Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

Doctoral Thesis

Clinical psychologists' experiences of negotiating dual identities as mental health service users and service providers

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August 2023

Doctorate in Clinical Psychology

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Statement of Total Word Count for the Thesis

	Text	**Appendices (including references, tables and figures)**	**Total**
Thesis Abstract	299	-	299
Literature Review	8000	10020	18020
Research Paper	8000	14007	22007
Critical Appraisal	4000	1702	5702
Ethics Application	3966	3516	7482
Total	**24265**	**29245**	**53510**

Thesis Abstract

This thesis consists of three papers: a literature review, research paper, and a critical appraisal. The systematic literature review explores how key individuals in a young person's life respond to the young person's self-harm. A thematic synthesis was undertaken on 12 papers. Five themes were identified: 1) initial responses fuelled by emotions, 2) the importance of a calm façade, 3) modifying my approach and our relationship, 4) offering support, and 5) we need more help! Recommendations highlight the importance of training for education and healthcare staff. The findings also illustrate the need for a greater focus on the experiences of peers caring for their friend who is self-harming, and the need for support programmes for parents of young people who self-harm.

The research paper explores the experiences of clinical psychologists in negotiating dual identities as both mental health service user and service provider. Narrative analysis was utilised to explore the experiences of 12 participants. The analysis resulted in the development of five chapters: Prologue: Developing Dual Identities, Chapter One: Separation of Identities, Chapter Two: Negotiation of Identities, Chapter Three: Co-Existence of Identities, and an Epilogue: Looking Forward. The findings discuss the initial separation of service user and service provider identities, often due to stigma, and community expectations placed on the service provider role. Participants negotiated their identities often by prioritising one identity and reframing their service user identity as part of their 'humanness'. Participants settled at different points of their negotiation, ranging from separate but alongside each other, to fully integrated identities.

The critical appraisal provides a personal exploration of multiple identities during clinical training and writing the two papers. The appraisal also considers how the two papers are connected to provide two perspectives on stigmatised experiences, and the commonality between the clinical implications for both papers.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from June 2018 to August 2023. The work presented here is the author’s own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Molly Rhinehart

Date: 23rd August 2023

Acknowledgements

I would like to begin by thanking the 12 participants who shared their experiences with me for this project. They gave me their time and trust, and it was a privilege to hear their stories. I hope that I have used what they so graciously gave me with the respect it deserves. Thank you also to the two psychologists who provided input on the interview schedule from their personal experiences and for their thoughts on the initial development of the project.

I am extremely thankful to have had the support and advice of my two supervisors, Dr Suzanne Hodge and Dr Hannah Wilson. Hannah, thank you for providing much-needed compassionate reassurance and for always being so containing. Suzanne, thank you for your endless support and gentle encouragement, and your unwavering belief in this project. I don't think it would have been possible without your support.

The idea for this project was partly borne from my own journey navigating dual identities, particularly during clinical training. This has not always been the easiest journey and would have been much harder without the support I received along the way. Thank you to my clinical tutor, Dr Ian Smith, for his constant wisdom and guidance during this time. Thank you also to my mentor, Dr Ian Rushton, for his enthusiasm for all my ideas, teaching me how to be a referencing guru, and for always believing in me, especially in those times when I didn't. Additional thanks go to Dr Jessica Read, for her support during challenging times.

My fellow members of the tortoise club, Sarah & Serena. Having two of my closest friends by my side has made all the difference whilst we have been building our creations. I don't know where I'd be without either of you, and I'm thankful to the course for leading me to lifelong friends in you both.

Thank you also to all those who have supported me during clinical training and the thesis. Including the car-share (and our ability to miss the junction on a regular basis!), all at

PRD (for reminding me there is a whole wonderful world outside of the thesis), my friends and family, and in particular, my feline research assistants, Toby & Oscar.

I am incredibly grateful to my partner, Andy. Thank you for your tolerance and understanding, for listening to my endless conversations about the thesis, and for your superior knowledge of grammar. Thank you also for always bringing me snacks whilst I’m working and encouraging me out of my office when needed! Thank you for being the amazing person you are and always knowing the right thing to say. For my stepson, Sacha, thank you for always reminding me of the need for a work-life balance, and your certainty that this balance must include time for Pokémon! I love you both.

Finally, to my Dad, who sadly died before this thesis was completed. I miss you every day and I only wish you were here to see this moment – I know you would have been proud.

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Appendices

Section One: Literature Review

How do key individuals in a young person's life respond to a young person's self-harm?

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(Author Guidelines are shown in Appendix 1-B).

Abstract

The review aims to understand how key individuals respond to a young person's self-harm, and whether there are similarities between individuals. A systematic literature search was conducted across six databases, identifying 12 papers comprising responses from peers, caregivers (including parents and residential staff carers), healthcare staff, and education staff. The papers were synthesised using thematic synthesis. Five themes were identified: initial responses fuelled by emotions, the importance of a calm façade, modifying my approach and our relationship, offering support, and we need more help! The findings illustrate the need for greater focus on the experiences of peers caring for their friend who is self-harming, and how peers can be better supported. Findings also discuss the importance of training for education and healthcare staff, and the need for support programmes for parents of young people who self-harm.

Keywords: self-harm, self-injury, adolescent, respond, attitude, parents, peers, teachers, nurses.

Prevalence and functions of self-harm

Self-harm in young people[1] is a long-standing mental health concern (Muehlenkamp et al., 2012). Rates have been increasing steadily (Cybulski et al., 2021) with the average age of onset also decreasing (Griffin et al., 2018). For this paper, self-harm is defined as the destruction of body tissue (Nock, 2009) carried out without suicidal, sexual, or decorative intent (Sutton, 2007).

Self-harm is a complex behaviour that serves differing functions dependent on the individual and situation (Gratz, 2006). Two of these include intrapersonal functions (e.g., emotion regulation, reduce dissociation, self-care, self-punishment; Edmondson et al., 2016; Rodham et al., 2004; Simopoulou & Chandler, 2020; Young et al., 2007) and interpersonal functions (e.g., communicating pain, asking for help, scaring someone; Nock, 2009; Scoliers et al., 2008; Stänicke, 2021).

Disclosing self-harm

Self-harm is a behaviour that is frequently shrouded in secrecy (Chandler, 2018), with adolescents anxious about being stigmatised (Fortune et al., 2008), viewed as an attention seeker (Heath et al., 2011), or provoking family breakdown (Wadman et al., 2018). When self-harm is disclosed or discovered, it can provoke strong emotional reactions from the individual who has found out.

For parents and caregivers, discovering that their child is harming themselves can evoke worry, shock, anger, guilt, and helplessness **(**Byrne et al., 2008; McDonald et al., 2007). This can lead to responses such as changes in the parent-child relationship (Kelada et al., 2016), and hypervigilance towards self-harm and increased supervision (Townsend et al., 2021).

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[1] For the purpose of this paper, 'young people' will encompass both children and adolescents up to the age of 18.

Adolescents may be more likely to disclose self-harm to a same-age peer first rather than caregivers or professionals (Doyle et al., 2015) although studies suggest that this can lead to mixed reactions. Positive responses may include a comforting feeling of mutual understanding (Reichardt, 2016) and an increase in closeness and friendship quality (Armiento et al., 2014). Whilst disclosures to peers are often reported as supportive, they can be unhelpful in the long-term, with high levels of co-rumination (Rose, 2002), a lack of encouragement to reduce self-harming behaviours (Gayfer et al., 2020), and potential stigmatisation (Smith, 2022).

Professional responses to self-harm

Teachers and education staff are often the first professional group to identify or receive a disclosure of self-harm from a child or adolescent (Heath et al., 2011). Whilst teachers may have an increased awareness of self-harm, they also frequently report negative emotional reactions such as shock and repulsion (Best, 2006), particularly if students are perceived to be from ‘privileged’ backgrounds (Dowling & Doyle, 2017).

A large majority of young people who self-harm do not access professional healthcare or mental health support (Rowe et al., 2014). For those who do access professional support, responses from staff can include empathy (McCarthy & Gijbels, 2010), antipathy (Dickinson et al., 2009), and apprehension and avoidance (Fisher & Foster, 2016). Studies specifically exploring mental health professionals’ responses towards adolescent self-harm are conflicting. Some report that psychiatric professionals demonstrate higher negativity towards self-harm (Crawford et al., 2003), whilst others suggest that staff working in UK CAMHS (Child and Adolescent Mental Health Services) hold more positive and knowledgeable attitudes towards self-harm (Timson et al., 2012).

Why are responses to self-harm important?

Responses to young people who self-harm are critical, as they can have a lasting impact on help-seeking and future self-harm (Williams et al., 2020). Strong emotional responses can increase distress and isolation (Toste & Heath, 2010), reinforcing underlying reasons for self-harm. Wadman and colleagues (2018) report that strong emotional reactions from parents discouraged young people from seeking help and often led to further instances of self-harm. Byrne et al. (2021) found that negative responses from healthcare professionals in an accident and emergency department led young people to feel that they needed to engage in more serious/dangerous self-harm to communicate the depth of their distress.

Whilst negative responses can discourage help-seeking and cessation of self-harm, positive responses can have helpful outcomes. Seeking support from peers can help a young person to delay or avoid an instance of self-harm (Wadman et al., 2018). Supportive and empathetic responses to disclosure can also reduce feelings of shame (Rosenrot & Lewis, 2018), increase help-seeking (Smith, 2022), and reduce suicidal ideation (Hasking et al., 2015).

Reviews exploring attitudes towards self-harm

Several systematic reviews have explored attitudes and responses towards self-harm in young people. Curtis et al. (2018) noted discrepancies between common parental responses such as heightened monitoring and disciplinary measures and responses that young people wanted, such as remaining calm and spending time together. However, this was a narrative review rather than systematic, limiting the depth and breadth of their findings. In addition, many of the participants in the studies did not have personal experience of acts of self-harm, potentially limiting the generalisability of the findings. Ribeiro Coimbra and Noakes (2022) explored the impact of attitudes displayed by healthcare professionals. They highlight that negative attitudes were displayed through apprehensiveness and avoidance of working with young people who self-harm, therefore hindering therapeutic relationships. Whilst there are no current reviews exploring teachers' attitudes towards self-harm, Evans and Hurrell's (2016) reviewed the role of schools in adolescent self-harm and suicide, noting that staff often responded to self-harm as 'bad behaviour'. They also reported that referring to external 'experts' reduced help-seeking behaviour from students who wanted support from teachers.

Rationale for the current review

One limitation across these reviews is that they focus on a singular group, e.g., parents. However, young people's mental health does not exist in isolation, but is located in their environmental context and affected by those around them. Ecological systems theory (Bronfenbrenner, 1979) commonly underpins biopsychosocial approaches to child and adolescent mental health, seeing the child and their emotional state and behaviour within the context and influence of the multiple systems in which the young person is embedded (these commonly include family, school, peers, community, but may also include mental health services for young people experiencing distress; Broad et al., 2017). Thus, a young person who is self-harming would be understood in relation to the people and context surrounding them (Tuls, 2011).

This review differs from previous reviews by bringing together responses to self-harm in young people from different stakeholder groups in order to explore similarities and differences in their responses. This macroscopic approach provides a more holistic understanding of the environmental context in which young people experience responses to their self-harm. A qualitative approach has been used because the National Institute for Health and Care Excellence (NICE, 2004) recommends using qualitative methods when researching self-harm, so that lived experience can further inform clinical practice.

Method

Search Strategy

A comprehensive search strategy was developed following consultation with a subject librarian. Free-text terms were informed by papers found during the scoping search and published reviews in similar areas. The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type; Cooke et al., 2012) model was utilised to operationalise the research question (Table 1).

Six electronic databases relevant to psychology (Academic Search Ultimate, socINDEX, CINAHL, PsycINFO, MEDLINE, and PubMed) were searched in May 2022 using highly sensitive search terms (Table 2). Searches combined database subject headings and text word searching in titles and abstracts, combining terms for self-harm, key individuals, reactions, and qualitative studies. Search strategy tests were completed to ensure the search terms were appropriate. No language, date, or location restrictions were applied. Reference lists of the identified papers and similar reviews were also scanned for prospective papers. However, no new articles were identified.

The term ‘respond’ was defined as something that was thought, felt, or done in response to a young person’s self-harm that would then impact on the young person who was self-harming, e.g., a change in parenting strategy. Papers that did not include clear responses, for example, if the participants in the study just spoke about the impact of self-harm on the family, but not about their emotional reaction or behaviour towards the young person who was self-harming (e.g., Emerson, 2010), were excluded.

Eligibility Criteria

Studies were deemed eligible if they reported data about key individuals’ (e.g., friends, parents, caregivers, therapists, teachers) reactions towards self-harm of a young person aged 18 or under. Qualitative and mixed methods studies reporting qualitative data were included. Eligibility was decided based on the inclusion/exclusion criteria outlined in Table 3.

Study Selection

After removing duplicates using the de-duplication strategy outlined by Bramer et al. (2016), 18,667 titles were reviewed using the inclusion/exclusion criteria, leaving 501 articles to be screened using the abstract. Following abstract screening, full texts were obtained for the remaining 103 papers. Figure 1 outlines the stages of the search on the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Page et al., 2021) flow diagram. Details of included papers can be found in Table 4.

Quality Appraisal

The quality of the included studies was appraised using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist tool (CASP, 2018). The tool comprises ten questions that focus on a different methodological aspect of a qualitative study. A scoring system suggested by Butler et al. (2015) was utilised to evaluate overall quality of reporting. Papers were rated as follows: thorough discussion (1), unclear or partial discussion (0.5), or absence (0) of discussion of each CASP domain. Scores for the papers can be found in Table 5, with a range from 6-10. To reduce potential bias, all studies were also independently appraised by a peer researcher and a final result was agreed. There was a high consensus in the ratings and any differences were resolved through discussion. Eight studies were of good quality, demonstrating clear evidence for at least seven of the ten items listed on the checklist. Scores on the CASP checklist were not used to exclude papers as factors such as submission word counts may be an influence (Atkins et al., 2008). Instead, the CASP tool was used to 'quality check' the current study.

Thematic Synthesis

Thematic synthesis was considered appropriate for this review due to variation in the selected studies, as some studies were relevant to the research question in their entirety, and some only contained one or two relevant themes (e.g., S11). Additionally, the depth of analysis varied, including both analytical analysis using in-depth interview data, and descriptive analysis, using data from open-ended questions on surveys (e.g., S7). Thematic synthesis is appropriate when synthesising both descriptive and analytic analyses (Flemming & Noyes, 2021), and was therefore chosen for this review.

The extracted findings incorporated both first-order participant quotes and second-order analytical themes drawn from the results and discussion sections (Sandelowski & Barroso, 2002). The findings of the included studies were synthesised using three stages proposed by Thomas and Harden (2008). First, the results and discussion section of each paper was coded line-by-line by the primary author using NVivo. Secondly, codes that appeared to be related were grouped together into descriptive themes. The original papers were re-read throughout to ensure close alignment with the experiences of participants in the original studies. The final stage involved identifying links between the descriptive themes to develop more analytical themes. These themes were identified through an iterative process of reflection and interpretation of the descriptive themes to address the focus of the synthesis (see Appendix 1-A for an excerpt of the analytic process). The analytical themes went beyond the primary research findings to develop a more in-depth level of conceptual understanding. These themes were discussed in supervision. Examples of descriptive and analytical themes can be seen in Figures 2 and 3 respectively.

Reflexivity

The researcher's personal, professional, and epistemological position is important to consider within thematic synthesis and how this may influence the process and findings

(Willig, 2021). This study is informed by a critical realist epistemology, i.e., an assumption that there is an external reality independent of human minds. Critical realism assumes that data is informative of reality but needs to be interpreted to provide access to the underlying structures of the data (Willig, 2021). The interview data in the included studies reflects the participant's perspective (whilst also being influenced by demand characteristics often present in research interviews), and the analysis is an interpretation made by the original researcher, further interpreted by the researcher in this study.

The researcher has a background in, and current role working in CAMHS, and it is likely that the research was influenced by the researcher's experiences supporting young people who self-harm. The researcher used discussion with supervisors to avoid their own assumptions and experiences unduly influencing the synthesis.

Results

Study Characteristics

Twelve papers published between 2008 and 2022 and across five countries were included in the synthesis. The total sample comprised 82 parents, 15 healthcare professionals, 13 peers, nine residential carers, and 21 education professionals (n=140). Sample sizes ranged from five (S2; S10) to 24 (S8), with an average of 12 participants. The total sample was 82% female (n=94), and the proportion of male participants ranged from 6% (S7: parents) to 44% (S5: residential carers). However, one paper (S11) did not report gender demographics, and one paper (S1) did not separate out participants who had completed a telephone interview from the wider participant pool for a survey study so gender could not be reported. No male peers were included in the sample, and it is unclear if any male education professionals were included as one study comprised only female participants (S12) and one paper did not report the gender of participants (S11).

All papers except for S7 used semi-structured interviews to collect their data. The remaining paper (S7) utilised a survey which included open-ended questions which provided the data for the analysis. Six studies used thematic analysis to analyse the data and six used interpretative phenomenological analysis.

Five main themes reflecting the behavioural responses of key individuals were developed, as shown in the table below:

Theme	Subthemes		
Initial responses fuelled by emotion			
The importance of a calm façade			
Modifying my approach and our relationship			
Offering support	An open and curious approach	The pressure to keep conversations confidential	Viewing cessation of self-harm as the marker of success
We need more help!			

A narrative summary of each theme is provided below, and Table 6 shows the papers relevant to each theme.

Theme one: Initial responses fuelled by emotions

Individuals' initial reactions were often couched in strong emotions, such as anger (e.g., S6) worry (e.g., S4), fear (e.g., S2), and shock (e.g., S7). Eleven papers detailed these reactions. Interestingly the participants in the remaining paper (S5) were carers working in a residential children's home who instead spoke about feeling desensitised and "robotified" (p.12) when responding to self-harm.

Parents often expressed anger and attempted to use anger to stop their child self-harming: "I saw her scars on the wrist, not deep. I immediately told her, "You can't do this! I am angry that you did that!"." (S8, p.6). Some felt anger due to a belief that the self-harm was an attempt at manipulation (S6).

Anxiety was also a common reaction and was often linked to fear that self-harm would lead to death, either accidental (Healthcare Professional; S2) or by suicide: "…at that point all I thought was like, self-harm, self-harm, suicide…" (Friend; S3, p.301). This anxiety often led to friends pushing forward, feeling that they needed to be there for their friend at all costs: "I'm always there to support her when she needs me and whenever she doesn't want me, I'll still support her through it." (S3, p.299). Increased vigilance was noted across parents, peers, and professionals. Peers used practical strategies to try to increase their presence: "We did FaceTime a lot, so like her phone's constantly moving so I could see the full thing so she couldn't cut or nothing…" (S3, p.302). Similarly, parents increased the time they spent with the young person to discreetly or overtly monitor them: "I was hiding the knives…I was knocking on her door every five minutes." (S9, p.142). Parents often became more authoritarian, for example, limiting interactions with peers they deemed to be a bad influence, reading their diaries, or searching their bedroom: "I keep check on his body and his bedroom without him knowing." (S7, p.3407).

Both peers and parents gave similar accounts of feeling unsure how to interact with the young person due to self-harm: "…we had to tip-toe around her I guess, it was quite like stepping on eggshells, I didn't want to say the wrong thing." (Friend; S10, p.149), and "It was just so hard knowing what we could do, it was like walking on eggshells with her." (Parent; S7, p.3411). Professionals did not report similar responses, perhaps signalling the difference between peers and parents - who have an emotional connection with the young person - versus professionals who may have received training in responding to self-harm and do not have the same emotional and reciprocal relationship.

Emotional responses often signalled a desire to stop the adolescent's self-harm: "I was very upset, crying, and begged her not to do it again." (Parent; S1, p.6). One parent attempted to stop their child's self-harm by threatening to hurt themselves, highlighting the underlying emotion: “I was worried and said that ‘don’t hurt yourself’ I said, ‘If you cut your hand again, I would cut it like you’.” (S6, p.5).

Initial avoidance was also reported by parents: “I thought paying attention was not good for her. Next time she wanted something, she would do it again. So, I just let it go.” (S8, p.6). Parents also reported initially minimising, dismissing, or ignoring self-harm (S6; S8; S9), often to hide their fear or worry. Avoidance was also linked to feeling helpless: “[I] tried to pretend it wasn’t happening because I had no idea how to deal with it.” (Parent; S1, p.8).

Theme two: The importance of a calm façade

Whilst emotional reactions were present for most participants, parents tried to manage their initial reactions: “Inside my heart broke. Outside I tried to quietly and calmly speak to my daughter about where the blood came from.” (S1, p.7). A calm façade was recognised as important: “I was angry at him and wanted to grab him and say, “What the hell are you doing?” and insist he stop doing it, but I knew I needed to stay calm.” (Parent; S1, p.6). Healthcare professionals also recognised the importance of a calm façade (S2; S4; S12), and the impact of maintaining this in long-term therapeutic support, and this was echoed by education staff: “You have to mask how it is.” (S11, p.683). However, this was not easy: “I have found it very hard trying to stay calm…while my daughter suffered self-harm.” (S7, p.3409). Anger often masked feelings that parents and professionals did not want to display. Parents were likely to feel anger as a secondary emotion, disguising their anxiety for their child. For healthcare staff however, the frustration was linked to not being able to effectively do their job for all the young people whom they supported: “I feel like saying you’re all messing, somebody is going to die because we’re attending to another young person” (S2, p.4).

Friends used different language to describe similar experiences, reflecting on having to suppress their own emotions: “I chose to forget about myself and think about them until their problems were sorted…" (S10, p.151). Experiencing their own emotions and needs was likened to giving up on their friend: "…but I'm not gonna quit, there had been nights where I thought no, this is my friend, I need to just sort of suck it up." (S3, p.299). Suppressing their own feelings may be a potential strategy to alleviate the responsibility friends felt towards preventing self-harm, as it was seen as easier to suppress than to be blamed: "I can't ever say anything, like any of this to her because she might take that as a 'oh my god…' and then go and do something ridiculous…and then I'd be like, that was my fault." (S3, p.301). Adolescents may be more likely to view this behaviour as emotion suppression rather than the need for a calm façade due to their own emotional development and egocentrism.

Residential staff reported a step further, feeling detached from their own emotions when presented with self-harm: "I think you get a bit robotified and just deal with it." (S5, p.12). This was echoed in healthcare professionals: "Part of it you become hardened to, you develop a thick skin." (S2, p.3). Adolescents viewed emotion suppression negatively due to the stressful impact on themselves, whilst professionals felt that detachment was a positive aspect as it allowed them to be more objective and to put their emotions aside in order to provide more effective support (S2; S4).

Theme three: Modifying my approach and our relationship

Individuals recognised that responding to self-harm was complex, meaning that ongoing evaluation and modification of their approach was necessary (e.g., S2; S6). Sometimes this came through feeling powerless and not wanting to make the situation worse. Some parents shifted to a permissive parenting style in an effort to reduce conflict and avoid triggering any episodes of self-harm: "I don't want to push that button and make her feel like she's done something wrong…and then she'll go and do something again, so I don't say anything to her, which is bad I suppose." (S9, p.144).

