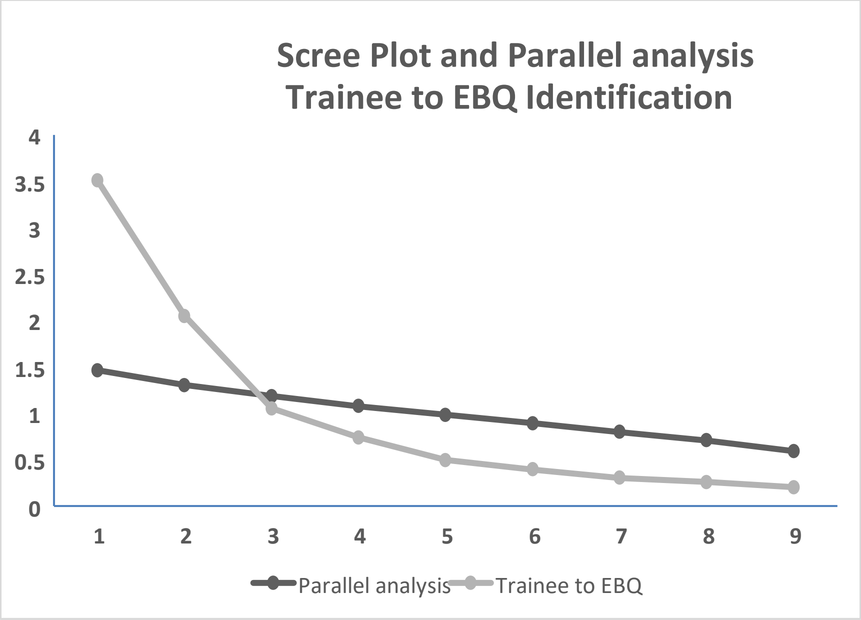


Figure 7. Trainee to Carer scree plot and parallel analysis of items and eigenvalues.

Appendix J



Appendix K

A reliable and valid In-group Identification measure for use between groups in Clinical Psychology

1. I feel happy to work with ( )	Affective
2. I am proud to work with ( ) within a Clinical Psychology programme	Affective
3. It feels good to work with ( )	Affective
4. If a ( ) was asked to leave their role I would be very disappointed	Evaluative
5. My self-identity is based in part on membership/connection to ( ) group	Cognitive
6. I think of myself as a member of a ( ) group and this is very important to my sense of who I am	Cognitive
7. My sense of self overlaps with the identity of ( )	Cognitive
8. If ( ) were criticised it would influence how I thought about myself	Evaluative
9. I identify with ( )	Identification

Measures of Mental health and Professional Identities

My experiences of mental health define who I am	Mental health identity	Cognitive
My occupational role defines who I am	Professional identity	Cognitive