Other parents made a conscious decision to change their interactions with the adolescent to better support them: “When I speak to her now, my voice is a little lower and softer. I will deliberately pay attention to the content and my way of talking to her.” (S6, p.5). Whilst modifying their approach may have begun as a method to better support an adolescent who is self-harming, parents spoke about an ongoing realisation that their own behaviour had been unhelpful and required a shift: “I don’t burden her with all my issues like I used to…We eat at the table and work together. We share the household duties.” (S7, p.3409).

For parents, evaluating and modifying their approach was often framed as positive or helpful. However, for peers, this wasn’t always the case. Friendships could shift from a reciprocal, equal relationship of both sharing feelings and problems to an unequal balance, with participants putting aside their own problems order to help to regulate their friend’s emotions: “I kind of forgot about what was going on in my life and made them [friend who was self-harming] more important because I felt like that my problems were slim to nil to what their big problems were.” (S10, p.151). Whilst seen as necessary, this approach could lead to resentment from the non-self-harming peer: “I know friends are there to support each other and it’s quite difficult when there’s like self-harm in the way I guess of the friendship.” (S10, p.151). Friends also modified their approach to be more vigilant by spending increased time together to try to stop self-harm occurring: “It makes me feel like I need to watch over him when we’re all hanging out because I’m the only one who knows about it.” (S3, p.299). Increased vigilance was echoed in both parents and residential carers in other studies (e.g., S5; S7; S9), indicating that peers felt similar levels of responsibility as parents and professionals.

Theme four: Offering support

This theme represents participants’ experiences related to ongoing support that they provided around self-harm.

An open and curious approach

Many participants tried to adopt an open and curious approach, and felt that this was successful (e.g., S2; S7). Various intervention strategies were utilised, including humour (S10), listening (S3), providing physical comfort (S10), spending more time with the adolescent at fun activities (S7), and talking with the young person about how they were feeling: "We'd always talk to her and like we always told her that if she needs someone to talk, like we'd always be there for her." (Friend; S3, p.299). For parents, adopting a curious approach often led to asking the young person about why they were hurting themselves. This was a shift from the initial, emotion-fuelled question described in theme one, and instead was asked in a calm, gentle manner which included lots of emotional connection: "I told her we love her, she can just ask for help." (S8, p.6). This approach often increased connection and empathy within the relationship: "I feel it has brought us closer and she knows she can come to me and talk about anything after this experience." (S7, p.3408).

The pressure to keep conversations confidential

Friends in particular experienced a lot of pressure to keep discussions confidential. This pressure came from both internal and external sources, highlighting the importance of loyalty in adolescent friendships: "I didn't feel like I should tell anyone due to confidentiality…we did not have many friends and I didn't want to sort of just spread it around." (S3, p.301). This desire for confidentiality is also a reminder of the fear of judgement and stigma attached to self-harm: "I couldn't even tell my Mum because she didn't want my Mum to tell people." (S10, p.150). Some friends kept conversations confidential to allow them to continue supporting their friend: "They open up like, because I won't say nothing to anyone…so they open up to me." (S3, p.301). Other friends experienced poor emotional wellbeing as a result of knowing this information and felt that they had no choice but to tell someone, but worried about this jeopardising the friendship: "It felt like I was carrying the weight of a thousand people on my back and I wasn't allowed to tell anyone because I didn't want to hurt her." (S10, p.150). One friend attempted to balance the two: "Some of it, she's told me not to like, tell the teacher or anything, so I just told things that she's not told me to not tell." (S3, p.302).

Professionals working in education settings also struggled with the dilemma of having to break confidentiality: "…they have trusted you, they have bared their soul and all they see is…you selling them out…" (S12, p.587). Whilst both healthcare and education professionals have professional and service guidelines including the need to share information, only education professionals in the included studies spoke about an emotional response to breaking confidentiality.

Viewing cessation of self-harm as the marker of success

Individuals were keen to support adolescents to reduce their self-harm, but often viewed the complete cessation of self-harm as the marker of whether they had been successful: "But if you still fail…that particular time you think, y'know, I haven't done my job today." (Healthcare Professional; S2, p.3). This view was echoed by community nurses: "You get that kind of rollercoaster recovery, you get to that place where you think, 'ohh, they're doing alright', then they do something, and it seems to come crashing down." (Nurse; S4, p.748), and also by friends:

> …every time I tried they would just go back to [self-harm] even if they had stopped for a period of time. So, it made me feel like it was my fault and that I couldn't stop them, and I couldn't do anything to help them. (S10, p.151)

Parents did not speak about the same level of responsibility, but held a similar view that no instances of self-harm meant that the young person had recovered: "When we took her on a trip, she was in a good mood and did not hurt herself, as if she had recovered from her illness." (S6, p.4).

Theme five: We need more help!

This theme represents individuals' journey to seek further help for the adolescent, usually via professional mental health support. This often began with parents or peers encouraging the adolescent to seek support themselves (e.g., S1; S10). When this was unsuccessful, there was often a period of avoidance of help-seeking, possibly linked to a desire to ignore or minimise self-harm: "Then she told me she wanted to see a psychiatrist, but I didn't even think of it because this didn't happen to any of the older kids in my family, so I didn't care." (Parent; S6, p.4). It often took another professional, such as a teacher, to give a clear message that professional intervention was needed (S1; S6). However, parents often wished that they had sought support earlier and would advise other parents to reach out sooner.

When the need for professional input was recognised, this was sought from either CAMHS or a private professional, such as a therapist or psychologist. Parents were keen to be involved in these sessions: "We need to feel included in the treatment, education, and support. We need to feel confident that when we leave the safety of your support that we have the knowledge and ability to provide our children with the right support so that we don't make things worse." (S1, p.10). This was also recognised by nurses, who noted the complexity and the impact on practitioners trying to balance this: "Those sorts of situations are so emotionally draining…you need to be there for the young person, but you can't alienate the parents." (S4, p.747). Parents often felt frustrated at not receiving guidance on how to support their child: "Therapists should not lock parents out of therapy and expect parents to support kids without recommendations." (S1, p.10), and remained unsure how best to respond: "How am I supposed to help, what am I supposed to do, if I'm not getting any feedback?" (S1, p.11). This desire to be involved was highlighted by Australian parents (S1) but not by Chinese parents (S6; S8), suggesting a cultural difference in how much involvement parents feel is appropriate in their child's therapy.

Parents and peers were not the only groups to look for further support. Despite their training, professionals also felt helpless and out of their depth when working with adolescents who self-harm (e.g., S11; S12). There was a desire for outside support to contain or reduce feelings of powerlessness, but similar to parents, they experienced barriers: "We make the referral and we got told there's a six-month waiting list…and we sit and watch our young people get destroyed." (Residential Staff; S5, p.16). Education staff had a similar experience: "You get two visits from a psychologist for the entire year, and they've generally got to do testing, they're not really going to get too worried about the self-harming out there…" (S12, p.588). For staff working in an inpatient setting, the feeling of helplessness was compounded by the sense that there was not anywhere for them to refer to: "All they have is us to help them feel better…We're supposed to be the professionals and if we can't do it, who can?" (S2, p.3).

Discussion

Main findings

This review aimed to synthesise qualitative findings regarding key individuals' responses to adolescent self-harm. It is the first systematic review to compare responses from four groups: peers, caregivers, healthcare staff, and education staff. Five themes were developed to encapsulate these responses. Initial responses were fuelled by emotions (theme one), but participants noted the importance of maintaining a calm façade (theme two). Individuals felt that they needed to modify their approach to the young person (theme three) to offer support around self-harm (theme four). Ultimately, all groups sought further help (theme five).

The review identified that initial responses to an adolescent's self-harm were often fuelled by strong emotional reactions, including anger and anxiety. This supports previous findings highlighting shock experienced by parents upon discovery of their child's self-harm (Hughes et al., 2017; Zhao et al., 2022). These initial emotional responses highlight the inner turmoil experienced by parents, including guilt for not realising what was happening (McDonald et al., 2007), concern for their child's future (Whitlock et al., 2018), or even bereavement for a child they feel is not there anymore (S9). Parents' worldview can be destabilised after discovering their child is self-harming (Hughes et al., 2016). Interestingly, the synthesis revealed that education professionals also experience these initial emotional responses, albeit to a lesser degree. These experiences have not been studied in-depth, with research into education professionals' experiences of self-harm being more likely to focus on their knowledge of and attitudes towards self-harm (e.g., Berger et al., 2015) rather than their emotional reactions.

Anger is commonly expressed by parents when learning of self-harm, though the synthesis highlighted that anger can be caused by misattributing the underlying reason for self-harm, for example, believing that the young person is trying to manipulate a parent (S6). Other reasons for anger include the potential danger, or if parents perceive self-harm as an ongoing issue that is beyond their control. Parents also modified their parenting style in response to self-harm. Often, their first reaction was to adopt an authoritarian or controlling style in an attempt to reduce risk and manage their own anxiety. However, an authoritarian parenting style is associated with repeated self-harm (Polk & Liss, 2007) and Patterson's Family Coercion Theory (2002) offers an explanation for this pattern, proposing that coercive parenting can unintentionally reinforce undesired behaviour. The more the parent tries to control the child, e.g., by increasing supervision and removing the child's access to a private space, the less in control a child feels and the more likely they are to self-harm. As time went on, parents recognised the importance of a calm façade when interacting with their child. This is mirrored in literature exploring the reactions of parents to their adolescent attempting to die by suicide (Wagner et al., 2000). Greene-Palmer et al. (2015) found that although 50% of parents reported experiencing anger and hostility following a suicide attempt, less than 10% verbalised this to their child. The importance of a calm manner and reduction in emotionally charged reactions was supported by adolescents in Curtis and colleagues' (2018) study, where adolescents were asked what support they would want after self-harm. The synthesis highlighted a path from modifying their parental style to a closer and more positive relationship with their child. This path suggests the occurrence of post-traumatic growth, characterised as the positive psychological change following a traumatic or challenging life event (Tedeschi and Calhoun, 2004). Post-traumatic growth in parents of adolescent self-harmers was also proposed by Zhao and colleagues (2022), and has been explored in literature focusing on parents who have experienced other traumatic events, such as their child receiving a cancer diagnosis (Nakayama et al., 2016).

Whilst healthcare professionals also experienced anger towards young people who self-harm, this was more often a result of frustration over limited resources and feeling stretched supporting other patients. This finding is mirrored in Kleaver's (2014) review exploring the attitudes of emergency care staff towards young people who self-harm. This finding is particularly concerning as young people pick up on these attitudes, perceiving staff members as disinterested, dismissive, and unknowledgeable about self-harm, and resolving to only seek future help if absolutely necessary (Byrne et al., 2021). It is important to note that healthcare staff may be confronted by multiple simultaneous episodes of self-harm (as reported by staff in S2), unlike parents or peers who are likely to only be responding to a single young person whom they have a personal relationship with. This highlights the need for systemic change to relieve these pressures in addition to changing staff attitudes towards self-harm.

Emotional detachment was reported by healthcare professionals in the synthesis, noting that they had become “hardened” (S2, p.3) and “robotified” (S5, p.12). These findings are mirrored in studies indicating that some healthcare professionals prefer to maintain a distance when supporting young people who self-harm (Fisher & Foster, 2016). However, this has the potential to be a barrier in the creation of a therapeutic relationship (Ackerman & Hilsenroth, 2001), which is recognised as one of the key cornerstones of therapy (Flückiger et al., 2012). Carter et al.’s (2018) study found that professionals’ gender, age, area of work, or length of employment did not impact feelings of apprehensiveness. However, apprehensiveness was reduced if they felt that their intervention was effective. This links to a later theme in the synthesis whereby participants only viewed their support as successful if the young person stopped self-harming. Apprehension and placing high importance on the cessation of self-harm could be explained by a number of factors, including discomfort with self-harm (Fisher & Foster, 2016), stigma towards self-harm (Sandy & Shaw, 2012), and lack of knowledge about functions of self-harm (Sandy, 2013). Whilst some participants in the synthesis felt that this detachment was helpful (S4), continued emotional detachment is linked to burnout in healthcare staff (Nasharudin et al., 2020), leading to poor psychological health outcomes for staff (Salvagioni et al., 2017) and poorer treatment outcomes for patients (Hall et al., 2016).

Whilst it is developmentally appropriate for young people to seek support from their peers prior to parents or professionals, literature in relation to self-harm is cautionary, highlighting the potential contagion effect of self-harm (Jarvi et al., 2013) or that peers may not encourage their friend to stop self-harming (Gayfer et al., 2020). This synthesis highlights a different perspective, showing that the responsibility peers feel for helping their friend to stop self-harming is akin to a parent or professional. Adolescents who self-harm often feel isolated (Hill & Dallos, 2012) and value feeling connected to peers (Lindgren et al., 2021). Some peers in the synthesis felt that their friendship had been strengthened through supporting their friend, which is echoed in studies exploring the experiences of university students who have supported a friend who has disclosed self-harm (Gayfer et al., 2018). However, peers also spoke of the emotional cost of supporting a friend who is self-harming, feeling overwhelmed, stressed, and isolated. This is mirrored in studies exploring the impact on friends receiving a disclosure of suicidal ideation who feel similar levels of responsibility and emotional turmoil (Garcia-Williams & McGee, 2016), suggesting a need to support the peers of those who self-harm as well as the young person themselves. Young adults who self-harm are acutely aware of the potential impact of their disclosures and worry extensively about being a burden or causing emotional pain by talking about their self-harm (Rosenrot & Lewis, 2018).

Parents in the synthesis often reported avoiding acknowledging their child’s self-harm. This is supported in other studies focusing on disclosures of self-harm (Rosenrot & Lewis, 2018). This also fits with wider literature exploring post-disaster topic avoidance (Felix et al., 2020), indicating that parents’ distress following discovery of their child’s self-harm is comparable to a traumatic life event. Overwhelming feelings of anxiety and uncertainty are often linked to not knowing how best to support their child with self-harm (Byrne et al., 2008) or where to seek support from (Raphael et al., 2006). This is also reported by education staff, who feel keen to avoid or ‘pass on’ instances of self-harm because they do not feel equipped to support students who are self-harming (Best, 2006). Unfortunately, this avoidance can delay seeking support for their child, as parents are often a key facilitator in help-seeking (Richwood et al., 2005). When parents feel informed and confident, they are perceived by young people as being more helpful and able to initiate seeking support (Curtis et al., 2018).

Clinical implications

Peers and family members are likely recipients of self-harm disclosures from a young person. However, the synthesis suggests that they are often unsure how to respond, and instead react emotionally. This can lead to young people feeling isolated, stigmatised, and lacking confidence in their ability to provide support. Friends report feeling overwhelmed and worried about breaking confidentiality to seek support for their friend. School-based suicidal prevention education programmes have been effective in preventing suicidal ideation and suicide attempts (Pistone et al., 2019). A universal education programme aimed at raising and deepening awareness about self-harm warning signs and help-seeking resources should be offered to secondary school pupils through PSHE (Personal, Social, Health, and Economic Education) lessons. This program should include strategies for self-care when supporting a friend who is self-harming and how to remove oneself safely from the situation if it becomes too much of a burden. It should also include strategies for discussing telling someone else (i.e., a teacher or a parent) with the friend, to avoid peers feeling that they are betraying their friend. School-based counselling services could offer a method for peers to anonymously share their concerns about their friend to seek support for them.

Parents did not feel equipped to respond to their child when faced with self-harm. They felt frustrated when their child's therapist did not provide guidance on how to support their child (Stewart et al., 2016) and highlighted the need for accessible information on self-harm for parents (Mughal et al., 2022). Local programmes to support parents of self-harming and suicidal adolescents have been shown to improve family functioning and reduce self-harm (Pineda & Dadds, 2013; Power et al., 2009). Young people who feel supported by their parents are also more likely to seek professional help (Curtis et al., 2018). Wider access to parent-specific programmes like these could offer parents opportunities to develop their knowledge about self-harm, as parents respond more helpfully when they understand self-harm as a mental health concern rather than ‘naughty behaviour’ (Ferrey et al., 2016).

Education professionals also reported similar concerns to parents around feeling that they did not have the knowledge and skills to support pupils who were self-harming. Training interventions for school staff have been shown to increase knowledge and confidence in responding to pupils who are self-harming (Pierret et al., 2020). These programmes could be offered across all primary and secondary schools on a regular basis to continue to upskill education professionals when responding to self-harm.

A lack of knowledge is often reported as a barrier to reacting effectively to adolescent self-harm by healthcare professionals (Ribeiro Coimbra & Noakes, 2022). Education on self-harm has been linked to more positive attitudes from healthcare professionals, due to increased understanding following these programmes (McHale and Felton, 2010), and there is a need for these to be widely available and staff members supported to attend. Practice educators should also have awareness of up-to-date information on self-harm, enabling dissemination of knowledge between healthcare professionals.

An additional concern for healthcare professionals is the potential for burnout when working with emotionally intense presentations such as adolescent self-harm. Resilience and empathy are crucial for staff working in these settings. Management support, including protected time for clinical and peer supervision is essential, alongside modelling conversations around wellbeing and burnout to reduce the potential for compassion fatigue (True et al., 2021).

Strengths and limitations of the review

This was the first review to bring together perspectives of parents, peers, and professionals of young people who self-harm. Findings provided an insight into reactions exhibited toward adolescent self-harm and how these responses change over time. Bringing together different perspectives enables a better understanding of the views and needs of key individuals who support young people, as well as providing an insight into the experience of adolescents when they disclose self-harm. The strengths of this review include quality appraisal of results from six databases adhering to PRISMA checklists, and the inclusion of studies from a range of settings. Thematic synthesis was conducted by a researcher with a background in working in child and adolescent mental health, promoting the credibility of findings. The studies were conducted over a broad geographical range, which may increase the review's generalisability across countries.

Sample sizes in the studies were small, due to the nature of qualitative studies. Due to multiple groups being studied in the synthesis, the sample sizes for each group are small, which could present a challenge in establishing relationships between studies and transferability to other groups, such as siblings. Some studies (e.g., S9) reported high drop-out rates for interviews, which could indicate a response bias.

Studies were conducted across five countries, although studies focusing on education or healthcare professionals were only carried out in the UK and Ireland. Studies involving parents were carried out in Australia, China, and England, providing perspectives from both Western and Eastern families. However, the small sample sizes from each country may pose difficulties for generalisability as Eastern and Western parents often have different parenting approaches (Ng et al., 2014), for example, Chinese parenting strategies are likely to be more controlling or authoritarian than Western parenting approaches (Wang & Liu, 2014). As described in theme five, Chinese parents were keen to be involved in their child's therapy, highlighting a contrast to Western values of individualism.

There are high levels of self-harm amongst male adolescents, but males may internalise negative views on help-seeking (Jordan et al., 2012). This can crossover to difficulties engaging with mental health services (Hassett & Isbister, 2017), highlighting a need for research to amplify the experience of male peers alongside male adolescents who self-harm. It is unclear if any male education professionals were included as only one of the papers which focused on education professionals (S12) included information on gender.

One study (S5) did focus on carers of children who are looked after, which is a group of young people who are specifically vulnerable. Grey literature was also excluded, so relevant reports from charities or unpublished research may have been missed.

Included studies relied on participants' retrospective reports of their emotional and behavioural reactions. Retrospective reports may be influenced by inaccurate or biased recall, or by social desirability. This may be especially true for professionals who are bound by professional codes of conduct and may not feel comfortable disclosing reactions they deem to be inappropriate or unprofessional. However, many participants did discuss emotions such as anger, frustration, and regret, suggesting that social desirability bias may have been limited.

Recommendations for further research

The systematic review provided an insight into how key individuals behave in response to a young person's self-harm. The study drew on Ecological Systems Theory (Bronfenbrenner, 1979) to consider responses within the multiple systems in which the young person is embedded. However, there are minimal studies that have explored this from the perspective of young people who self-harm: both in the responses they have received, and the reactions that they would have liked from peers, caregivers, education staff, and healthcare professionals. Further research into this would improve our understanding of how to support young people who self-harm and those who support them and would centre the experience of young people who self-harm.

Little research into therapists' and mental health professionals' attitudes to and responses to disclosures of adolescent self-harm has been conducted. Previous research has considered nurses and A&E staff, however therapists and mental health professionals such as psychologists and psychiatrists are likely to be the individuals providing long-term support to adolescents who self-harm. Future research should address this gap, to inform our understanding of how mental health professionals respond and to improve retention rates in therapy for these young people.

Conclusion

The present review is novel in that it considers perspectives from different groups on how they respond to a young person’s self-harm. The review draws on Ecological Systems Theory to consider how young people are supported by the multiple systems they are located in. The review contrasts the experiences of peers, parents, residential carers, and education and healthcare staff from their initial responses through to long-term support of a young person who self-harms. Findings have implications for education and healthcare services, in particular the need for education, training, and parent support programmes.

Acknowledgements

The author would like to thank Serena Hannah for her support with the quality appraisal process.

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Tables and Figures

Table 1

Completed SPIDER Model (Cooke et al., 2012)

Sample	Key Individuals	social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR probation OR GP OR parent* OR mother* OR father OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist
Phenomena of Interest	Self-Harm	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted use proximity searching: (harm OR mutilat* OR injur*) N5 (self OR oneself OR selves OR ourselves OR them*)
	Young People (0 – 18)	Adolesc* OR "young person" OR "young people" OR teen* OR child* OR "young adult" OR juvenile OR minor* OR "0-18 year*" OR youth OR kid OR pupils
Design		grounded theory OR narrative OR thematic analysis OR phenomenology* OR ethnograph* OR focus group* OR interview OR story OR stories OR discourse analysis OR interpretative *phenomenological* analysis
Evaluation	Attitudes/Reactions	react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR

		affect OR empath* OR sympathy* OR influenc* OR belief* OR opinion OR judgement
Research Type	Qualitative	

Table 2

Search strategy showing free text and database search terms

Concepts	**Academic Search Ultimate**		**PsycINFO**		**CINAHL**		**socINDEX**		**PubMed**	**Medline**	
	DE terms	Title/ Abstract	DE terms	Title/ Abstract	MH terms	Title/ Abstract		Title/ Abstract	Title/Abstract		Title/ Abstract
Concept 1 Self-harm	DE "SELF-injurious behavior in adolescence" OR DE "SELF-mutilation" OR DE "SELF-injurious behavior" OR DE "SELF-injurious behavior in adolescence" OR DE "SELF-mutilation" OR DE "CUTTING (Self-mutilation)"	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR oneself OR selves OR oneselves OR	DE "Self-Mutilation" OR DE "Self-Injurious Behavior" OR DE "Self-Inflicted Wounds"	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR oneself OR selves OR oneselves OR themselves OR themselves) N5 (harm OR mutilate*	(MH "Injuries, Self-Inflicted/DI/ED/EI/EH/ET/HI/FG/NU/OG/PC/PR/PF/RF/SS/TH/TD") OR (MH "Self-Injurious Behavior/DI/ED/EP/EI/EH/ET/EV/FG/HI/NU/PC/PR/PF/SS/TH/TD") OR (MH "Risk for Self-Mutilation (NANDA)") OR (MH "Self Mutilation Risk (Saba CCC)")	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR	DE "SELF-injurious behavior" OR DE "SELF-injurious behavior in adolescence" OR DE "SELF-mutilation" OR DE "SELF-mutilation in adolescence"	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR oneself OR selves OR oneselves OR	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR oneself OR selves OR oneselves OR	(MH "Self-Injurious Behavior") OR (MH "Self Mutilation")	self-harm* OR self-injury OR self-mutilat* OR parasuicide OR non-suicidal self-injury OR cutting OR self-inflicted violence OR self-injurious behaviour OR deliberate self-harm OR self-destruct* OR injuries self-inflicted OR ((self OR oneself OR selves OR oneselves OR

		themselves OR themselves) N5 (harm OR mutilate* OR injur*))		OR injur*))		oneself OR selves OR oneselves OR themselves OR themselves) N5 (harm OR mutilate* OR injur*))		themselves OR themselves) N5 (harm OR mutilate* OR injur*))	themselves OR themselves) N5 (harm OR mutilate* OR injur*))		themselves OR themselves) N5 (harm OR mutilate* OR injur*))
Concept 2 Key Individuals		social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR probation OR GP OR parent* OR mother* OR father		social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR probation OR GP OR parent* OR mother* OR father OR sibling* OR		social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR		social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR probation OR GP OR parent* OR mother* OR father	social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR probation OR GP OR parent* OR mother* OR father		social workers OR foster carers OR emergency staff OR nurs* OR inpatient staff OR psychologist* OR CAMHS OR psychiatrist* OR therapists OR school nurses OR school staff OR teach* OR faculty OR probation OR GP OR parent* OR mother* OR father

		OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist		brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist OR professional OR healthcare professional OR healthcare worker OR		probation OR GP OR parent* OR mother* OR father OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR		OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist	OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist		OR sibling* OR brother* OR sister* OR friend* OR peer OR mentor OR coach OR youth work* OR residential staff OR care staff OR support work* OR counsellor* OR doctor OR mental health practitioner OR care assistant OR tutor OR clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist

		OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist		caregiver OR music therapist OR play therapist		clinician OR paramedic OR occupational therapist OR speech and language therapist OR physiotherapist OR art therapist OR drama therapist OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist		OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist	OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist		OR professional OR healthcare professional OR healthcare worker OR caregiver OR music therapist OR play therapist
Concept 3 Young	DE "TEENAGERS" OR DE "YOUTH"	Adolesc* OR “young person” OR “young people” OR	(DE "Adolescent Psychopathology" OR	Adolesc* OR “young person” OR “young people” OR	(MH "Adolescent Psychiatry") OR (MH "Adolescence	Adolesc* OR “young person” OR	DE "ADOLESCENCE" OR DE "TEENAG	Adolesc* OR “young person” OR “young people” OR	Adolesc* OR “young person” OR “young people” OR	(MH "Adolescent") OR (MH "Minors")	Adolesc* OR “young person” OR “young people” OR

People	OR DE "TEENAGE boys" OR DE "TEENAGE girls" OR DE "ADOLESCENCE" OR DE "CHILDREN" OR DE "MINORS" OR DE "PRETEENS" OR DE "YOUNG adults"	teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen	DE "Adolescent Psychology" OR DE "Adolescent Health" OR DE "Adolescent Psychotherapy" OR DE "Adolescent Psychiatry" OR DE "Adolescent Development")	teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen	") OR (MH "Adolescent Psychology")	“young people” OR teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen	ERS" OR DE "YOUTH"	teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen	teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen		teen* OR child* OR “young adult” OR juvenile OR minor* OR “0-18 year*” OR youth OR kid OR pupils OR preteen
Concept 4 Perspectives		react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath* OR sympathy* OR	DE "Attitudes" OR DE "Health Attitudes"	react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath* OR sympathy* OR influenc* OR belief* OR opinion		react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath*		react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath* OR sympathy* OR	react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath* OR sympathy* OR		react* OR attitude* OR view* OR respond OR perspective* OR understanding OR think OR experience* OR thought OR impact OR effect OR affect OR empath* OR sympathy* OR

		influenc* OR belief* OR opinion OR judgement		OR judgement		OR sympathy* OR influenc* OR belief* OR opinion OR judgement		influenc* OR belief* OR opinion OR judgement	influenc* OR belief* OR opinion OR judgement		influenc* OR belief* OR opinion OR judgement

Table 3

Inclusion and exclusion criteria utilised for all search results

Inclusion criteria	Exclusion criteria
Studies that report accounts of individuals' reactions to a young person's self-harm. Young people are defined as being aged 0 – 18.	The young people who self-harmed were over the age of 18 or not separated from individuals over the age of 18.
The sample of participants have at least one self-reported experience of working with or having a personal connection (e.g., sibling or parent) with a young person who has self-harmed.	The self-harming behaviour described includes acts with suicidal, sexual, and/or decorative intent, or was not separated from these acts.
Studies which use a qualitative research design or mixed methods design with qualitative reporting.	Studies which utilised quantitative methods only.
Studies published in peer reviewed journals.	Unpublished theses, dissertations, opinion pieces.
Self-harm falls under the definition of the intentional destruction of body tissue without decorative intent.	The harm to self was accidental or socially sanctioned (e.g., 'Tide Pod challenge').
	The young people who self-harmed were drawn from populations with developmental disabilities.

Table 4

Description of the 12 included studies

Title (Study number)	Authors (Location)	Year	Participants	Method	Analysis	Themes **Themes extracted for current review**
Adolescent self-harm: Parents' experiences of supporting their child and help-seeking (S1)	Townsend, Matthews, Miller, & Grenyer (Australia)	2022	For telephone interviews: ten parents of young people who self-harmed whilst under the age of 18. Gender: separate demographics were not provided for participants who completed the telephone interview.	Semi-structured interview as part of larger survey study.	Thematic analysis on telephone interviews	**1. An emotional journey into the dark unknown.** **2. The promise of psychological help.**
An exploration of the impact of self-harm in an inpatient adolescent setting on staff: a qualitative study (S2)	Rouski, Hodge, & Tatum (England)	2017	Five staff members from a CAMHS inpatient unit, England. Gender: 3 females, 2 males. Professional role: two	Semi-structured interviews	Thematic analysis	**1. The journey of adaption.** **2. The personal impact: feeling responsible.** **3. The nature of self-harm.** **4. The quest to understand.** 5. Finding support in the team. 6. Risk management plan: creating clarity and certainty?

			nurses, two healthcare assistants, one teacher.			
I Just Pulled Myself Together and Realised I had to be Responsible: Adolescents' Experiences of Having a Friend Who Self-Harms (S3)	Hall & Melia (England)	2021	Eight young people aged between 13 – 18 who had a friend who has self-harmed. Gender: eight females.	Semi-structured interviews	IPA	**1. Desperately searching for meaning.** **2. I will be there at all costs.** **3. Too hot to handle.** 4. **Identification.**
Nurses' experiences of working in the community with adolescents who self-harm: A qualitative exploration (S4)	Leddie, Fox, & Simmonds (England)	2021	Ten nurses working in community CAMHS. Gender: eight female, two male.	Semi-structured interviews	IPA	**1. Personal and professional conflicts (a. keeping everyone happy; b. double-edged sword).** **2. Personal and professional development (a. I can switch off…. from being a professional and be a person; b. it has got easier, just with experience).**
One moment you're covered in blood and next it's what's for tea? An interpretative phenomenological analysis of residential care staff's experiences of managing self-harm with looked after children	Brown, Chadwich, Caygill & Powell (England)	2019	Nine carers in residential Local Authority children's homes. Gender: five female, four male.	Semi-structured interviews	IPA	**1. Surviving (a. creating an understanding; b. constantly on the lookout; c. I think you get a bit robotified; d. it's like a little family).** **2. We're out here alone (a. it's on me; b. somebody help us!).** 3. Losing control (a. reliving the chaos; b. spilling into outside life).

(S5)						
Parents' Attitudes Toward and Experience of Non-Suicidal Self-Injury in Adolescents: A Qualitative Study (S6)	Fu, Yang, Liao, Lin, Peng, Shen, Ou, Li, & Chen (China)	2020	Twenty parents of young people (up to age 18 years). Gender: 16 females, four males.	Semi-structured interviews	Thematic analysis	**1. Attitude to children's NSSI behaviour (a. ignore; b. shame; c. stereotype).** **2. Coping strategies of parents (a. initial response to adolescents' NSSI; b. the way of help seeking).** **3. The impact on family (a. increased psychological pressure; b. limited personal life; c. altered parenting and communication style)**
Parents' Experiences of Non-suicidal Self-Injury Among Adolescents and Young Adults (S7)	Kelada, Whitlock, Hasking, & Melvin (Study 1: Australia)	2016	Study 1: Sixteen parents of adolescents (aged 14 – 17) who have self-harmed. Gender: 15 females, one male. Themes from study 2 were not used due to participants being parents of young people aged 15 – 24 and thus not meeting the inclusion criteria for the study.	Measures & open-ended questions	Thematic analysis on open ended questions	**Themes from study 1:** **1. Initial responses to NSSI (a. negative emotional reactions; b. calm communication; c. searching for reasons).** **2. Negative interactions with professionals (a. lack of empathy; b. lack of support).** **3. Changes in parent-adolescent relationship (a. increased vigilance; b. shift in power dynamic; c. brought them closer; d. modifying problem behaviours).** 4. **Parents' perceived helpfulness (a. talking, listening, and being non-judgmental; b. offering support, showing love, and spending more time together; c. seeking professional help).**

Parents' lived experience of adolescents' repeated non-suicidal self-injury in China: a qualitative study (S8)	Wang, Huang, Huang, & Zhao (China)	2022	Twenty-four parents of adolescents (aged 12 – 18) who have self-harmed. Gender: 18 females, six males. Relationship to child: mother (18), father (6).	Semi-structured interviews	Thematic analysis	**1. Attribution of NSSI.** **2. Perceptions of NSSI.** 3. **Coping behaviours of NSSI.**
Parents' perspectives on adolescent self-harm: qualitative study (S9)	Oldershaw, Richards, Simic, & Schmidt (England)	2008	Twelve parents of adolescents (aged 13 – 18) who have self-harmed. Gender: ten females, two males. Relationship to child: mother (9), father (2), grandmother with maternal role (1).	Semi-structured interviews	IPA	**1. The process of discovery.** **2. Making sense of self-harm.** **3. Psychological impact of self-harm on parents.** 4. **Effect of self-harm on parenting and family.**
Peer Responses to Non-Suicidal Self-Injury: Young Women Speak About the Complexity of the Support-Provider Role (S10)	Fisher, Fitzgerald, & Tuffin (New Zealand)	2017	Five adolescents aged 13 – 15 who had experience supporting a peer with self-harm. Gender: five females (participant inclusion criteria specified female).	Semi-structured interviews	IPA	**1. Helping responses.** **2. NSSI and relationships.** **3. The costs of caring.** **4. Supporter needs.**

Primary school children and self-harm: the emotional impact upon education professionals, and their understandings of why children self-harm and how this is managed (S11)	Simm, Roen, & Daiches (England)	2010	Fifteen school staff members from primary schools who have experienced a pupil self-harming. Gender: not stated. Professional role: teachers and support staff (no specific information provided).	Semi-structured interviews	IPA	1. **How self-harm affects staff emotionally.** 2. Ascribing reasons for children's self-harming. 3. Management of self-harm in schools.
Responding to self-harm in the school setting: the experience of guidance counsellors and teachers in Ireland (S12)	Dowling & Doyle (Ireland)	2016	Six participants from schools including teachers and guidance counsellors. Gender: six females. Professional role: guidance counsellors (3), teachers (3).	Semi-structured interviews	Thematic analysis	**1. Discovering self-harm in the school setting.** **2. Reaction to and impact of self-harm.** **3. Managing self-harm and the personal and professional impact.**

Table 5

Summary of quality assessment scores for each study

Quality was assessed using CASP (CASP, 2018).

Authors	**Study Number**	**CASP (2018) rating scores**										
		Clear statement of aims	Appropriate methodology	Appropriate research design	Appropriate recruitment strategy	Appropriate data collection	Researcher-participant relationship	Ethical issues considered	Rigorous data analysis	Clear statement of findings	Valuable research	Total score (max 10)
Townsend et al. (2022)	(S1)	1	1	1	0.5	0.5	0.5	1	1	1	1	8.5
Rouski et al. (2017)	(S2)	1	1	0	0.5	0.5	0	0.5	0.5	1	1	6
Hall & Melia (2021)	(S3)	1	1	1	1	1	0.5	1	1	1	1	9.5
Leddie et al. (2021)	(S4)	1	1	1	0.5	1	0.5	1	0.5	1	1	8.5
Brown et al. (2019)	(S5)	1	1	1	0.5	0.5	0.5	0.5	1	1	1	8
Fu et al. (2020)	(S6)	1	1	0.5	1	0.5	0	0.5	0	1	1	6.5
Kelada et al. (2016)	(S7)	1	1	0	0.5	0.5	0	1	0.5	0.5	1	6
Wang et al. (2022)	(S8)	1	1	1	1	1	0.5	1	1	1	1	9.5
Oldershaw et al. (2008)	(S9)	0.5	1	1	1	1	1	0.5	1	1	1	9
Fisher et al. (2017)	(S10)	1	1	1	1	1	1	1	1	1	1	10
Simm et al. (2010)	(S11)	1	1	1	1	1	0.5	1	1	1	0.5	9
Dowling & Doyle (2016)	(S12)	1	1	1	1	1	0	1	0.5	0.5	1	8

Table 6

The occurrence of analytic themes in each study

Main Theme	Study Number	**Initial responses fuelled by emotions**	**The importance of a calm façade**	**Modifying my approach and our relationship**	**Offering support**			**We need more help!**
Subtheme					*An open and curious approach*	*The pressure to keep conversations confidential*	*Viewing cessation of self-harm as the marker of success*	
Townsend et al. (2022)	(S1)	X	X					X
Rouski et al. (2017)	(S2)	X	X	X	X		X	X
Hall & Melia (2021)	(S3)	X	X	X	X	X		
Leddie et al. (2021)	(S4)	X	X				X	X
Brown et al. (2019)	(S5)		X	X				X
Fu et al. (2020)	(S6)	X	X	X	X		X	X
Kelada et al. (2016)	(S7)	X	X	X	X			
Wang et al. (2022)	(S8)	X		X	X			X
Oldershaw et al. (2008)	(S9)	X	X	X	X			X
Fisher et al. (2017)	(S10)	X	X	X	X	X	X	X
Simm et al.	(S11)	X	X					X

(2010)								
Dowling & Doyle (2016)	(S12)	X	X			X		X

Figure 1

PRISMA Flow Diagram (Page et al., 2021)

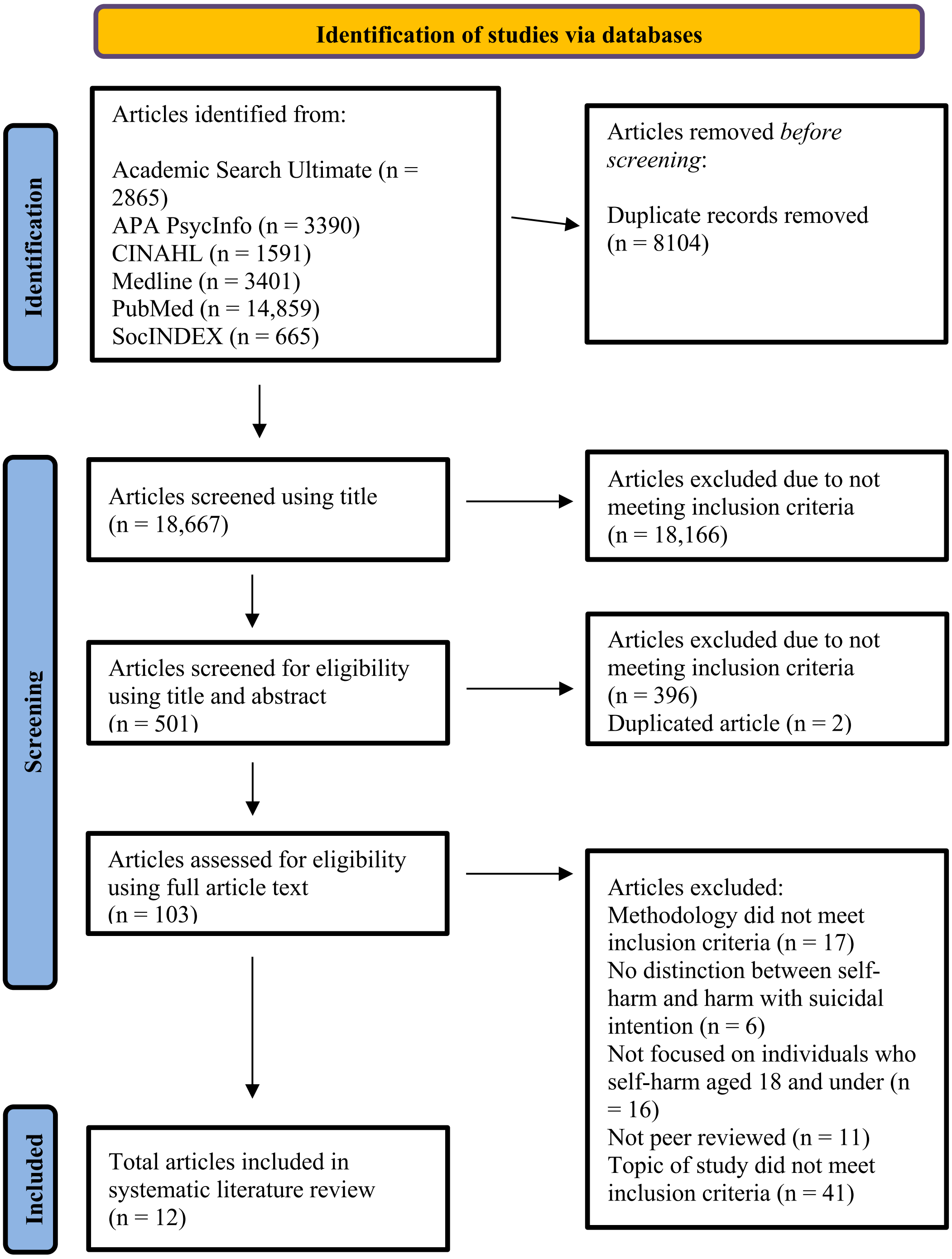


Figure 2

Example map showing three descriptive themes

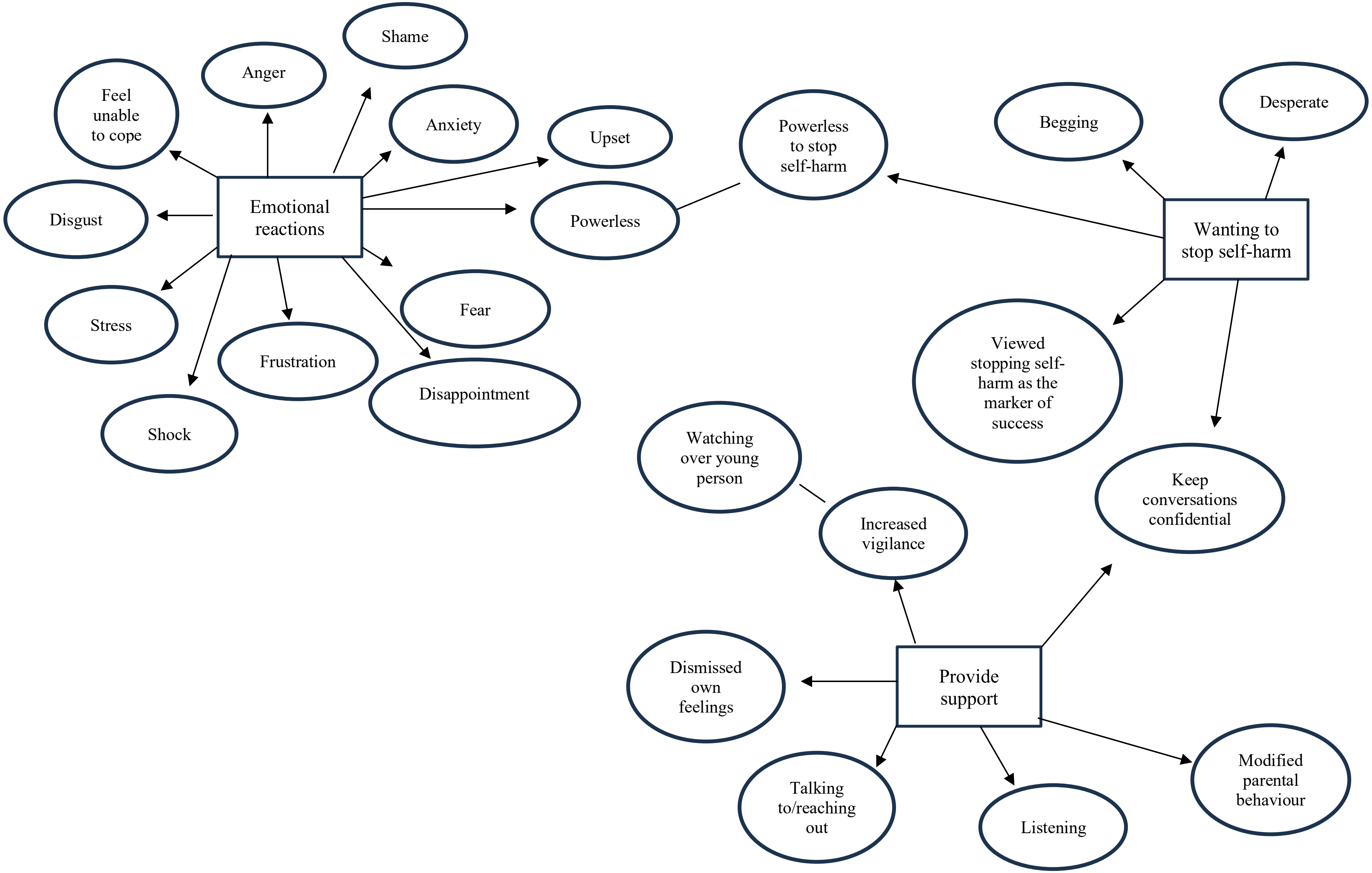
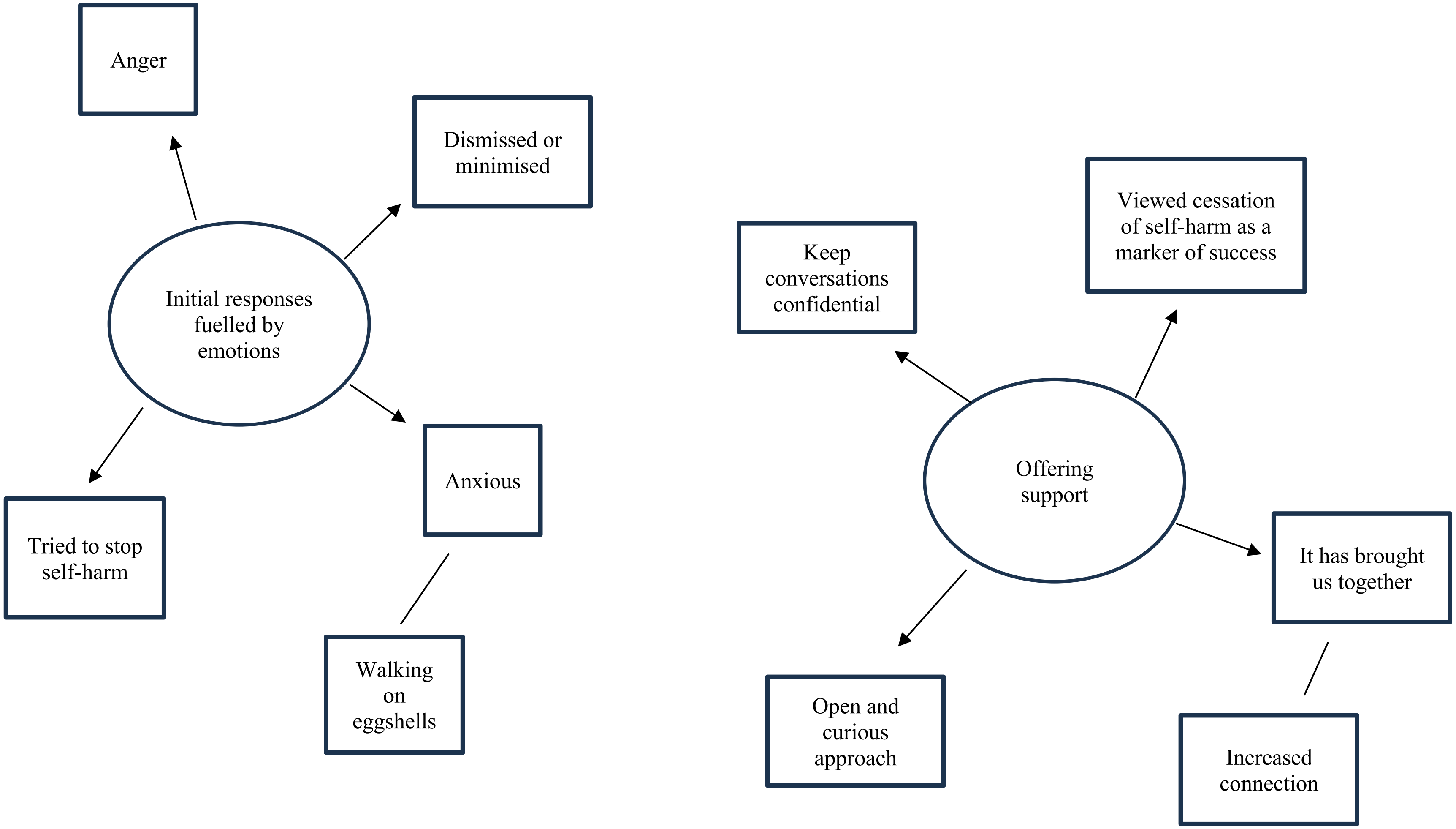


Figure 3

Example map showing two analytical themes



Appendix 1-A - Example of analytic process

Partial extract from analysis of Theme two: The importance of a calm façade

Study (study number)	**Original theme** *Original subtheme*	**Original quotes**	**Line by line coding**	**Descriptive themes** *Subgrouping*	**Analytical themes**
Parents' attitudes toward and experiences of NSSI in adolescents – A qualitative study (S6)	The impacts on family *Altered parenting and communication styles*	Some parents reported being more patient with and paying more attention to their children. (p.5)	Importance of patience Change to parenting style	Staying calm *Calm parenting* Modified parental behaviour	The importance of a calm façade Modifying my approach and our relationship
Parents' experiences of NSSI among adolescents and young adults (S7)	Parents' perceived helpfulness *Talking, listening, and being non-judgemental*	The most common theme, reported by nine parents (56.3 %), was talking to their adolescent and listening to what they had to say while remaining calm and non-judgmental. (p.3409)	Importance of listening to young person Staying calm and non-judgemental	Provide support *Talking to/reaching out* Staying calm *Presented a calm front*	Offering support The importance of a calm façade
Parents' experiences of NSSI among adolescents and young adults (S7)	Parents' perceived helpfulness *Talking, listening, and being non-judgemental*	Nevertheless, remaining calm in the face of NSSI is challenging for parents, as one mother of a 17-year-old states: "I have found it very hard trying to stay calm and being positive while my daughter suffered self-harm." (p.3409)	Importance of remaining calm Calm isn't easy	Staying calm *Importance of staying calm* Staying calm *Not easy!*	The importance of a calm façade The importance of a calm façade

Adolescent self-harm: Parents’ experiences of supporting their child and help-seeking (S1)	An emotional journey into the dark unknown	Parents reported a range of initial feelings and responses including distress, shock, anger and confusion while also trying to remain calm. (p.12)	Shock, anger, confusion in initial responses	Emotional reactions *Shock, anger*	Initial responses fuelled by emotions
			Tried to remain calm	Staying calm *Presented a calm front*	The importance of a calm façade
Adolescent self-harm: Parents’ experiences of supporting their child and help-seeking (S1)	An emotional journey into the dark unknown	A number of parents also shared how they tried to manage their initial reactions in front of their child despite strong internal feelings: “I went and talked to my daughter told her I loved her and went away and cried hysterically for an hour.” (Cass). (p.7)	Trying to remain calm but not feeling this inside	Staying calm *Presented a calm front*	The importance of a calm façade
			Feeling upset	Emotional reactions *Upset*	Initial responses fuelled by emotions
Adolescent self-harm: Parents’ experiences of supporting their child and help-seeking (S1)	An emotional journey into the dark unknown	“Inside my heart broke. Outside I tried to quietly and calmly speak to my daughter about where the blood came from”. (Elizabeth). (p.7)	Feeling heartbroken inside	Emotional reactions *Upset*	Initial responses fuelled by emotions
			Staying calm when talking to daughter	Staying calm *Presented a calm front*	The importance of a calm façade
Adolescent self-harm: Parents’ experiences of supporting their child and help-seeking (S1)	An emotional journey into the dark unknown	“I’m not an angry person but I was angry at him and wanted to grab him and say “What the hell are you doing?” and insist he stop doing it but I knew I needed to stay calm.” (Jane). (p.6)	Angry reaction Wanted to demand he stopped self-harming	Emotional reactions *Anger*	Initial responses fuelled by emotions
			Noted importance of appearing calm	Staying calm *Importance of a calm presentation*	The importance of a calm façade

An exploration of the impact of self-harm in an inpatient adolescent setting on staff: A qualitative study (S2)	The personal impact: Feeling responsible	Participants adopted a parent-like position, containing the young person's emotions and consciously avoiding showing their own emotions, mindful of how their own response might affect the young people. (p.4)	Contained young person's emotions Pull to step into parenting role	Provide support *Dismissed own feelings*	Offering support
			Noting important of concealing their own responses	*Dismissed own feelings*	Offering support
			Needing to appear calm to young person	Staying calm *Importance of a calm presentation*	The importance of a calm façade

Appendix 1-B – Author Guidelines for Clinical Child Psychology and Psychiatry Journal

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The Editor will screen manuscripts for their overall fit with the aims and scope of the journal, especially in terms of having clear relevance for clinicians. Those that fit will be further reviewed by two or more independent reviewers in terms of merit, readability and interest.

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For journal queries: ccp@sagepub.com

Section Two: Research Paper

Clinical psychologists' experiences of negotiating dual identities as mental health service users and service providers

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Prepared for submission to Psychology and Psychotherapy: Theory, Research, and Practice Journal

(Author Guidelines are shown in Appendix 2-E)

Abstract

Objectives: Clinical psychologists report high rates of mental health difficulties. However, stigma within the profession is high, leaving many concealing these experiences. This research explores the experiences of UK clinical psychologists in navigating dual identities as mental health service users and service providers.

Design: Twelve clinical psychologists took part in semi-structured interviews exploring their narratives of navigating dual identity.

Method: Participants took part in a narrative interview, which was audio-recorded, transcribed verbatim, and analysed using narrative analysis.

Results: The analysis resulted in the development of five themes. The narratives move from the Prologue: Developing Dual Identities; through to Chapter One: Separation of Identities; Chapter Two: Negotiation of Identities; Chapter Three: Co-Existence of Identities; and an Epilogue: Looking Forward.

Conclusions: This research explored how clinical psychologists negotiate dual identities as mental health service users and service providers. This included initial separation of identities, often due to stigma, and community expectations placed on the service provider role. Participants negotiated identities by prioritising one identity and reframing their service user identity as 'human'. Participants settled at different end points of their negotiation, ranging from separate but alongside each other, to both identities fully integrated.

Keywords: dual identity, clinical psychologist, lived experience, identity negotiation, stigma.

Prevalence of dual identity

Studies suggest that the prevalence of mental health difficulties amongst clinical psychologists is high, with reported rates between 63-82% (Grice et al., 2018; Tay et al., 2018; Victor et al., 2022). However, studies are often based on small, self-selecting samples (Tay et al., 2018). The definition of 'mental health difficulties' also varies between studies (Smith & Moss, 2009), with some measuring this through use of diagnosis or outcome measure score, and some utilising self-diagnosis, making generalisability difficult.

Many studies focus on experiences of accessing personal therapy (e.g., Wilson et al., 2015). However, this may not necessarily indicate mental health difficulties or even psychological distress, as many professions require practitioners to access their own personal therapy or clinicians may access therapy for personal or professional growth (Daw & Joseph, 2007). Causality is often not considered, i.e., whether historic mental health difficulties were a motivator for pursuing a career in mental health (Barnett, 2007) or if the difficulties are a result of the pressure and vicarious trauma from working in these services (Cooke & Watts, 2016; Hannigan et al., 2004; Makadia et al., 2017). Stigma towards mental health difficulties is prevalent in mental health staff (Servais & Saunders, 2007), potentially hindering research participation.

Some UK qualified clinical psychologists have shared their experience of mental health difficulties, including Emma Harding (2010), Anonymous (2016), Jamie Hacker-Hughes (2016), and the in2gr8mentalhealth (2020) video series "In conversation with…". Few published accounts exist from trainee clinical psychologists or those in pre-training roles, and those that do are typically anonymous (for example, Anonymous, 2018; SA, 2018). Recently, the British Psychological Society (BPS) published guidance on supporting trainees with lived experience (BPS, 2020), and the Division of Clinical Psychology (DCP) published a briefing paper on clinical psychologists with experience of mental health difficulties (Hogg & Kemp, 2020), signalling a move towards valuing dual identity within clinical psychology.

A note on terminology

For this paper, the term ‘mental health difficulties’ includes both diagnosed and undiagnosed difficulties. This has been chosen to reduce perpetuation of stigma experienced by participants (Granello & Gibbs, 2016; Tyler, 2020) and the focus on clinical psychologists who are less likely to use diagnostic terms (DCP, 2013; Randall & Coles, 2018).

There is a lack of consistent terminology to refer to mental health clinicians with personal experience of mental health difficulties. Snow (2002) suggests that the lack of a common language is a consequence of the ‘us-and-them’ discourse which renders a ‘both’ position invisible. Previous terms have included ‘wounded healer’ (Jung, 1951), i.e., one who uses their wounds for healing, or ‘impaired professional’ (Jackson & Ta, 2001), i.e., one whose wounds have a negative impact on their work. Huss (2020) notes the shift in language for the latter, whereby their wounds have precluded them from being described as a ‘healer’. To avoid the duality of these two positions, the terms ‘dual identity’ or having ‘dual experience’ have been utilised.

‘Patient’ has been used as it is reported to be the preferred term of individuals accessing mental health services (Simmons et al., 2018) and is suggested to provide parity of esteem with physical healthcare patients (Priebe, 2021).

Benefits of dual identity

There is emerging evidence of benefits to clinical practice from dual identity, including increased compassion and understanding towards patients (Richards et al., 2016) and an appreciation for the commitment and energy required to engage in psychotherapy (Oates, 2017). Personal experience of accessing services may also help clinicians to be more aware of the power imbalance inherent in the therapeutic relationship and avoid behaviours that further this imbalance (Adame et al., 2017). Sharing experience of dual identity challenges the ‘us-and-them’ dichotomy within both mental health services (Wasyliw, 2014) and society (Pilgrim, 2017). Clinicians with dual identity report feeling more able to engage in positive social action at both an individual and a wider level (Richards et al., 2016) and that their professional training helps them to understand their own experiences of distress (Gilbert & Stickley, 2012).

Sharing or concealing dual identity

Whilst dual identity amongst clinical psychologists may be high, disclosure and openness about these difficulties is low (Grice et al., 2018). Stigma linked to mental health difficulties is high amongst psychologists (Cain, 2000) and may lead clinicians to conceal their service user identity due to fears about judgement from colleagues (Waugh et al., 2017), professional competence (Zamir, 2022), or disciplinary action from a regulatory body (Lovell et al., 2020). Stigma could be due to community messages suggesting that it is not acceptable to need personal support as a psychologist (Charlemagne-Odle et al., 2014). This may be key when considering UK clinical psychology as it is not a requirement to access personal therapy, subtly suggesting that clinical psychologists are different from the patients they work with (Davidson & Patel, 2009). UK clinical psychology training has been described as implicitly stigmatising, with messages from the wider psychology community suggesting that trainees need to be “in perfect mental health” (Willets, 2018, p.90). Mental health training can create a myth of therapists being “immortal and invulnerable” (Pope et al., 2006, p.21) and contribute to a dualistic perspective on wellbeing (Good et al., 2009). Positioning themselves within an ‘us-and-them’ dichotomy may be protective for therapists (Maccallum, 2002), but creates a barrier to disclosing experiences that place them within the ‘other’ group. As described by a trainee clinical psychologist: “The implication that we must be either, not both, is pervasive, unaddressed, and exhausting.” (Rhinehart et al., 2020, p.74). In addition, disclosures of dual identity within clinical psychology generally come from ‘recovered’ perspectives and qualified psychologists at an established point in their career (Aina, 2015). This may leave trainees or early-career clinicians feeling unsafe disclosing experiences of current difficulties and could lead to clinicians concealing mental health difficulties and instead presenting a narrative of ‘wellness’ (Wasyliw, 2014).

Holding dual identities

When considering dual identity, it is important to consider the development of the two identities within this concept and why holding these simultaneously is challenging. UK clinical psychology training is competitive and often requires many years of applying to be successful (Clearing House for Postgraduate Courses in Clinical Psychology, 2022), signifying the high value of this identity. The selection process can encourage competitiveness and perfectionism (O’Shea & Byrne, 2010), dissuading trainees with mental health difficulties or disabilities from disclosing anything which signifies them as ‘different’ (Coop, 2018).

During training, the development of a professional identity is a key outcome, often via teaching on ‘personal and professional development’ (BPS, 2019, 2021). This professional identity is incorporated into an existing sense of self to become a member of the clinical psychologist community (Schubert et al., 2023; Tan & Campion, 2007).

Whilst a psychologist identity is desirable, mental health difficulties are conceptualised using theories of psychopathology within the dominant medical model (Held, 1991). Individuals with mental health difficulties are seen as ‘mad’ (Harper, 1995; May, 2001), needing the ‘expert’ (i.e., un-impaired) clinician to ‘fix’ them (Bassman, 1997). Although UK clinical psychology is not led by the medical model, the scientist-practitioner model used may implicitly support an ‘us-and-them’ dichotomy by creating an unequal hierarchy between the therapist as the ‘expert’ and the patient as the ‘help-seeker’ (Spence et al., 2014). Reconciling these identities may be challenging due to the power difference between the two identities (Sampson, 1993).

Navigating multiple identities that intersect and potentially conflict with each other is a complex process (Cerezo et al., 2020). If perceived important identities are incongruent, then a conflict or identity gap can arise (Jung & Hecht, 2004). The Communication Theory of Identity (CTI) focuses on the communicative negotiation of identity and proposes that identity is composed of four interconnected layers or frames: 1) the personal frame is identity as perceived and defined by the individual; 2) the enacted frame is how the identity is shown in social interactions; 3) the relational frame is aspects of identity shaped by social relationships or relationships among different identities; and 4) the communal frame is the identity from belonging to a certain group (Faulkner & Hecht, 2006, 2011). These frames are not independent, but instead intersect, e.g., an individual's personal identity cannot be examined without considering how society and others view this identity. Applying the CTI to dual identity could include conceptualising the *personal frame* as including individual qualities and attitudes relevant to an individual's self-concept as a clinical psychologist or service user; the *enacted frame* representing how an individual communicates their dual identity; the *relational frame* as the relationship between service user and clinical psychologist identities; and the *communal frame* representing the identity and belonging held within the dual identity community.

Jung and Hecht (2004) propose that identity gaps occur when there are discrepancies between the identity frames, such as when they contradict or exclude each other. Consequences of gaps include concealment (Wagner et al., 2016), depression (Jung et al., 2007), and feeling inauthentic (Newheiser & Barreto, 2014). Individuals negotiate these gaps through compartmentalisation, ignoring the gap, reconciling the gap (Trinh & Faulkner, 2023), or bridging the gap through renegotiation (Kuiper, 2023). We can consider dual identity within the identity gaps which can potentially form from holding these two identities. For example, a *personal-communal gap* arising from the personal identity of being someone with mental health difficulties alongside the societal and peer expectations of a clinical psychologist being resilient and mentally well.

Integrating these identities can lead to reduced identity stress, increased social support and community belonging (Wedow et al., 2017). Trinh and Faulkner (2023) propose that individuals could reconcile the gap using either internal resolution or self-advocacy. Considering dual identity, self-advocacy could occur through disclosing dual identity to a colleague (relational frame) or through publishing experiences of dual identity (communal frame).

Rationale for the Current Research

Studies exploring the experiences of clinicians navigating dual roles as service user and clinician are limited. Nikolopoulou (2016) studied counselling psychology trainees integrating identities as both a trainee and a client, including considering how trainees make sense of their own experiences of vulnerability in relation to their professional identity. However, counselling psychology trainees are required to attend their own therapy as part of training, so participants in this study may not necessarily identify as mental health service users. Richards et al. (2016) explored how mental health professionals from various disciplines constructed dual identities and found participants often constructed separate identities as ‘professional’ and ‘patient’. Participants spoke about the value of an ‘integrated’ identity as being the most helpful approach, though recognised the difficulty in achieving this.

This study builds on Richards and colleagues’ 2016 study by utilising narrative analysis to explore the experiences of clinical psychologists negotiating dual identities as both service user and service provider. There is sufficient difference across mental health professions to warrant specific attention to disciplines (Snell et al., 2020), therefore this study focuses specifically on UK clinical psychologists, offering the opportunity to place participants' narratives within a similar context.

Identity negotiation in this study is conceptualised using the CTI as it proposes that identity frames are dynamic and overlapping, and identity is relational, negotiable, and adjustable: different situations (such as beginning clinical training) may provoke opposing dialectical tensions which lead to identity negotiation (Hecht et al., 2019; Kuiper, 2023).

Directives for psychologists (BPS, 2021; Health and Care Professionals Council, 2023) advise to monitor their own mental health. Stigma may be a barrier to seeking help, suggesting a need for studies to explore how psychologists navigate these experiences. Initiatives such as Honest, Open, Proud (Scior et al., 2019) and the in2gr8mentalhealth forum are actively trying to reduce stigma associated with dual identity. This study may have relevance in supporting these initiatives, as well as for clinicians with dual identities, and training courses and supervisors in considering how dual identities may be negotiated and supported.

Method

Design

Narrative analysis has been chosen as the analytical approach as it facilitates an in-depth exploration of how participants view themselves within their story (Creswell, 2012). Narrative analysis also considers the influence of cultural and socio-political factors (Weatherhead, 2011), both of which are linked to stigma and identity development (Abdullah & Brown, 2011). Narrative analysis and CTI may be particularly well-suited as both consider meaning making being influenced by both the internal voice and the socially situated context of that voice. This is particularly relevant to dual identity research due to the influence of stigma originating from cultural and professional attitudes towards mental health difficulties.

Additionally, narrative analysis is often used to provide a voice to excluded groups (Endo, Reece-Miller & Santavicca, 2010), and intends to avoid ‘othering’ of participants (Ballantine, 2022), a key attitude when interviewing participants with experience of mental health difficulties, who frequently experience ‘othering’.

Epistemology and Reflexivity

In narrative analysis, the researcher is unavoidably involved in the co-construction of narratives (Riessman, 2008), and epistemology should therefore be considered (Willig, 2021). This research aimed to explore the intra-psychic negotiation of identity, while assuming that the experience of these internal worlds is shaped and influenced by external social constructs, institutions, and contexts. This suggests a social constructionist epistemological stance (Willig, 2021). However, the research assumes that an internal world does exist, and accepting the experience of a subjective reality influenced by social and cultural contexts brings a critical realist stance to the study (Bhaskar, 2013; Clarke et al., 2015). Viewing relativist and realist positions on a continuum rather than binary opposites (Ruttkamp-Bloem, 2015), positions this study on a critical realist epistemological position whilst acknowledging a moderate social constructionist perspective: a realist social constructionism (Elder-Vass, 2012). Both critical realism and social constructionism are compatible with narrative analysis (Silver & Willig, 2021).

The lead researcher is a female trainee clinical psychologist who identifies as holding dual identity: an ‘insider’ researcher (Kanuha, 2000). It is likely, therefore, that the research was influenced by the researcher’s experiences and views on dual identity within clinical psychology. Insider research can lead to challenges such as objectivity (Roennfeldt & Byrne, 2020), and so the researcher used a reflective diary (Ortlipp, 2008) and discussion with supervisors to ‘bracket’ their own assumptions and experiences (Berger, 2015; Tufford & Newman, 2012).

The Consolidated criteria for Reporting Qualitative research Checklist (COREQ) checklist (Tong et al., 2007) has been completed to enhance transparency (see Figure 1).

Ethics

Following ethical approval from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University, the study was advertised on Twitter and Facebook using the lead researcher's account, and by word-of-mouth. Social media has previously been used successfully to recruit participants from stigmatised groups (Moreno & Bull, 2014). Once potential participants contacted the researcher, the research was discussed, and a copy of the information sheet and a consent form (detailed in Section 4) were provided. Potential participants were assessed against the inclusion criteria:

- HCPC-registered UK-based clinical psychologists.
- Have been employed as a clinical psychologist for at least one year in at least one role in the two years prior to taking part in the study.
- Self-identify as being a service user or an ex-service user of mental health services based in the NHS, third sector, and/or private sector.

Participants

Twelve clinical psychologists (eleven females, one male) participated in the study. Their ages ranged from 30 to 52 years (mean=37 years). A small sample size of a maximum of twelve participants was chosen as it was felt that this would provide sufficiently rich data for a detailed interpretative account. Participant demographic information is provided in Table 1.

Data collection

Data was collected using one-to-one semi-structured interviews (Hiles & Cermák, 2008) with the lead researcher. Three interviews were conducted in-person at the participants' place of work, and nine were conducted using Skype. The interview schedule (Appendix 2-

A) was designed to be ‘lightly structured’ to avoid the researcher dictating or imposing a structure that might hinder participants’ responses (Willig, 2021). The schedule was informed by previous qualitative studies looking at clinicians’ experiences of identity development (for example, Harvey, 2017; Tarik, 2017), and received input from two qualified clinical psychologists with dual experience. The schedule began with an open question to provide a narrative opportunity (Riessman, 2008): “To begin, please could you tell me about your experience of developing identities as both a mental health service user and a service provider, and your experience of negotiating both of these identities?”

Analysis

This research drew upon the narrative analysis frameworks suggested by Crossley (2000) and Weatherhead (2011). Analysis was carried out by the lead researcher. Interviews were audio-recorded, and pseudonyms applied. Interviews were transcribed verbatim by the lead research or a professional transcriber. Externally transcribed interviews were quality checked by the lead researcher.

Stories were re-ordered into a chronological sequence to create a summary story highlighting the core elements of the story told (Crossley, 2000; see example in Appendix 2-B). Ten participants requested to receive their summary story, with one requesting minor changes. Transcripts were imported into NVivo and reviewed in-depth by identifying narrative concepts such as life chapters and characters (Crossley, 2000) and the lead researcher’s reflections on narratives. Table 2 provides an example of how data was organised for each narrative, and Table 3 provides a summary of each narrative. Each transcript was then coded individually, noting content and underlying themes. Patterns and connections across themes were then identified (Crossley, 2000). An excerpt of an interview transcript demonstrating line-by-line and focused coding can be seen in Appendix 2-C. Attention was paid to the progression of themes within narratives (Squire, 2013) to identify overarching themes in each chapter that helped illuminate how participants negotiated dual identity. For an example of a thematic map see Appendix 2-D. The analysis and themes were discussed with the project supervisors to support validity.

Results

Chapters developed from the participant narratives are outlined below. The narratives moved from the Prologue, through to Chapter One: Separation of Identities, Chapter Two: Negotiation of Identities, Chapter Three: Co-Existence of Identities, and an Epilogue. A visual representation is shown in Figure 2.

Prologue: Developing Dual Identities

Most participants had been service users prior to becoming clinical psychologists, accessing services as adolescents or during early service provider roles, such as healthcare assistants or assistant psychologists. Their experience of services was often a motivator to pursue a career in mental health: "…having experienced how helpful it was to be heard…that felt very powerful…I thought, that I would really like to be able to offer that to people in the future." (Naomi). Unhelpful experiences or difficulties accessing services were also motivators: "I think wanting to help, knowing how awful it was, how alone I felt, wanting to give people a different experience." (Amber).

Three participants (Susan, Elena, and Harriet) had been in-training or qualified as a clinical psychologist prior to accessing services.

Chapter One: Separation of Identities

After developing dual identities, this chapter represents participants' initial challenge with this, including the pressure which led to a perceived incompatibility with holding both identities, and the resulting separation of identities.

Expectations of Service Provider Role

Participants felt that there was a societal expectation that service providers were seen as not having experienced distress: "I felt that was not encouraged by society at all, I felt I had to be strong and knowledgeable and this perfect little cardboard cut-out of a person" (Mary). Participants perceived the UK clinical psychology community to encourage this expectation: "We have this idea of the scientist-practitioner, and that went along with this empiricist, this highly competent practitioner, and highly competent practitioners don't ever get unwell or experience distress." (Isabelle). The lack of a requirement for personal therapy as part of clinical psychology training was also seen to perpetuate this expectation: "*[sarcastic]*…we don't need to have therapy during training because clearly none of us had any personal issues that need to be thought about" (Beth). This perceived incompatibility was also voiced by other students: "…one of the women in my cohort said that it's a really bad idea for people who have had difficulties to go and help other people" (Adam).

Participants also internalised these expectations, often at a young age: "I remember as a 16-year-old thinking, 'I'm not going to get to do [clinical psychology] because I have mental problems." (Naomi), but also post-qualification: "Being a psychologist is a huge part of my identity and I do hold that perception sometimes that other people should think that I'm okay, that I'm completely sorted." (Skye). Susan worried about whether being a service user would affect applications for qualified roles: "I worried that they would see that I've had my own therapy, there would be other candidates who hadn't and so they would be preferential to someone who's seen as mentally weaker.". Stigma held towards service users was also internalised: "I think it is so in-built…like an internal 'us-and-them'." (Beth).

Participants compared their experiences and hopes for their future against this expectation, leading to shame that they did not meet it: "It just became this shameful part of me that had to be pushed down and not really spoken about." (Laura). Skye described how this shame had affected her: “I have just carried a lot of shame and a lot of guilt. And it’s really fed into my sense of failure, and being a fraud, being an imposter.”

Separation and Concealment

Participants realised there was a perceived discordance between their experience of mental health services and clinical psychology training: “When I was becoming a clinical psychologist, I don’t think there was much possibility of having an identity of being a service user at the same time.” (Harriet). They distanced themselves from their experiences: “I was quite desperate not to be seen as a mental health service user, because I very much wanted to be a psychologist.” (Isabelle). This distance became a conscious separation of their identity as a mental health service user and service provider: “I had this story of it doesn’t come into me as a psychologist, it’s totally separate to me who experiences x, y, z.” (Laura). The separation often developed into concealing their service user identity: “…with the idea of getting onto training, I was like, I’ve got to keep this shit hidden.” (Mary). Isabelle felt that it had to be hidden at all costs, including refusing treatment following attempts to end her life:

> …I removed myself [from hospital] extremely quickly as soon as I was physically able to because I absolutely wanted to be a psychologist and I wouldn’t have any mental health team asking me any questions that might lead to somebody saying you’re not going to be able to apply for that doctorate.

Isabelle and Laura characterised the training course as omniscient, with the power to reveal their service user identity: “In the back of my mind, you may not be allowed to pursue this if anybody accesses your medical records, if anybody digs too deeply.” (Isabelle), “I remember…being absolutely terrified that someone would see or know or would just somehow crack my secrets.” (Laura). They feared that their training place could be removed if they were uncovered as a service user: “There is always a fear…something that you have strived to all your life to get to could be removed from you.” (Isabelle). Participants dealt with this fear in different ways, including distancing themselves from their cohort to avoid accidentally revealing their other identity (Isabelle, Laura), or striving: “I felt like that meant I had to be the perfect trainee and work really hard and not do anything wrong, not struggle with anything.” (Skye). For Kate, it felt more palatable to reframe her therapy as professional development: “I told my clinical tutor, I’ve started going to therapy, just as part of my development rather than having to admit that maybe I was quite distressed at that time.”

Chapter Two: Negotiation of Identities

Following separation of identities, this chapter explores participants’ experiences of negotiating between the identities. This negotiation often began with prioritising their service provider identity.

Prioritising Service Provider Identity

When the separation occurred, participants usually hid their service user identity and prioritised their service provider identity: “…the clinical psychology interviews, I kept it really separate, I didn’t put it down…I felt like I had to deny the service user identity and portray this coping professional.” (Laura). When accessing therapy, some participants found that their service provider identity pushed to the forefront:

> When I’m in the room, that’s when the psychologist part is resisting staying at the door because it wants to understand the formulation…but then it doesn’t allow me to let the emotions come up because it’s like my professional identity. (Naomi)

Often, other professionals prioritised participants’ service provider identity. Susan found it natural to step away from her service provider identity when she accessed mental health services, however her therapist felt unable to ignore that identity:

> One of the counsellors actually finished a session with me and then asked for a bit of advice about another client she was seeing. I remember thinking, that’s not what I’m

> supposed to be here for! It felt like she had crossed something and blurred those two identities where I had been happy to keep them very distinct from each other.

Prioritising Service User Identity

At other times, participants prioritised their service user identity: “I’m giving more attention to the lived experience part, the distressed part of me” (Harriet). For Mary, this was a conscious choice: “I have to put down this professional identity for a bit and let go of this idea of me as this strong, professional person, and actually just focus on allowing myself to heal while I need to.”. Changing priorities often resulted from suppressing their service user identity. This was particularly true following difficult life events, as described by Susan: “…my anxiety was so intense…there wasn’t really space for me as a mental health professional in those times.” Many participants characterised their service user identity as fragile and needing nurturing: “…it’s like a vulnerable part of me that I’m now taking care of, rather than just letting sit in the dark on their own.” (Kate). For Mary, even though it was often a conscious choice to prioritise her service user identity, it wasn’t always an easy process as this opened her up to sitting with a less secure identity: “It can be pretty scary to do because the professional identity is a lot less vulnerable than the service user identity; it gives me a lot more standing in society.”

Many participants disliked the term ‘service user’ and part of inhabiting and healing this identity involved reframing it as human suffering: “As time has evolved, I identify less with being a mental health service user. I think that identity has evolved…I see suffering as part of human experience.” (Naomi). For Mary, it was important to understand her service user identity as “humanness” and to root its origins in distress rather than service use: “It was borne out of pain rather than trying to treat that pain”. She later referred to this identity as her “wounded identity”. Reframing the service user identity as the universal nature of human suffering helped to sow seeds of co-existence between the identities: “I am bringing those parts of me together, the whole human being who's experienced the wonderfulness and the horrendous of life." (Skye), a view echoed by Adam: "…it was my integration as a human being and those two aspects are elements that integrated along with everything else."

However, Mary and Amber needed to completely reject their service provider identity in order to look after their service user identity:

> [I] eventually reached a place where I un-chose psychology as my identity, I just thought that…I can't hold it together with my own identity struggles and my own pain…I decided that I wasn't going to be a clinical psychologist. (Mary)

Later in training, Mary re-chose a service provider identity training from a more integrated position: "I re-selected that identity…from a very different position, a position of somebody who was more embracing who I am, not having to hide it away anymore." Conversely, Amber found that training as a family therapist allowed her to feel more comfortable with her dual identity: "I probably identify more as a family therapist because it's so much more accepted to be human and have difficulties."

Chapter Three: Co-Existence of Identities

After a period of negotiating these two identities, participants identified a desire for the identities to co-exist. Co-existence meant different things to participants, with some wanting their identities to be separate but alongside each other, and some desiring them to be integrated. These subthemes are split into participants, but it is important to note that this is where participants were at the time of the interview. Many participants noted that negotiation was a dynamic process and they shifted between different positions over time. Participants often reflected on their shifting position in response to receiving their summary story.

Identities Sitting Alongside Each Other (Susan)

Susan chose for her identities to be separate but next to each other: "In terms of my whole identity, I do keep [dual identities] very separate and that works for me.". Susan made this decision as she felt it allowed her to prioritise both roles: "…be the best clinical psychologist I can be and also access the best support I need…by just being a service user or just being a clinical psychologist, not being the combination.". For Susan, this was an important act of self-care, ensuring that she could access support when needed: "I wouldn't want anybody to not reach out to support, to think, oh she won't need it because she's a clinical psychologist."

Partially Integrated, Partially Fragmented (Beth, Elena, Harriet)

These participants characterised their dual identities as being partially integrated, but still separate. Beth and Harriet described dual identity as uncomfortable. Harriet felt that due to the personal nature of her service user identity, it did not always feel comfortable or appropriate to bring it into her service provider role. Elena experienced integration when she was carrying out clinical work, but her identities felt fragmented when she was with other clinical psychologists. This was also reflected by Beth and Harriet who had made contact with other dual identity practitioners but remained on the edges.

Integration of Identities (Adam, Amber, Isabelle, Kate, Laura, Mary, Naomi, Skye)

Many participants spoke about their dual identities feeling integrated, using phrases such as "intertwined" (Adam), "in harmony" (Kate), and "at peace" (Naomi). Isabelle and Naomi found clinical psychology training helped to understand their own experiences and this increased understanding facilitated greater compassion for their own distress and hope that these identities can coexist. This led to reduced internal stigma: "…there's something about the process of moving from my shame to being proud of it." (Kate). Participants acknowledged the experiences leading to a service user identity needed to be processed: "It took a long time for me to be able to process my personal pain enough to get to the point that they could slot in together and actually become integrated." (Mary).

Participants spoke about the two identities feeding into each other. Many felt that their service user identity enriched their service provider identity: “I came to realise that actually there are, not silver linings, but so many important points about my experiences that help me to be the psychologist that I am.” (Laura). This enrichment included an awareness of what it was like to be a client (Adam, Isabelle, Naomi, Skye), keeping them grounded (Kate), feeling more able to sit alongside pain (Amber, Mary), and disclosing aspects of their experiences to clients (Amber, Laura). Participants felt cautious about over-identifying with clients, and some felt that their service user identity inevitably restricted potential employment roles due to wanting distance from their own experiences.

Participants also noted the effect their service provider identity had on their service user identity, including an awareness of their own wellbeing. Mary reflected that her service provider identity gave her strength and purpose and helped to channel using her wounds for good: “I think if all I had was a wounded identity, then life would be a lot trickier.” Amber, who had chosen to work in the same field as her own experiences, felt that her service provider identity was protective: “There’s something about working [in this area] that makes you so resistant, it reminds you of the pain, that keeps you away from it again.” However, she did note that this added pressure to ‘stay well’, and the potential to experience difficulties was again framed within ‘being human’: “I am adamant now that I’ll never become unwell again, but how helpful is that because I’m human.”

Epilogue: Looking Forward

The epilogue describes the hopes participants had for holding dual identities, both for themselves but also for the wider clinical psychology community. Some participants had begun identifying with the dual identity community, and how helpful this was: “I’m able to see that I am part of a group, it’s not just me.” (Kate). Many participants remarked on the need for dual identity role models in clinical psychology: “Having people like Jay

Watts…people like that who are really inspirational, they make me think we should own this, this is a positive.” (Laura). Harriet noted the importance of sharing experiences which were not polished: “Everyone views it from a position of recovery, there’s not many people going, well today I completely screwed up everything.”

Other participants communicated their dual identity with colleagues or patients and had generally received positive reactions. There was often a sense of wanting to bring their identity out into the open: “Part of me just wants to out myself and be like, ‘This is me, this is my experience’.” (Amber).

Participants noted a shift in attitude towards dual identity within clinical psychology which provided hope: “It was just really, weirdly nice, to see people talking about their experiences, I want things to be different.” (Laura). However, participants were keen for this shift not to become tokenistic: “It’s all very well having a session on dual identity [in clinical training], but if you’re in the background suggesting that they might not be resilient, we’ve got to get the balance right.” (Isabelle).

Discussion

Main findings

This study aimed to explore clinical psychologists’ experiences of navigating dual identities as both service user and service provider. The overarching arc of the narratives for participants is of initial separation of the identities and a negotiation towards co-existence, although participants settled at different stages within this (see Figure 2).

Identity gaps

When participants began holding two identities, they experienced a conflict between these identities. This description fits with Jung and Hecht’s (2004) construct of ‘identity gaps’, highlighting participants’ difficulties in reconciling the idea of being both a service user and service provider. Trinh and Faulkner (2023) built upon the CTI by interviewing

LGBTQ+ college students about their experiences of negotiating identity gaps. They identified three identity negotiation strategies to manage these gaps: identity compartmentalisation, gap reconciliation, and ignoring the gap. Their model of these strategies is shown in Figure 3. Participants' narrative chapters are considered within this model.

Identity concealment

Identity concealment is one of the components of the identity compartmentalisation strategy (Trinh & Faulkner, 2023) and participants went to great lengths to conceal this identity, particularly in pre-training roles. Whilst participants in Trinh and Faulkner's (2023) study cited interpersonal relationships as the main motivator for concealing a perceived undesirable identity, participants were motivated by wanting to achieve a goal of a place on a training programme or maintaining their career as a psychologist. Even when participants had reached a point of integration, many continued to conceal dual identity in the presence of other clinical psychologists, indicating the depth of stigma within the clinical psychology community.

Shame was a driving force for participants to hide their service user identity, and this mirrors stigmatising views towards mental health difficulties held by the public (Schomerus et al., 2012) and healthcare professionals (Corker et al., 2018). Good et al. (2009) propose that shame around help-seeking is magnified in psychologists and impacts on both personal and professional aspects of their identity, with Davies et al. (2023) noting that clinical psychology trainers felt shame about distress they feel they "should not" experience as psychologists (p.6). Internalised shame about service user identities could have clinical implications if this leads to discomfort when working with patients with similar presentations (Ruttan et al., 2015), as they may manage this by stepping further into their professional identity, therefore widening the gap between service users and service providers (Adame et al., 2017).

Prioritising one identity

Trinh and Faulkner (2023) suggest that identity prioritisation may be key for complex identity gaps to avoid intrapersonal consequences. Practitioners with dual identity are at the intersection of personal-communal CTI frames, as described by Adame and colleagues (2017): “Survivor-therapists are in an unusual position of having been both marginalised and granted professional authority within the same institutional system.” (p.79). When participants felt shame about their service user identity, they instead prioritised their service provider identity. Goffman (1963, p.42) proposed that “passing” serves dual purposes of hiding the stigmatised identity whilst also claiming membership of a more desirable social group to avoid the negative consequences of this stigmatised identity.

Service users have historically been placed into passive, disempowered roles (Lammers & Happell, 2003) and are likely to be defined and overshadowed by these identities (DeRuysscher et al., 2019). In contrast, service providers are perceived as knowledgeable, competent, and powerful (Richards et al., 2016). The highly competitive nature of UK clinical psychology training promotes a perfectionist and striving culture (Golding, 2018) with a narrative that only the best and strongest can get onto training (O’Shea & Byrne, 2010). This narrative creates clinical psychology as a highly desirable identity, further fuelling the prioritisation of participants’ service provider identity.

In the long-term, concealment of a stigmatised identity is likely to lead to psychological stress (Lloren & Parini, 2017). Concealing or suppressing their service user identity drew parallels with how participants were treated within mental health services where service users are often powerless, having to ‘comply’ with the treatment prescribed by those in power (Fisher, 2023). Participants shifted to prioritising their service user identity within a ‘personal recovery’ narrative, which is in keeping with narratives from Richards and colleagues’ (2016) study. However, not all participants supported a recovery narrative. Harriet noted dual identity narratives in clinical psychology were often “clean” or framed from a “position of recovery”, which did not allow for space for those who were experiencing ongoing difficulties. The recovery model has been proposed to reduce service users to a ‘recovered ideal’ (Gupta et al., 2023). Reframing service user identity within the universality of human suffering was more palatable for participants, possibly due to UK clinical psychology being aligned with a non-diagnostic framework (DCP, 2013).

Separated or partially integrated identities

Susan chose to keep her identities separate but alongside each other, mirroring participants in Richards and colleagues’ (2016) study, who described ‘unintegrated’ identities and chose to switch between ‘professional’ and ‘patient’. This fits with the ‘ignoring the gap’ process in Trinh and Faulkner’s (2023) model, which proposes that identity gaps can be ignored if individuals feel there is a threat to their well-being by negotiating it (Hirsh & Kang, 2016), as Susan feared she would not receive support if she integrated her identities.

Kuiper’s (2023) description of identity bridging describes participants who chose a partially-integrated position. Kuiper (2023) builds on CTI by proposing identity bridging as an additional response to identity gaps and suggests that an identity bridge involves reducing the gap between the identity without full integration.

Integrated dual identity

Many participants constructed a new ‘integrated identity’ which included both identities, fitting with the internal resolution process of the gap reconciliation strategy (Trinh & Faulkner, 2023). Within the dual identity literature, an integrated identity is one that incorporates positive identities of ‘wounded healer’, ‘human suffering’, and authenticity (Adame et al., 2017; Perkins and Slade, 2012; Richards et al., 2016). Integrated identities are linked to greater authenticity (Ebrahimi et al., 2020) and a reduction in internalised stigma (Barlow and Grant, 2015).

Participants endorsed the narrative of lived experience enriching their service provider identity. Research evidence supporting this is less robust (Conchar & Repper, 2014), however, Zamir et al. (2022) highlighted a lack of research investigating positive effects, and Bridge (2019) notes the lack of robust research examining patients' views. A novel finding was the converse relationship of how service provider identity had a positive impact on their service user identity. Limitations and negative effects in this relationship have been documented, such as the barriers in accessing therapy as a service provider (e.g., Edwards and Crisp, 2017), however participants also discussed the protective effects, such as giving hope and meaning, and supporting self-care. One participant, Amber, cautioned that this effect could go too far and add pressure to 'stay well' in order to continue in her professional role, an experience echoed by therapists working in eating disorder services with personal histories of eating disorders (Rance et al., 2010).

Sharing dual identity

Trinh and Faulkner (2023) found that openness about stigmatised identities was influenced by interpersonal and community relationships. Participants supported this idea, noting the importance of dual identity role models in the clinical psychology community. Role models can provide examples of how to integrate dual identities (Newcomb et al., 2017). Trinh and Faulkner (2023) propose self-advocacy as a strategy to reconcile an identity gap, which would take place within the communal frame of the CTI. Participants felt that disclosing helped them to engage in activism and social change (Beagan et al., 2022) although integrating dual identities came with the risk of being excluded from service user communities (Adame, 2011; Fisher, 2023).

Clinical implications

The findings provide further support for the challenges clinical psychologists with dual identities face in negotiating these identities. The stigma within both the clinical psychology community and internalised within participants was stark, leading some participants to avoid medical treatment out of fear that this would be held against them when they applied for clinical psychology training. Clinical psychologists who share their experience of dual identity are important in reducing stigma. However, there are few examples of this, and many share from a 'recovered' perspective or avoid topics such as self-harm, psychosis, and suicidal ideation. There is a need for increased sharing, and normalisation of 'living experience' rather than polished narratives. In their guide to dual identity in clinical training courses, the BPS advocates for clinical psychology to promote a stance which normalises and values lived experience (BPS, 2020). Given the well-documented prevalence of stigma within mental health services, staff working in these services and on clinical psychology training programmes should challenge behaviour or language which perpetuates stigma or an 'us-and-them' discourse. Trainers on clinical psychology courses could also model sharing dual identity (Davies et al., 2023), though training environments need to be safe for staff to feel able to do this.

Limitations

The study has made useful contributions to an emerging research base, providing novel findings of the positive impact of participants' service provider identity on their service user identity, and the first account of UK clinical psychologists navigating dual identity.

Although the current research has made useful contributions to an emerging research base, the limitations must also be highlighted. Participants in the study volunteered to take part based on information provided about the study's focus being on dual identity. Self-selection bias may have meant that participants felt able to discuss a more integrated dual identity and saw this as important, whereas participants who were currently struggling with navigating dual identities may not have volunteered. The recruitment criteria also specified participants to be currently working as a qualified clinical psychologist, meaning that those who had left the profession due to not being able to reconcile dual identities were excluded. No criterion was placed on participants' use of mental health services, other than that they had accessed a service and self-identified as having a service user identity. This meant that participants' experience with mental health services was wide-ranging, with some participants accessing primary mental health services for less than a year and some accessing services over a period of many years or including inpatient admissions.

Whilst the lead researcher took steps to encourage open answers from participants, participants may have felt the need to conceal parts of their experience or present an edited narrative. This may have been due to stigma and UK clinical psychology being a small community of which the lead researcher is a member. Although this was not evident in the transcripts, it should be considered when assessing the credibility of the results. Interviews were conducted online and in-person, with the in-person interviews often lasting longer. This may indicate a greater level of comfort and trust when meeting, and mirrors other studies comparing the two mediums (Krouwel et al., 2019). However, given the sensitive nature of the interviews, it was important for participants to be given a choice of medium (Saarijärvi & Bratt, 2021), and to not exclude participants who could not attend an in-person interview. Furthermore, due to the sensitive nature of the experiences being discussed, participants were reminded to only share what they felt comfortable sharing, for example, some participants did not want to discuss childhood or traumatic experiences leading to the development of their service user identity. This is a limitation of the data but demonstrates a strength in the ethical approach taken.

Future Research

Participants in this study were qualified clinical psychologists and so may be at more established points in their service provider identity. Many participants were service users first, experiencing high levels of self-stigma during their pre-training and trainee roles. Research exploring trainees' experiences with dual identity, and the development of support for individuals in this category is necessary, particularly to support recruiting individuals with dual identity to clinical training.

Participants framed dual identity negotiation as dynamic and fluctuating. Research into factors that impact ongoing integration or fragmentation could help to understand the identity negotiation process further.

Data on participants' protected characteristics such as ethnicity or disability was not collected due to the potential for identification. However, it is possible that these characteristics could have influenced participants' negotiation of dual identities, and further research is needed to explore the intersection of protected characteristics with dual identity.

Conclusion

This research explored clinical psychologists' experiences of negotiating dual identity. Data was gathered from semi-structured interviews with 12 participants. Using narrative analysis, five themes were identified. Participants spoke about an initial separation of identities due to external and self-stigma, often leading to initial prioritisation of their service provider identity. Some participants reframed their service user identity as 'being human', allowing for the possibility of co-existence. Co-existence took different forms: separate but alongside; partially integrated; and integrated. The findings of this study have implications for clinical psychology training courses and individuals: if clinical psychology wants to value and support dual identity, then support and increased conversation on this topic is essential.

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Tables and Figures

Table 1

Participant demographics at time of interview

Participant (pseudonyms have been used to preserve anonymity)	**Gender**	**Years qualified**	**Current service user of mental health services at the time of the interview?**	**Length of time as a service user** (years)
Mary (P1)	Female	1	Yes	16
Susan (P2)	Female	2.5	No	6.5
Kate (P3)	Female	3	No	7
Adam (P4)	Male	4	No	7
Laura (P5)	Female	6	No	3
Beth (P6)	Female	6	No	8
Elena (P7)	Female	22	No	0.5
Isabelle (P8)	Female	3	No	0.5
Amber (P9)	Female	7	No	Not known
Naomi (P10)	Female	1	Yes	9
Skye (P11)	Female	11	No	1.5
Harriet (P12)	Female	19	Yes	3

Table 2

An example of how data was organised for each narrative

Participant	Life chapters (narrative breaks)	Personal Ideology	Significant events	Significant characters	Stresses and problems	Life theme	Negotiations of Identities	Future script
Mary (P1)	- Chapter 1: sought help following traumatic events, told "you're fine", had to accept this. - Chapter 2: breakdown, 'service user' identity and psychiatric labels done *to her*, further entrenchment of service user identity. - Chapter 3: pursued clinical psychology training, had to keep service user identity hidden, internal and community/societal expectations of service provider, sought private therapy which was helpful. - Chapter 4: rejected service	- Frustration at lip service re. dual identity in CP - Anger at silence around dual identity - My experiences of being a service user give me strength and confidence - Dual identity is a gift, brings greater depth to therapeutic work, it's a "secret weapon" and an "Achille's heel" - Dual identity separates from other CPs - Re-framing mental health	- Experienced **[redacted]** as a teenager; contact 1 with services, rejected by services - Mental health difficulties at uni; contact 2 with services, contact 3 with private service - **[redacted]**, given medication, confirmed identity as someone who needs MH services, contact 4 - Contact 5: assessed by IAPT, rejected again - Decided to train as CP, trying to understand	- Therapist 1, rejecting - Therapist 2, uni counselling - Therapist 3, private psychodynamic - Therapist 4, psychologist - Therapist 6, sought out by self whilst on training. Still therapist, significant char. She has also experienced pain - Others with dual identity give confidence that it is important to discuss this	- Medication unhelpful - Service user identity = passive, hopeless, helpless; message given by MH services - Start of aspiring CP path = start of negotiation of identities - Must keep SU identity hidden on training, referred to as "shit hidden" - Strong sense of stigma in the UK - Expectation that CPs are 'perfect' (pre-training) - CP training stressful	- Ideas/identity placed on me, e.g., diagnostic labels, or "you're fine" - Identity of someone who struggles with mental health or needs support - 'done to' by services - Psychology opens something deep inside me - Becoming somebody who experiences distress and acknowledges that and struggles with that - Why are we not more open about our own experiences? - Assume/hope people will be supportive of dual identity	- Gap between experience and "becoming" - Done to = separation from identity - Deciding to train as CP, beginning of service provider identity - Societal and internal expectations of service provider as 'together' and competent - Saying goodbye to service provider identity helpful as allowed to re-choose it rather than it being imposed; needed to make SP identity her own rather than expectations of what a CP should be - When two	- Confidence in ongoing CP work as don't have to bring defences, can work in a different way with clients - Discussions starting to happen about dual identity

	provider identity, reframed service user identity as human pain, re-chose service provider identity on her own terms. Disclosed to other trainees. - Chapter 5: holding both identities, though this ebbs and flows and requires work to keep both in balance. Hope for future with others starting to speak out about dual identity.	difficulties as pain/wounds	self - Got onto CP training - Contact 6 – sought out by self during training - Gave up service provider identity during training to prioritise self-healing		- Not everyone is supportive of dual identity - Hard to hold both identities when there is strong splitting, sense of 'us and them' - Feels risky to be the vulnerable one to step into the middle - Tension from other service users as dual identity holds power - SP identity can sometimes take over, meaning SU identity is pushed down	- Dual identity gives me a sense of integrity	identities kept separate, it doesn't work - Needed to mature in professional identity so that integration is possible - Being able to bring humanness as well as service user experience - Too focused on SP identity can leave SU identity neglected and not cared for - SP identity has public support - SU identity separates from other CPs	

Table 3

Table showing a summary of each narrative

Participant	Short summary of main narrative	Metaphor/key idea
Mary (P1)	Mary experienced having labels of 'service user' and of various psychiatric diagnoses imposed on her by others. She felt able to integrate these identities after making the choice to reject identities as a service user and then later as a service provider and re-select these identities when this was her choice.	Service user/dual identity is a gift, but it's not a free gift.
Susan (P2)	Susan accessed mental health services for the first time during clinical psychology training, and then later on following a bereavement. Susan was keen to set her service provider identity aside when accessing therapy, but her therapists found this challenging and often invited her service provider identity into the room. Susan currently keeps her identities separate but alongside each other and feels comfortable with this.	Easier to share dual identity with clients as it highlights similarities, hard to share with colleagues as it might highlight difference, which creates a distance.
Kate (P3)	Kate felt a lot of shame about accessing therapy and chose to do this privately and under the guise of 'professional development' to avoid being a service user. She initially strove to keep her identities separate, but positive experiences with other clinical psychologists have allowed her to feel proud of her experiences and have her identities sit side by side.	Sometimes accessing support felt more comfortable under guise of 'professional development'.
Adam (P4)	Adam's experience of accessing services directly led to him choosing to become a service provider, though he felt a pull to downplay these experiences early on in his training. His clinical psychology course and cohort were welcoming and supportive of dual identities and he feels that these identities are integrated and intertwined now.	Disclosure is invited, but not welcomed.
Laura (P5)	Laura wanted to be a psychologist from an early age and was spurred on in this by feeling that the whole picture was missed when she received mental health support in CAMHS and adult services. She initially strived to keep her two identities very separate and found the lack of others talking about dual identities continued that separation. Following qualifying and accessing private therapy, along with finding dual identity role models on Twitter, she made a conscious decision to bring these identities together and feels that this has enhanced her clinical practice.	Kintsugi, Japanese art of putting something back together with golden glue: brokenness becomes celebrated, more beautiful, and stronger than it was before (described by participant).
Beth (P6)	Beth's adolescent experiences of mental health services motivated her to become a service provider, however she felt an internal pressure to keep these identities very separate. Feeling more settled and confident in her service provider role has allowed for moments of integration of these identities, though these are still tentative and feel stressful.	Sleeves being rolled up bit by bit, revealing self-harm scars.
		Identities feel most

Elena (P7)	**[redacted]**	integrated during clinical work and feel most fragmented when with other clinical psychologists.
Isabelle (P8)	Isabelle wanted to be a psychologist from an early age but felt that this would be impossible due to her experience of mental health difficulties, so kept these very separate. The fear of being ‘discovered’ meant that she often prioritised the idea of getting onto clinical training over accessing support services. Clinical training provided an opportunity to consider distress from a relational perspective, which shifted the way Isabelle viewed her own experience of distress, allowing the two identities to sit alongside each other.	An underlying, lurking fear that somehow, someone would see her medical records and put a stop to her aspirations to become a psychologist.
Amber (P9)	Amber’s experience of mental health difficulties and her experience of the support she received motivated her desire to become a clinical psychologist and work in the same field that she experienced mental health difficulties in. She has found that her own experiences have become a passion and driver for her service provider role, and that her professional role is a protective factor for her service user identity.	Service provider role is protective – reminds of the pain of **[redacted]**; but also adds pressure to ‘stay well’ in order to keep job role.
Naomi (P10)	Naomi wanted to be a clinical psychologist from an early age and began accessing mental health services from adolescence. Naomi’s pre-training role was in a service which fuelled stigma and separation between two identities. Naomi felt that her clinical training reduced some of her shame linked to her service user identity, which in turn promoted integration between the two identities, but this has been difficult to maintain post-qualification.	Hard to leave the psychologist ‘at the door’ when accessing own therapy: the psychologist wants to resist being a client.
Skye (P11)	Skye’s difficult experience in CAMHS led to a hope that things could be done differently. During pre-training and trainee roles, she felt a pressure to keep her dual identity hidden and to instead appear as the ‘perfect trainee’. Following some difficult life events, she resolved to be more open and honest, allowing her to make connections with other individuals with dual identity and to bring all the human parts of herself together.	Creeping along the corridor to the staff counsellor’s room, hoping no one would see.
Harriet (P12)	**[redacted]**	Hard to know if you belong in the ‘service user’ box when you don’t know who else is in the box. Labels fit you into a box, but the box doesn’t quite fit you.

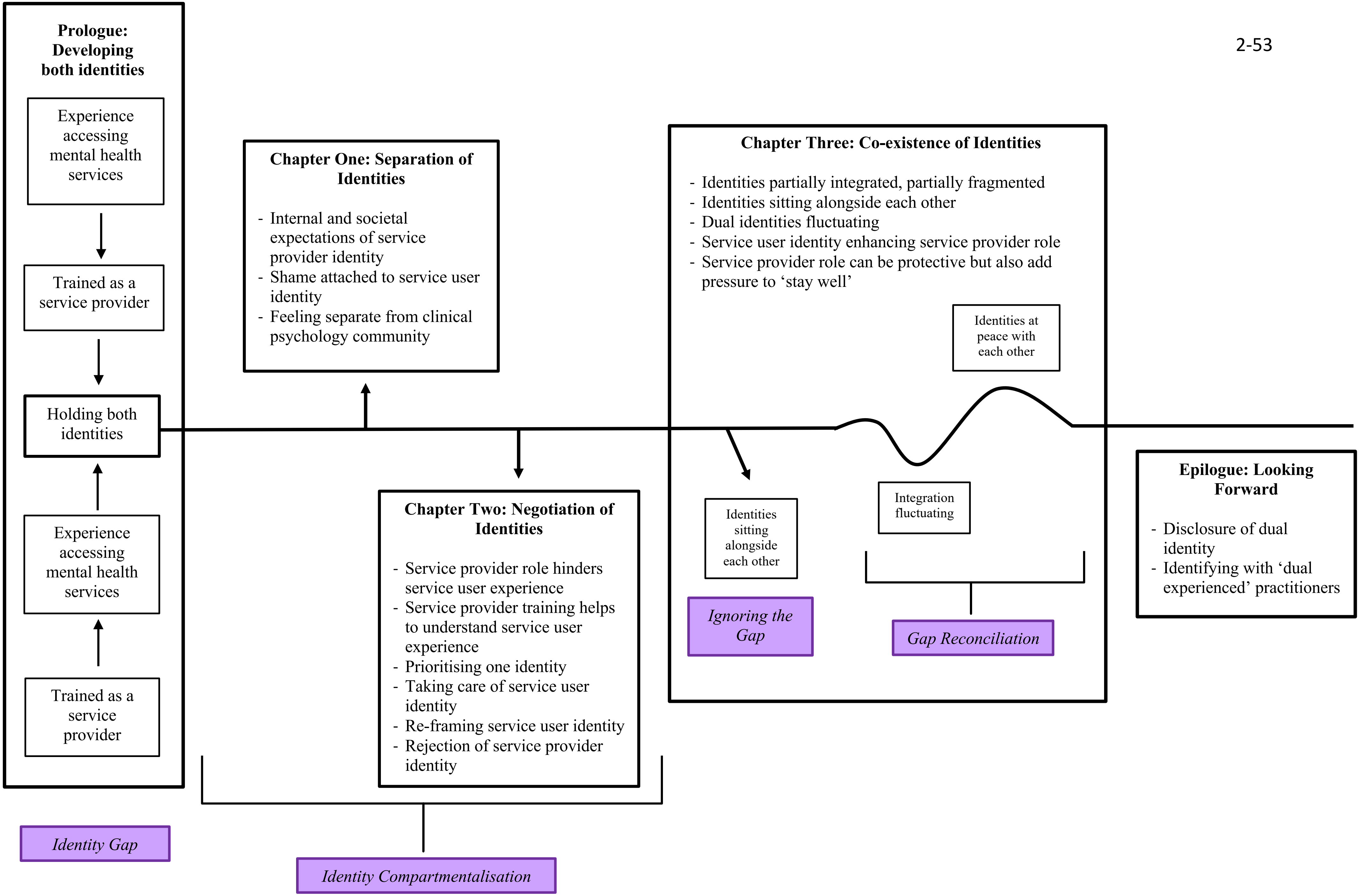
Figure 1

Completed consolidated criteria for reporting qualitative research checklist (COREQ; Tong et al., 2007)

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	2-11
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	N/A
Occupation	3	What was their occupation at the time of the study?	2-10
Gender	4	Was the researcher male or female?	2-10
Experience and training	5	What experience or training did the researcher have?	2-10
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	N/A
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	3-8
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	2-10
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	2-9
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	N/A
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	2-11
Sample size	12	How many participants were in the study?	2-11
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	N/A
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	N/A
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	2-45
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	2-11
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	2-12
Field notes	20	Were field notes made during and/or after the inter view or focus group?	N/A
Duration	21	What was the duration of the inter views or focus group?	N/A
Data saturation	22	Was data saturation discussed?	N/A
Transcripts returned	23	Were transcripts returned to participants for comment and/or	2-12 (summary stories)

Figure 2

Visual representation of themes (displayed on next page)



Prologue: Developing both identities

Experience accessing mental health services

Trained as a service provider

Holding both identities

Experience accessing mental health services

Trained as a service provider

Identity Gap

Chapter One: Separation of Identities

- Internal and societal expectations of service provider identity
- Shame attached to service user identity
- Feeling separate from clinical psychology community

Chapter Two: Negotiation of Identities

- Service provider role hinders service user experience
- Service provider training helps to understand service user experience
- Prioritising one identity
- Taking care of service user identity
- Re-framing service user identity
- Rejection of service provider identity

Identity Compartmentalisation

Chapter Three: Co-existence of Identities

- Identities partially integrated, partially fragmented
- Identities sitting alongside each other
- Dual identities fluctuating
- Service user identity enhancing service provider role
- Service provider role can be protective but also add pressure to ‘stay well’

Identities at peace with each other

Identities sitting alongside each other

Integration fluctuating

Ignoring the Gap

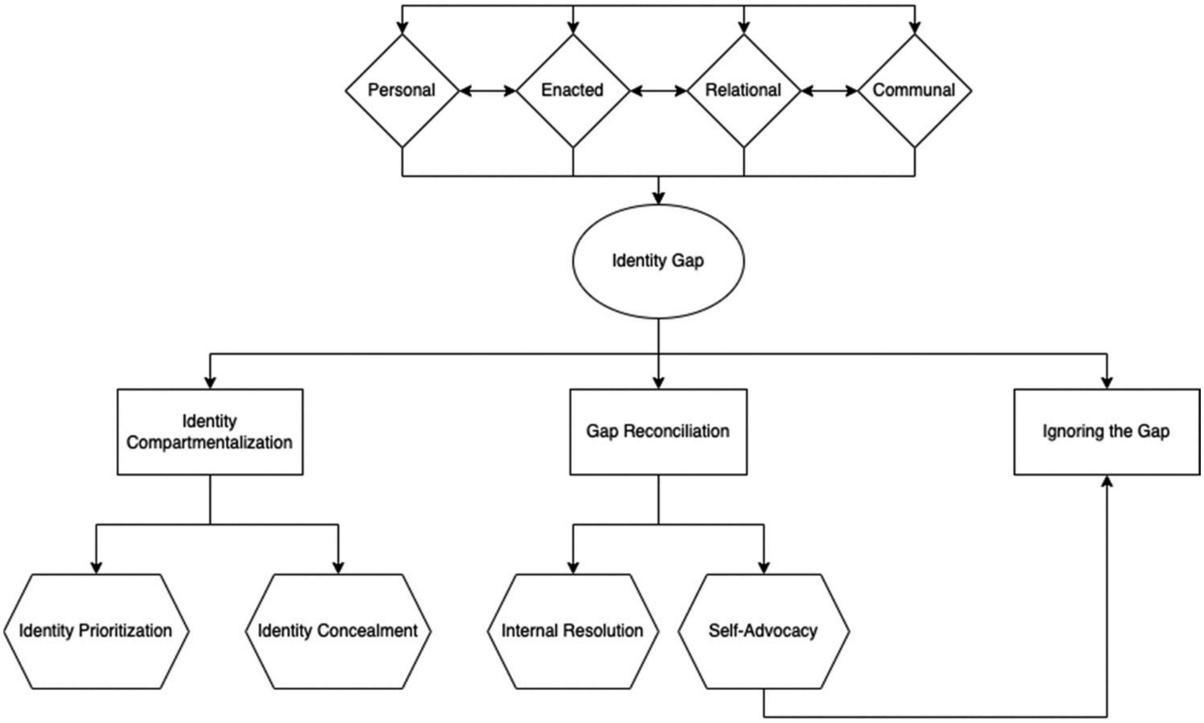
Gap Reconciliation

Epilogue: Looking Forward

- Disclosure of dual identity
- Identifying with ‘dual experienced’ practitioners

Figure 3

Conceptual model of identity negotiation pathways (Trinh & Faulkner, 2023)



Appendix 2-A - Narrative interview schedule

The following interview schedule is a guide for the researcher for questions to be used in face-to-face or Skype interviews.

The questions may be adapted or changed according to individual responses.

Introduction

- Introduce self and remind of title and focus of project.

- Confirm that the participant has read through the information sheet, and check if they have any questions.

- Outline recording and anonymity – ask if participant has a preferred pseudonym they would like to use.

- Check if participant knows either project supervisor, and if they would like to request that a particular supervisor doesn't read or listen to their interview. Interviewer to make a note of this if this is the case.

- Confirm with participant if they are happy to receive a summary story of their interview, which will allow them to make any comments or suggestions on the accuracy/representation.

- Remind of confidentiality and its limits. If using Skype, remind participant that this may not be secure, and to use pseudonyms if discussing any clinical work, and avoid any potentially identifying information.

- Remind participant of their right to take a break at any point, or to withdraw from the interview either during the interview of up to two weeks following completion of the interview.

- Check if participant feels okay to start.

Opening question

I'm interested in your experience of dual identities as a mental health service user or ex-service user and someone who provides a mental health service. These services could be within the NHS, private sector or the third sector. In particular, I'm interested in how these two identities developed and how you negotiate holding both identities. There are a few topics I would like to explore with you, however I would like you to feel that you can talk freely about all areas of your experience.

There are no right or wrong answers to the questions, and the interview is flexible to allow us to explore any areas you feel may be important. I would like to hear your personal version of events and accounts of your experiences as they happened to you. I'll listen first, I won't interrupt, and I may take a couple of notes that I'll ask you questions about later. Please take your time with any experiences you want to share and let me know if you would like to take a break at any point.

To begin, please could you tell me about your experience of developing identities as both a mental health service user and a service provider, and your experience of negotiating both of these identities?

Further prompts

These questions are prompts for further exploration if needed. They may not be used with every participant, and additional questions may be asked which follow on directly from a participant's experience.

Introducing identities

- How would you describe your identity as a service user or ex-service user?

- Did these identities change or develop through particular experiences?

- Which identity do you feel came first in your experience?

Dual identities

- Do you feel that your identity as a service user influenced your decision to pursue clinical training? *Or (dependent on order)*, do you feel that your identity as a mental health provider influenced your decision to access mental health services?

- What does dual identity mean to you?

- When did you start to consider yourself as having dual identities as service user and service provider?

Negotiating holding both identities

- How are you currently negotiating these dual identities? *Or*, how are you currently holding both of these identities?

- Were there particular experiences which influenced your negotiation/holding of these dual identities?

- Have you been influenced by anyone else's experiences of holding dual identities?

- Were there any experiences which felt like they lead to your identities as service user and service provider being fragmented from each other?

- How do you feel these identities influence each other?

- Are there times when your dual identities have felt more in synchrony with each other? *Prompt:* does it always feel like that? *Follow up:* are there any systemic influences which impact on this?

- Are there times when your dual identities have felt like they are in conflict with each other? *Prompt:* does it always feel like that? *Follow up:* are there any systemic influences which impact on this?

Impact of holding both identities

- Do you feel there are any gains/positives/strengths from holding dual identities?

- Do you feel there are any negatives/challenges from holding dual identities?

- Are there times when you feel "most" like a service user?

- Are there times when you feel "most" like a service provider?

- Have there been times when you felt you had to sacrifice one of your identities in favour of the other?

- Have there been times when you felt yourself aligning with one identity more than the other?

Sharing information about dual identities

- Have you shared information about your dual identities with others?

- What has influenced your decision to share or not to share?

- What were the reactions to sharing information about your dual identities?

Impact of dual identities on wider group identities

- How does holding dual identities impact on your identity as a member of the group 'clinical psychologist'?

- How does holding dual identities impact on your identity as a member of the group 'service user' or 'ex-service user'?

- Do you identify as being a member of the group 'dual experienced'? *If yes,* how has this influenced your experience of holding both identities?

- How do these dual identities contribute to how you see yourself?

- How important are these identities to each other?

- How important are these identities to you?

Appendix 2-B – Example Summary Story for 'Mary' (P1)

(Published with participant's consent)

You began by explaining that your experiences of using services came long before becoming somebody providing services. You were 16 when you started counselling, and your main memory of this intervention was the counsellor saying "oh, you're fine" and conveying the same message to your Mum. You didn't agree with this assessment, but this signalled the end of the intervention.

Your next experience of mental health services was when you were 20, After accessing some counselling through university, you then accessed private psychodynamic therapy for about a year, then a long period of being prescribed anti-depressants, before seeking support from a psychologist again. You described your identity of a mental health service user beginning to develop after you received input following a breakdown. You received support for a while whilst living abroad, but this input wasn't consistent when you moved back to the UK, and you ended up discharging yourself. During this time, you decided to pursue training as a clinical psychologist and your identity as a service provider began to develop.

You described these two identities as being confusing to hold simultaneously at that time, particularly as you described yourself as struggling quite a lot with your mental health. You felt that some of your studying at the time was about trying to work out what was going on for you. This led to you wanting to help people with a similar pain and felt that some of your desire to become a psychologist was from your experience of pain rather than of being a service user.

As you started in clinical psychology, you realised there was a lot of stigma around being a service user. You felt that there was no integration at this time between the two identities due to the stigma and felt a pressure to be "strong and knowledgeable". From this, you made a conscious decision to "un-choose" psychology as your identity as it was too painful to try to hold both identities. You felt that this helped you later to re-choose psychology from a different position – realising that you liked the work and that your own time in therapy helped you to be able to sit with other people’s pain as well and that this means you can offer an amazing quality service. This shift helped you to embrace both identities and start to be more open about your own difficulties on your DClinPsy course and question why this wasn’t talked about more. You spoke about this leading to feeling that you had “processed your personal pain enough to get to the point where I could mature in my professional identity, and then they could slot in together to actually become integrated and coherent and actually work to the service of each other”, although at times your lived experience, or ”wounded identity” as you have come to describe it, can feel like an Achilles heel. On the other hand, your professional identity helps to give a sense of meaning and purpose to your wounded identity through helping some good to come out of the wounds, whilst also keeping an awareness on your wounds to make sure that you don’t shut that part of you away as the integration is always ongoing. You spoke about this shift to integration being possible through the work you had done in therapy about processing your own pain, but also reclaiming psychology by finding your own identity and path in this field and making it personal, rather than trying to be ‘a clinical psychologist’.

During your first qualified role, you were open about holding both identities and felt that the integration between your two identities was strong, particularly with clients with being able to hold your own pain and being able to connect with somebody else’s pain and not run away from it.

However, there are still points in your role where the two identities of service provider and service user are in conflict. You noted the internal conflict with these two identities, such as being caught up in your professional identity meaning that you can neglect providing kindness and empathy to the service user part of yourself. You reflected that perhaps it is that whilst the two are pretty integrated these days, there can also be lots of movement when one identity is stronger than the other and you might have to put down one identity and allow yourself to heal when needed.

You have started to be able to disclosure your service user identity when in a group comprised of professionals, though it can be difficult for you being the visible person who steps out, though sometimes it's also "fucking cool" and gives you confidence. You often assume other professionals will be supportive and understanding, in the same way that your colleagues are, but sadly this hasn't always been the case and can feel particularly galling as they are people who really should know better. However, when you do receive validation from other professionals, this really helps to maintain the integration of these two identities. On the other side, you've felt subtle push back from service user groups for being an individual who also has a professional service user identity and the power that is linked to this identity.

Appendix 2-C – Example of analysis

Transcript – ‘Laura’ (P5)

(Published with participant’s consent)

Line no.	Original Transcript	Noting content and underlying themes	Focused coding	Own interpretations
1	**Researcher: So, to start, is it okay to tell me about your experiences of**			
2	**developing identities as both a mental health service user and a service**			
3	**provider, and what your experiences are negotiating both of these?**			
4				
5	Participant: I started seeing a therapist or using services around the age of, I	Service user experience	Service user experience	
6	think I was referred when I was around 14, and got a service when I was 15,	came first	came first	
7	so CAMHS at the time. At that time, understandably, there was a lot kind of		**Prologue**	
8	going on at home and looking back now I can see there were lots of good			
9	reasons why the problems that I had developed at the time. But when I was			
10	that age, so I was referred for bulimia basically, but at that time it was just	Minimising, passive		Sense of this not
11	something I did. It started and then became what seemed a really bad habit	language		feeling like an identity
12	that I was stuck in. So my identity, I can remember I would go to these			at the time, but just
13	appointments and then I would go to school and there was never any	Beginning of separation of	Separation of identities	something that
14	discussion with school or teachers or even my other classmates and then you	identities, decided by others	**Separation and**	happened to her?
15	know even as I got older, I think there must have been conversations between		**concealment**	
16	the school and my parents about where it was going and needing time off, but			
17	none of this was ever discussed with me so I think from a really early age,			
18	this was something that was very separate to the rest of me in a way and I			
19	don’t know that I necessarily, I didn’t necessarily see using services as part of	Service use separate from		
20	my identity, I very much felt stuck wrapped up in the bulimia. And then I	mental health difficulty		
21	suppose my mood deteriorated early after that, and I ended up in A&E. And			
22	at that time, I remember, I suppose, kind of recognizing that this was	Minimising language		
23	something not great and there was talk of me going into the local mental			
24	health hospital or institution and things like that. And I can remember being			
25	in hospital, and realizing that there was a bit of a choice point really and you	Turning point, shift in		
26	know at that time, I had the choice whether I wanted to go in or not, they	narrative		
27	weren't formally, weren’t sectioning me as such. And I remembered thinking	Hospital risked identities		
28	that I didn’t want that, and that I felt that almost if I went there, that that part	coming together		Can visualise it being
29	of me that felt like it just happened in appointments or that it would take over			like Pandora’s Box –
30	all of me. I don't know if it would. It just felt like I had to keep it very	Sense of identity being		pressure to keep the lid
31	separate. And maybe in a way, I actually looked depriving myself of help and	consumed by service user		pressed down at all

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support that would have been really helpful. But I don't know at time it felt like, I didn't want all those bits of me to be together.	part?	Continued separation **Separation and concealment**	costs, even if this meant depriving herself of support. Invoked feelings of sadness in me of how strong the pull for separation must have been
And so I didn't go into the hospital and, I don't know how, but I ended up being discharged and went to uni and things and I can remember obviously studying undergrad psychology and just wanting so much to be like everyone else. And moving away from home which helped in some ways, but I still didn't have great coping strategies for my mental health and obviously the bulimia was still there. And so what would happen every so often was that I'd end up back in A&E, usually after a night out or something or impulsive kind of actions that took hold, and but then I'd always kind of say, Oh no, no, it was just, you know, it was just the drink or whatever and, you know, I'd try very, very hard then not to do anything. And then I ended up realising that I did need support and I went to the university counselling and speaking to them, and they suggested that I access adult mental health services as well, so I was referred to them for CBT. And I guess, again, bulimia was seen to be the main, those were all the discussions that me and the CBT therapist had, and I always remember that at no point did this guy ever say, what's going on for you? Why do you think that your body looks different to other people's, or why is it okay for other…? I felt that no one was ever trying to make sense of this experience. And you know, doing psychology, I was like, oh, this fits for me, this makes sense.	Service use experience often described passively: being done *to* by services Feeling of being *different* to peers Shift in narrative to actively seeking support Feeling of not being seen (similar to A&E) Studying psychology helping to understand own difficulties	Shame about mental health difficulties/service use Service provider training helping to understanding service user experiences/identity	Minimising difficulties, whilst also asking for help (e.g., through A&E attendance). Awareness of patchy mental health support in A&E departments, wondering if anyone saw and offered support

Appendix 2-D - Example of thematic map

Partial extract from analysis of Chapter Two, Subtheme Two:

Prioritising service user identity

Overarching theme	Subgrouping within overarching theme	Participant quote	Name and *line*	Individual narrative theme
Prioritising service user identity	Need to take care of service user identity	I'm giving more attention to the lived experience part, the distressed part of me is getting more time. And so, it's not crammed into a short space of time and it's not pushed down as much.	Harriet *208-210*	Need to give attention to service user identity in order to integrate
Prioritising service user identity	Need to take care of service user identity	I feel slightly more attached to my identity as being somebody who has difficulties, just because when I'm in that, then that becomes quite problematic. But accepting it means that I can make wiser choices. But I have to look after myself so that feels like more important to me as a human that my [inaudible] letting go the importance of being a clinical psychologist identity because it's a job and it's interesting but the world will continue if I stop being a psychologist.	Harriet *533-538*	Need to give attention to service user identity in order to integrate
Prioritising service user identity	Need to take care of service user identity	Maybe one of them is taking care of yourself. I think for people who haven't experienced any distress or been a service user, this still applies, but maybe there's something a bit extra about, it is a tough job, you're sat there talking to people about distress, about their experiences of distress, and it's going to resonate occasionally, and how do you then manage that? That's a challenge.	Kate *296-300*	Taking care of service user identity
Prioritising service user identity	Need to take care of service user identity	I don't want to let go of that, it's like a vulnerable, fragile part of me that I'm now taking care of, rather than just letting sit in the dark on their own.	Kate *439-441*	Taking care of service user identity
Prioritising service user identity	Need to take care of service user identity	So, you know, having a dual identity gives me the ability to look towards and turn towards my own suffering, my own distress. but it gives me the motivation and the tools to do something about that.	Laura *500-502*	Needing to take care of service user identity
Prioritising service user identity	Need to take care of service user identity	So there might be times, actually if I'm not particularly well in myself, actually I have to put down this professional identity for a bit and let go of this idea of me as this strong, professional person, and actually just focus on allowing myself to heal while I need to.	Mary *418-422*	Taking care of service user identity Putting service user identity first
Prioritising service user identity	Need to take care of service user identity	I think there are definitely times where it feels hard to give myself the empathy and the kindness towards my vulnerable service user side when I'm very caught up in my professional identity.	Mary *400-402*	Taking care of service user identity
Prioritising	Need to take care	I was just so overwhelmed with grief and my anxiety was so intense, I just	Susan	Service user identity had to be

service user identity	of service user identity	felt like that completely consumed me and there wasn't really space for me as a mental health professional in those times.	*41-43*	priority during difficult life events
Prioritising service user identity	Dislike of term 'service user'	…but to describe myself as a mental health service user, it felt really uncomfortable.	Beth *7*	Feel uncomfortable with term 'service user'
Prioritising service user identity	Dislike of term 'service user'	Yeah, I don't actually really like the phrase 'service user', I've never really liked it.	Beth *627-628*	Feel uncomfortable with term 'service user'
Prioritising service user identity	Dislike of term 'service user'	"Oh, service user." It's not a label I used for myself ever.	Elena *8*	Dislike of term 'service user'
Prioritising service user identity	Dislike of term 'service user'	I don't know what it is about the term service user that I don't like. I know I don't like it but I don't know why.	Elena *477-479*	Dislike of term 'service user'
Prioritising service user identity	Dislike of term 'service user'	There's something about the phrase service user that made me think, "Oh, that was me. It might be me again." But it doesn't feel like me right now even though being depressed is still a part of my identity.	Elena *498-501*	Dislike of term 'service user'
Prioritising service user identity	Dislike of term 'service user'	So for me, dual identity is not necessarily a clinical psychologist and a service user, it's about being a clinical psychologist and somebody with deep wounds and pain and how I deal with that pain, with the wounds [inaudible]. So it's more about that than the act of having used a service.	Mary *623-627*	Not about service use
Prioritising service user identity	Dislike of term 'service user'	I guess when I talk about being a service user, it was borne out of the terms of being borne out of being somebody who experiences distress and acknowledges that and who struggles with that, rather than it being because of the service use. So, it was borne out of pain rather than trying to treat that pain.	Mary *125-129*	Not about service use
Prioritising service user identity	Dislike of term 'service user'	I think sometimes it's about just being able to bring my humanness, rather than it having to be labelled as service user identity, well actually we all experience pain and can all go through shit in our lives.	Mary *284-287*	Not about service use
Prioritising service user identity	Reframed as human suffering	I wouldn't say that it was specifically working on the identity as service user and as a psychologist, it was my integration as a human being and those two aspects are elements that integrated along with everything else.	Adam *144-147*	Suffering part of being human
Prioritising service user identity	Reframed as human suffering	So wanting to study psychology very much came out of being, my experiences of pain and not necessarily being a service user, because actually my experience of being a service user in the UK hadn't been great, but it was more about the fact, so I guess when I talk about being a service user, it was borne out of the terms, of being borne out of being somebody who experiences distress and acknowledges that and who struggles with that, rather than it being because of the service use. So, it was borne out of pain rather than trying to treat that pain.	Mary *122-129*	Rejection of service user identity, reframed as human pain

Prioritising service user identity	Reframed as human suffering	…so I'm quite proud of that, but at the same time, I don't know how often I need to openly bring that part of myself, I think sometimes it's about just being able to bring my humanness, rather than it having to be labelled as service user identity, well actually we all experience pain and can all go through shit in our lives.	Mary *283-287*	Rejection of service user identity, reframed as human pain
Prioritising service user identity	Reframed as human suffering	So for me, dual identity is not necessarily a clinical psychologist and a service user, it's about being a clinical psychologist and somebody with deep wounds and pain and how I deal with that pain, with the wounds [inaudible]. So it's more about that than the act of having used a service.	Mary 623-627	Rejection of service user identity, reframed as human pain
Prioritising service user identity	Reframed as human suffering	I'd say as the time has evolved, I identify less with being a mental health service user. I think that identity has evolved and interacted with my clinical experience, possibly due to feeling less shameful about accessing services, and I see suffering as part of human experience.	Naomi *21-24*	Service user identity reframed as human suffering
Prioritising service user identity	Reframed as human suffering	Actually, dual identity is about being a human who has suffered and continues to suffer and by providing or being a psychologist, I can connect with other humans in that way.	Naomi *78-80*	Service user identity reframed as human suffering
Prioritising service user identity	Reframed as human suffering	…being in training, we're taught about so many different complex processes like attachment, deprivation, culture, society, you know, et cetera, et cetera, et cetera. And I think that helped me to develop a greater sense of flexibility in how I relate to myself and how I identify as someone who also suffers and has suffered. And I think also having maybe greater compassion or understanding for my own distress.	Naomi *131-136*	Service user identity reframed as human suffering Service provider training has helped to understand service user identity
Prioritising service user identity	Reframed as human suffering	And then I found out about CFT [Compassion-Focused Therapy], and from that point, I think, is where I started to develop or integrate my identities a bit more because of the language and how we're seen as humans and just not pathologizing, trying things in here.	Naomi *143-146*	Service user identity reframed as human suffering Service provider training has helped to understand service user identity
Prioritising service user identity	Reframed as human suffering	We're all human. That's the bottom line. And, you know, sometimes really bad stuff happens to us. And that affects us, it doesn't mean we're bad people. It means that having perfectly understandable normal reactions to the shit that life throws at us sometimes.	Skye *330-333*	Service user experiences reframed as humanness
Prioritising service user identity	Reframed as human suffering	I think that's taken me quite a long time to reconcile. I feel like that's the path that I'm on now, where I am bringing those parts of me together, the whole human being who's experienced the wonderfulness and the horrendousness of life.	Skye *424-427*	Service user experiences reframed as humanness Dual identities coming together as part of complete human

Appendix 2-E - Author Guidelines for Psychology and Psychotherapy: Theory, Research and Practice

PAPTRAP AUTHOR GUIDELINES

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

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- theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
- behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
- psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

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- qualitative and other research which applies rigorous methods
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Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

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- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

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In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

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4. PREPARING THE SUBMISSION

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Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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All articles must include Practitioner Points – these are 2-4 bullet point with the heading ‘Practitioner Points’. They should briefly and clearly outline the relevance of your research to professional practice.

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As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

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Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Acknowledgments;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
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- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
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Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

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- The Gold Standard Publication Checklist from Hooijmans and colleagues
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Section Three: Critical Appraisal

Navigating multiple identities during clinical training and thesis

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This section begins with a summary of the findings from both research papers. I consider my experiences of negotiating multiple identities during clinical training and the thesis, including the interaction between my identities as clinician and researcher, as researcher and 'insider', and service user and service provider.

Summary of research

The thesis consists of three papers, including this critical appraisal. The first paper is a systemic literature review exploring how key individuals in a young person's life respond to the young person's self-harm. Twelve papers met the criteria, and five themes were identified from these papers: 1) initial responses fuelled by emotions, 2) the importance of a calm façade, 3) modifying my approach and our relationship, 4) offering support, 5) we need more help!

The second paper was an empirical paper that used narrative analysis to explore 12 participants' experiences of negotiating dual identities as both service user and service provider. This research resulted in the development of five chapters: Prologue: Developing Dual Identities, Chapter One: Separation of Identities, Chapter Two: Negotiation of Identities, Chapter Three: Co-Existence of Identities, and an Epilogue: Looking Forward.

The combined papers provide two perspectives on stigmatised experiences, with the literature review examining caregivers, professionals', and friends' experiences of supporting an individual and the empirical paper exploring the perspective of individuals who are navigating experiences of mental health difficulties. Both papers highlight the importance of improved information and education about self-harm and mental health difficulties, and the importance of clinicians challenging stigmatising language and concepts such as 'us-and-them'. The two papers situate the target issue within wider understandings: self-harm within the context of a system around the young person, and dual identity within the clinical psychology community. There are overlaps in the recommendation for future research, with both papers advocating for exploration of therapists' and psychologists' attitudes towards self-harm and dual identity respectively.

Finally, the critical appraisal provides a personal exploration of my own identities during the course of clinical training. In keeping with the narrative methodology utilised in the empirical paper, the appraisal adopts a narrative approach to examine my experience of writing these two papers and my experiences of negotiating multiple identities. The appraisal continues a focus on both self-harm and dual identity and how these may intertwine.

Preface: Developing Dual Identities

Like many mental health service providers (Huynh & Rhodes, 2011) and many participants in the empirical paper, my own experiences of mental health difficulties prompted my decision to pursue training as a clinical psychologist. My first experience of accessing mental health support was through Child and Adolescent Mental Health Services (CAMHS). Similar to Amber and Skye, I found much of the support provided unhelpful, and wanted to offer a different approach. Part of my experience included assumptions of my experiences which led to a formulation of my difficulties that was created without me and used to assign an identity to me. Similar experiences are still commonly reported by patients (Perkins et al., 2018). This experience was mirrored during my undergraduate psychology degree, when I proposed writing my third-year dissertation on self-harm only for my research supervisor to assume I must have a history of self-harm to be interested in writing about this topic. Similar experiences have been noted by Chaney (2020) and Victor et al. (2022) when the authors proposed to conduct research projects focusing on self-harm.

Chapter One: Separation of Identities

When I applied for clinical psychology training, I never considered sharing my identity as an ex-service user. Although there has been a push to encourage applicants with personal experience of mental health services to apply for clinical training, I am not alone in keeping my service user identity separate and hidden. Whilst research suggests that a high proportion of clinical psychologists have historical or re-occurring experience of mental health difficulties, stigma attached to these experiences remains high in these professions (Tay et al, 2018) and clinicians are concerned about confidentiality and being seen as unfit to practice (Turner et al., 2021). As a trainee, I sadly witnessed the stigma within clinical psychology towards personal experience of mental health difficulties, including the discussion held on the letters page of The Psychologist (Lindsay, 2017) and read about the experiences of clinicians who disclosed dual identity and received stigmatised responses (e.g., Anonymous, 2016a; Rouf, 2020). These experiences made me feel certain that I could not reveal my historical experiences and fuelled my feeling of being an ‘imposter’ within the profession. Like Skye, this belief pushed me further into prioritising my service provider identity and wanting to present as the ‘perfect trainee’, a common response to holding a stigmatised identity (van Amsterdam & van Eck, 2019).

Chapter Two: Negotiation of Identities

Collision of Identities

I was able to sustain this separation and façade for a period of time, until I experienced some traumatic challenges in my personal life. Being a trainee had led to high levels of self-criticism and a drop in self-compassion, and the combination of these experiences led to a ‘perfect storm’ for the resurgence of mental health difficulties. My identities as a trainee clinical psychologist and someone with mental health difficulties collided, and the impact of this collision led to a realisation of how exhausting it was to sustain the separation of these identities. I started to consider bringing these identities together and how I could integrate my personal experiences in a meaningful way within my chosen profession. I looked to published literature in an effort to find accounts of experiences of clinicians who were both service users and service providers. I was interested in the experiences of how these two identities influenced each other, rather than just the impact on clinical practice, but struggled to find many examples. I felt that it was likely that there would be multiple points at which these two identities could be either in conflict or in harmony with each other. For example, I had begun to see the impact that my identity as a trainee clinical psychologist was having on my journey of accessing support from mental health services. Whilst there were occasional advantages early on, such as the use of 'shared language', there were a number of unexpected challenges. Like Susan, I was keen to keep my service provider identity outside of my contact with mental health services, but this was often out of my control. The challenges ranged from practical issues (e.g., navigating confidentiality when a trainee I was familiar with was on placement at the same specialist service I was accessing) to clinicians actively prioritising my service provider identity (e.g., explicitly skipping certain sections of psychoeducation or therapeutic work because "you know this already"). I wanted to capture these navigations of identities and roles, rather than restricting my view of personal experiences through the lens of clinical practice, and this became the basis of my empirical research idea.

Negotiating researcher and clinician identities

As a trainee clinical psychologist, there were points during interviews for the empirical paper where I felt a strong internal pull to respond to participants, particularly when they had shared their accounts of difficult or traumatic life events. I wanted to offer a response which felt human and compassionate, yet worried that this might result in stepping into a clinician role (Hay-Smith et al., 2016). This dilemma is common amongst researchers with dual roles as clinicians (Gilbert, 2001) particularly in qualitative approaches where the relational nature of the interview can lead to identity diffusion (Haverkamp, 2005). I also felt an initial internal pull to structure the summary stories in a similar fashion to the therapeutic letters I often write in my clinical role, in which I am sharing a written formulation of a patient’s difficulties. This would have likely led to a re-structuring of the participants’ experiences rather than the planned summary of their experiences and may have become akin to therapy (Buchbinder, 2011). In order to avoid this, I discussed this pull with my research supervisors and shared my initial summary stories with them.

There are clear commonalities between both clinicians’ and researchers’ roles, with both wanting to support individuals to feel comfortable and unjudged in order to share their experiences (McVey et al., 2015). Whilst some researchers advocate for neutrality to avoid bias (Seidman, 2019), others argue for the need for empathy and care (Gair, 2012). I reflected on this dilemma following the initial interviews, and particularly the experiences of stigma that participants had experienced or anticipated within the clinical psychology community. I wondered if staying neutral could potentially mirror the experiences they had had of disclosing their dual identities and conflict with my research aims (and personal values) to reduce stigma and promote acceptance of dual identities. Whilst Asselin (2003) suggests that role confusion can occur when researchers step outside of a neutral role, others argue that these “muddy” interviews are where new knowledge and insights can be gained (Lippke & Tanggaard, 2014, p.137; Theusen, 2011). I was also conscious that I was an ‘insider-outsider’ researcher (Dwyer & Buckle, 2009) as I was a member of the clinical psychology community, and therefore my responses could be seen as representative of the profession. I felt that providing human responses of warmth and empathy were important in the interviews to support participants in feeling comfortable, both within the interview and when looking back on the interview, whilst remaining aware my role was not to provide clinical or therapeutic support.

Navigating researcher and ‘insider’ identities

Part of my own journey of negotiating my service user and service provider identities included connecting with other psychologists with dual identities, which included making small disclosures on Twitter. As I also used Twitter as a recruitment strategy, it is possible that participants were aware of my status as a member of their community, i.e., an ‘insider’, or may have wondered about my experiences from the research topic. In one of my interviews, the participant wanted to caution me about including information on my own experiences of mental health difficulties in my thesis, suggesting that she saw me as a fellow member of the dual identity community. It is possible that if participants knew or suspected my ‘insider’ status, then this may have aided in building trust (Berger, 2015) and rapport (Bonner & Tolhurst, 2002). Chaney (2020) suggests that there has been a shift from *assuming* a researcher should have a personal connection to an *expectation* that they should have a connection. This has been advocated for when researching experiences of service users. Attempting to understand the narratives of psychiatric survivors without insider experience can present challenges (Faulkner, 2017) and has the potential to replicate the power imbalance within mental health services (Davies, 2005). This may mean my ‘insider’ status could have been helpful in building a relationship with participants and supporting them to feel comfortable during the interview.

However, I was cautious not to assume my own experience was representative of participants (Foster, McAllister, & O’Brien, 2005). Insider research can pose a number of drawbacks, such as participants assuming researcher knowledge (Breen, 2007), concerns about objectivity (Roennfeldt & Byrne, 2020), or participants having specific expectations about how their community is represented (Watts, 2006), in particular expecting a sympathetic portrayal (Taylor, 2011). When conducting qualitative research, particularly in an insider role, it is imperative for researchers to ‘bracket’ their own assumptions and experiences (Berger, 2015). To support me to do this, I developed an interview guide in collaboration with my research supervisors, which was further expanded on by two experts by experience. I often found that participants would discuss various aspects of the interview guide without prompting, suggesting that whilst there was likely to have been an impact from my personal bias when developing the guide, the topics within it were salient to participants' experiences. I also kept a reflective diary during the process of collecting and analysing data in order to help mitigate any influence from my own experiences (Tufford & Newman, 2012) and discussed codes and themes with my research supervisors. Whilst I attempted to bracket my own experiences and assumptions as far as possible, there are naturally limitations to any degree of reflexivity (Palaganas et al., 2017).

Razon and Ross (2012) posit the term 'fluid identity' to describe the overlapping and at times conflicting identities that researchers hold. I feel that this description best captured my experiences in negotiating multiple identities during this project as I did not always see myself as an 'insider'. Labaree (2002) argues the research process challenges the 'insider' identity, forcing insiders to distance themselves in order to assume the researcher identity. I also did not share my own experiences unless asked by participants, to avoid centring myself in the research (McDonald, 2001, as cited in Foster et al., 2005).

Juggling multiple identities

During my empirical paper write-up after the end of clinical training, I sadly experienced the unexpected and sudden death of my Dad. This naturally meant that I needed to step back from my research and focus fully on my identities as daughter and older sister in order to support myself and my family. When I returned from compassionate leave, I returned to my paid clinical role as a mental health practitioner in an NHS community CAMHS team. This was now during the COVID-19 pandemic. Pressures on CAMHS were significant (Bentham et al., 2021; Huang & Ougrin, 2021), particularly with the impact of lockdown and social isolation on children and adolescents (Bignardi et al., 2021), and an increase in referrals to CAMHS (McNicholas et al., 2021). Due to the combination of the stresses of this role and the challenges in my personal life, I made the decision to intercalate from my thesis for a significant period as I was unable to devote time to both identities of clinician and researcher.

One of the consequences of this decision was that there was a long period of time between the research interview and member checking with participants. I had chosen to provide summary stories to support the validity of the research by accurately understanding the participant's worldview and narrative (Thomas, 2017) and to reduce the power differential in the research relationship (Koelsch, 2013). Due to the length of time that had passed, I was concerned that participants may feel unfamiliarity with the re-presented narrative or that the transcript may no longer represent their experience (Goldblatt et al., 2011). Thankfully, none of the contacted participants reported any shifts in their experiences that would necessitate a change to the analysis, though Harriet noted that her relationship with 'dual identity' had shifted. She understood this as reflecting the dynamic nature of the relationship that she had described in her interview and did not wish to alter her summary story or narrative due to this. Mary also reflected that the gap had allowed her to appreciate how much deeper the integration had gone since our interview. There were two participants whom I was unable to contact upon my return. One participant had provided their work email address as a contact, and I received an automatic reply advising that they had left the service. Another participant did not respond when contacted to offer the summary story, but it is unclear if the lack of reply was due to the time gap between the interview and my contact or whether they had chosen not to receive the summary story.

Chapter Three: Co-Existence of Identities

Co-existence of clinician and researcher identities

When I returned from intercalation, one of my primary tasks was to choose a topic for my literature review. I had originally planned to conduct a literature review on the benefits of discussing dual identity, however much of the literature was found within 'grey literature' which presented a challenge. Whilst there is disagreement about what constitutes grey literature (Tillett and Newbold, 2006), grey literature is defined within this appraisal as research which has not been published in a peer-reviewed journal. There are a number of advantages to including grey literature in a literature review, including the potential to reduce publication bias (Hopewell et al., 2007) and provide a more balanced picture of available evidence (Paez, 2017). Unfortunately, one of the challenges of including grey literature is the increased time needed, such as developing internet-based keywords (Benzies et al., 2006). Many of the proposed included studies were unpublished doctoral theses, which were much larger than published journal articles. As I was now completing my thesis alongside working full-time in a clinical role and under significant time constraints, I needed to consider an alternative focus.

In my clinical role, I frequently work with young people who self-harm. I began noticing similarities between self-harm and my empirical research project, such as the lengths to which young people went to hide their self-harm from others, and the stigmatised responses they received, such as reducing self-harm to ‘attention-seeking’. I felt that a literature review that focused on reactions to self-harm could be antithetical to the empirical research project so that the full spectrum of experiences could be captured from individuals in the empirical paper, and carers and professionals in the literature review.

Service user and service provider identities: Partially integrated

When I consider my current experience of ‘dual identity’, I am most closely aligned with Susan and Harriet: my identities feel partially integrated, yet I have made a conscious choice for there to be a distance between them. I have felt able to let go of a lot of the internalised stigma I felt, and this has often occurred through connection and identification with other ‘dual experienced’ clinicians. Connecting with others has helped to reduce the isolation and shame I felt about my experiences, and this is mirrored in studies observing that identification with an individual’s stigmatised group (Major & O’Brien, 2005) helps to reduce self-stigma. However, whilst I have chosen to be involved in projects or publications in which I am open about my dual identity, I remain in the ‘selective disclosure’ stage of disclosure (Corrigan & Rao, 2012). This could be due to being at an early stage in my career, with Adame et al. (2017) and Turner et al. (2021) noting that many accounts of clinicians sharing their dual identity occur later in established careers, leaving trainees without a template of how to navigate dual identity whilst they are establishing themselves in their career.

Whilst reflecting on my own current perspective on dual identity, I wondered if one of the barriers to integration was a distance between my experiences and experiences of dual identity in the profession being shared publicly. Harriet spoke about struggling to connect with other ‘dual experienced’ practitioners’ accounts as they were often written from a position of recovery, a finding echoed by Gupta and colleagues (2023). Isabelle and Kate also spoke about feeling that there are varying degrees of stigma dependent on the experience, with experiences such as self-harm, suicidal ideation, psychosis, choosing to take psychiatric medication, and hospital admission being further stigmatised within the clinical psychology community. Studies have reported clinicians have differing attitudes towards different diagnoses, with diagnoses such as personality disorder (Newton-Howes et al., 2008) or bulimia (Hayes & Wall, 1998) being more stigmatised, perhaps due to the perceived responsibility in these diagnoses. Clinicians are less stigmatising towards patients in recovery (Rao et al., 2009) and disorders such as post-traumatic stress disorder (Maier et al., 2015), possibly due to the perceived ‘external cause’ for the latter (Maier, 2006). Clinicians also respond inconsistently to dual identity disclosures, dependent on whether the disclosure includes social taboos or how recovered the healer is (Zerubavel & Wright, 2012). It is possible that clinicians who fear that their own experiences are more stigmatised are uncertain if they fit with the current disclosures of dual identity and recovery, and many have argued that there is a need for more accounts to be shared in order to reduce stigma within the clinical psychology community (e.g., Aina, 2015; Anonymous, 2016b; Corrigan & Rao, 2012; East, 2016; Turner et al., 2021).

Whilst my negotiation of dual identities has led me to step closer to the dual identity community, I have felt more distanced from the service user community. When I had previously been under the care of secondary mental health services as an adolescent and young adult, I connected with other patients and felt a strong sense of solidarity within this identity. When I re-entered these services as a trainee clinical psychologist, I felt unable to connect with the service user community in the same way due to my concurrent role as a service provider. Being a service provider placed me within a system which has historically exerted power over patients or colluded with abusive practices (e.g., aversion therapy; Spandler & Carr, 2022). Similarly, Mary and Susan also spoke about feeling that their service provider identities created a separation from service user communities and that they felt less welcome in these communities due to their clinical training. Within physical healthcare, concerns have been raised about professionals co-opting service user groups under the tagline ‘We are all patients’ (Gilbert, 2014), and similar concerns have been voiced by mental health service users about the fear of ‘dual identity’ clinicians colonising service user roles and narratives (Byrne & Wykes, 2020). Adame (2011) interviewed psychiatric ‘survivor-therapists’ and observed that they felt others in the psychiatric survivor community felt that their clinical training now precluded them from being a ‘real’ psychiatric survivor. This was also discussed by participants in Wasyliw’s (2014) study of mental health clinicians who have experienced psychosis. These participants were ‘othered’ by service users due to their professional role and told: “You’ll never know what it’s like to be one of us” (p.51). Whilst it is important to respect the autonomy of the psychiatric survivor movement, not overrule their identity, and remain mindful of the professional power that clinicians hold, there could be some positives in ‘dual experienced’ individuals and psychiatric survivors working together to reduce stigma and the us-versus-them dichotomy (Adame, 2001). Bassman (2007) suggests the need for “A necessary but uneasy collaboration between professionals and [consumers-survivors-ex-patients].” (p.188).

Epilogue: Looking Forward

Whilst I have discussed a number of challenges and difficult situations in my experiences of navigating dual identities, there have also been genuine moments of connection and hope for the future. I am heartened to see more clinical psychologists speaking out about dual identity and initiatives such as in2gr8mentalhealth offering safe spaces to connect with others. In addition, the British Psychological Society has published guidance for supporting trainees with dual identity (BPS, 2020) and the Division of Clinical Psychology has issued a briefing paper supporting clinical psychologists with dual identity (Hogg & Kemp, 2020). This is mirrored in research, where there are now a number of in-progress and completed projects looking at different aspects of dual identity. These include stigmatised experiences such as self-harm (Victor et al., 2022), and the EMERGES framework for understanding the identity of lived experience researchers and providers (Gupta et al., 2023). Topics such as psychosis (e.g., Vierthaler & Elliott, 2022) and self-harm (e.g., Stirling and Chandler, 2021) are being spoken about by clinicians as well, and trainee clinical psychologists are also beginning to share their experiences, albeit often still anonymously (e.g., Anonymous, 2018). I hope that my literature review and research paper will help to expand professional understanding of stigma, self-harm, and dual identity, and I hope that my research paper can contribute to reducing stigma and add evidence to the argument for continued initiatives to encourage and support individuals with experience of mental health difficulties to apply for clinical training.

In regard to my own dual identities, I feel content with my current partially integrated, partially separate position. As I transition to the next stage of my clinical psychology career, I hope to continue talking within the community about dual identity and arguing for the need for support and discussion. I am also looking forward to my researcher and trainee identities reducing to make more space for other important identities in my life, such as partner, step mum, sister, and friend, which have all been neglected during my thesis!

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Section Four: Ethics Application

Ethics application for research paper: Clinical psychologists' experiences of negotiating dual identities as mental health service users and service providers

Molly Rhinehart

Doctorate in Clinical Psychology

Lancaster University

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Bailrigg, Lancaster

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

Application for Ethical Approval for Research

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

Highlighted yellow = relates to amendments requested June 2018

Title of Project: Exploring the experiences of clinical psychologists of negotiating dual identities as mental health service users and service providers.

Name of applicant/researcher: Molly Rhinehart

ACP ID number (if applicable)*: N/A **Funding source (if applicable)** N/A

Grant code (if applicable): N/A

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

Type of study

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

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

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee clinical psychologist, Division of Health Research.

2. Contact information for applicant:
E-mail: m.rhinehart@lancaster.ac.uk **Telephone**: 07583 029491

Address: Department of Clinical Psychology, Furness College, Lancaster University, Bailrigg, Lancaster, LA1 4YG

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

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

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

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

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

4. Project supervisor(s), if different from applicant:

Research supervisor: Dr Suzanne Hodge.
Field supervisor: Dr Hannah Wilson.

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

Dr Suzanne Hodge: Lecturer in Health Research and Research Tutor. Division of Health Research, Lancaster
University, Bailrigg, Lancaster, LA1 4YW.

Dr Hannah Wilson: Clinical Psychologist and Senior Clinician. Central & West Lancashire Eating Disorder Service, Tudor House, 18 Euxton Lane, Chorley, Lancashire, PR7 1PS.

SECTION TWO

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

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

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

Data Management

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

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

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

4b. Will you be gathering data from websites, discussion forums and on-line ‘chat-rooms’ no

4c. If yes, where relevant has permission / agreement been secured from the website moderator? no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

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

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

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

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

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

8. Confidentiality and Anonymity

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

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

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

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

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

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

Mental health clinicians, including clinical psychologists, have high reported levels of mental health distress. However, stigma in this profession around experience of mental health difficulties is high and may discourage disclosure and openness. Concealing the identity of 'service user' may lead to increased psychological distress and feeling inauthentic, which may also be perceived negatively by clients.

Research has suggested that there may be positive benefits for dual identities as service user and service provider, such as feeling increased levels of empathy. This study proposes to conduct qualitative, semi-structured interviews with clinical psychologists who identify as having lived experience of being a service user of mental health services. The interviews will focus on their experiences of negotiating these dual identities. Narrative analysis will be used to explore how participants have developed and negotiated dual identities, and how they view themselves within this narrative.

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

Start date: August 2018   End date: May 2019

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

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

The researcher aims to recruit a minimum of eight participants (up to a maximum of twelve). Participants will be aged 18 and over, and be UK-based, HCPC-registered clinical psychologists. Participants will have at least one year of employment as a qualified clinical psychologist and will have been recently in employment as a clinical psychologist (i.e. in at least one role within the two years prior to taking part in the study). Participants will self-identify as being a 'service user' or 'ex-service-user' of mental health services. The criteria for the service which participants have accessed is open to services based in the NHS, third sector, and/or private sector.

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

Participants will be recruited from five different sources:

The study will be advertised on Twitter from the lead researcher's account, which is a professional account. The link for the study will request that any potential participants contact the lead researcher's university email account if they are interested in participating.

North-West Psychological Professionals Network (NWPPN) is a network representing psychological practitioners working in the North West of England. The network will be contacted to ask if their members would be interested in participating. With their consent, details of the study will be sent to NWPPN to be distributed through their mailing list. Potential participants will be directed to contact the lead researcher via email if they are interested in participating.

www.in2gr8mentalhealth.com is an online forum for clinicians who identify as 'dual status' (i.e. being both a clinician in mental health services and a service user). The study will be advertised on the forum using the lead researcher's account. Potential participants will be directed to contact the leader researcher via email if they are interested in taking part.

There are multiple groups on Facebook specifically for clinical psychologists working in the UK. The study will be advertised in these groups using the lead researcher's account. Potential participants will be directed to contact the lead researcher via email if they are interested in taking part. If any potential participants contact the researcher via Facebook messages, they will be advised that this is not an appropriate medium for this, and will be directed to contact the researcher using the researcher's university email account.

The study will also be advertised via word-of-mouth by the lead researcher, and contacts will be encouraged to pass on information about the study to individuals who may be interested in participating.

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

It is anticipated that interviews will be conducted face to face or via Skype, using the lead researcher's dedicated, professional account. It is noted that a secure connection may not be guaranteed through the use of Skype, and so participants will be reminded of the need to anonymise and clinical details they may mention.

Interviews are anticipated to last between 60 - 90 minutes. Face to face interviews will take place at a mutually agreed location and Lancaster University's Lone Working Guidance will be followed (please see Question 11 for further details of this).

As the study is seeking to explore identity development, narrative analysis will be used, as it is a method which seeks to explore how meaning is applied to participants' experiences (Finlay, 2011). Narrative analysis also considers the influence of culture and socio-political factors (Weatherhead, 2011), both of which may be linked to stigma and the development of identity (Abdullah & Brown, 2011). As the development and negotiation of multiple identities is likely to change over time, narrative analysis offers an opportunity to explore the development of this, rather than focusing on a single experience (Creswell, 2012). As it is hoped that the findings of the study will be useful to other clinicians with dual identities, thematic narrative analysis will be used to explore themes emerging from the content of participants' experiences (Lyons & Coyle 2016; Riessman, 2008).

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

During transcription of the audio recordings of the interviews, all identifying information will be removed and codes will be used to enable the researcher to identify participants. All documents will be password protected and all data stored electronically on a secure drive (Lancaster University's H:Drive). Physical copies of consent forms will be scanned and stored securely on the VPN. The physical consent forms will then be shredded. At the end of the study, the anonymised transcripts will be transferred electronically to the DClinPsy

Research Coordinator using Box, a secure method supported by the University. They will be instructed with a date of when to delete the anonymised transcripts. These transcripts will be stored for 10 years before being deleted. Files containing participants' personal/identifying details will be kept in a separate, password-protected file on the secure H:Drive. This file will contain with an ID number used to match participants' identifying details to their transcripts. This is needed to allow participants the right to withdraw their data following the interview if desired, and to allow the researcher to send a summary narrative to participants following the interview. All personal/identifying details relating to the participants will be deleted once the thesis has been assessed.

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

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

Audio data generated from the interviews will be deleted from any portable device used as soon as possible and
transferred to the University's secure H:Drive. The reason for this is because it is not possible to encrypt the portable device. For the likely short time between the interview and transfer, the audio data on the portable device will be stored as securely as possible, and kept with the lead researcher. In all other cases, where they are used for identifiable data, all portable devices (laptop, USB drives etc) will be encrypted. All files will be kept on the H:Drive, apart from when they are being shared with the research supervisors (who will not have access to the researcher's H:Drive). In this instance, an encrypted, password-protected file will be saved into a folder on Box which only the researchers will have access to. As soon as the researchers have read/listened to the file, this will be deleted from Box.

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

Audio recordings will be stored securely on the university's H:Drive. Audio files will be stored until transcription is
complete. At the end of the study, anonymised written transcripts will be transferred electronically to the
DClinPsy Research Coordinator using Box, a secure method supported by the University. These transcripts will be
stored for 10 years before being deleted by the research co-ordinator. Audio data generated from the interviews
will be deleted from any portable device used as soon as possible and transferred to the secure University VPN.
The reason for this is because it is not possible to encrypt the portable device. For the likely short time between
the interview and transfer, the audio data on the portable device will be stored as securely as possible, and kept
with the lead researcher.

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

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

At the end of the study, anonymised written transcripts will be transferred electronically to the DClinPsy Research
Coordinator using a secure method supported by the University. These transcripts will be stored for 10 years
before being deleted by the research co-ordinator.

8b. Are there any restrictions on sharing your data?

Data will not be shared due to the sensitive nature of the topic and the small sample size meaning that participants may be identifiable even if the transcripts are anonymised.

9. Consent

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

b. Detail the procedure you will use for obtaining consent?

Potential participants will contact the lead researcher to express an interest in being involved in the study. Potential participants will be emailed a copy of the information sheet and a consent form, which will be requested to be returned to the researcher prior to the interview taking place. Immediately prior to the interview, the researcher will check the participant's understanding of the study and their willingness to participate. Participants will be reminded that participation is voluntary. Participants will be reminded that they can withdraw from the study at any time during the interview and up to two weeks following their interview.

10. What discomfort (including psychological e.g. distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

The study is not anticipated to cause significant distress. However, there is a possibility that the topic of the interview could potentially be an emotive or difficult topic for participants to discuss. Particular care will be taken to ensure that participants are fully informed as to the nature of the study prior to beginning the interview (including on the information sheet). Participants will be made aware of their right to pause or withdraw from the interview at any point during the interview or within the two weeks following completion of the interview. Participants will be debriefed at the end of the interview, and will be given information on the information sheet about appropriate numbers to contact if they are experiencing distress following the interview.

Due to the personal nature of the content of the interview, it is possible that participants may feel keen to make sure that their story is heard and represented accurately within the study. The lead researcher will write a summary story of each participants' narrative following transcription, which will be shared via an individualised folder on Box (if they have consented to receive this). The participant will have the option of making any changes or suggestions to ensure that their story is an accurate representation of their experience, and that they can feel reassured that their narrative has been heard and ‘protected’ by the researcher.

Participants will be fully informed of the limits of confidentiality within the interview, including the researcher’s duty to pass on any concerns about risk to self/others, or unsafe/unethical practice. If any issues of significant risk or unethical practice are identified, the researcher will contact their supervisor and the appropriate procedures will be followed (please see question 14b for further information).

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

Any face to face interviews will involve the interviewer following Lancaster University’s Lone Worker Guidance. This policy outlines the health and safety requirements where persons work alone and the implementation of safe working arrangements. The interviewer will provide her destination and name of the participant in a sealed envelope to a peer or colleague (e.g. another Lancaster DClinPsy trainee), along with an estimated time of return. The interviewer will then advise the peer upon her return. If contact is not made, the peer will attempt to contact the interviewer. If this contact is unsuccessful, the peer will open the envelope and contact the appropriate authorities (i.e. the police), passing on the participant name and destination.

The lead researcher’s email address will be used as a primary point of contact for participants. This will be a university email address.

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

There may not be a direct benefit to participants for taking part in the study. It is hoped that the study will contribute to the evidence base for experiences of clinicians who are dual-experienced.

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

Travel expenses up to £20 per participant may be refunded following prior agreement with the researcher

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

yes

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

Interviews may take place at the participant's workplace if they would prefer this and this is in the local area. Participants will be asked to consider the use of a private room to ensure their interview will remain confidential. This will also be the case if the participant is based at their workplace when taking part in an interview over Skype. If participants are not able to secure the use of a private room for their interview, the researcher will be flexible with timings to try and support this, or will remind the participant that confidentiality may not be able to be ensured, and check if this is okay with the participant.

When the audio recordings are transcribed, any identifying data will be removed, and codes/pseudonyms will be used to identify participants. The recordings will be transcribed by the lead researcher. Direct quotes may be used in the write up, and these will be anonymised.

The limits of confidentiality will be outlined in the information sheet. Confidentiality will only be broken if the researcher identifies any issues of risk or unethical practice. Due to participants discussing their historical or current mental health difficulties, there may be limits to confidentiality both in terms of risk to self from participants and/or unsafe or unethical practice. If the researcher is concerned about a significant risk of harm, she will raise this with the participant and discuss the steps which will need to be taken, e.g. the participant to access support from his/her GP. Participants will be debriefed at the end of the interview, which may include discussion around accessing support. The lead researcher will discuss any safeguarding concerns with the project supervisors following an interview, including reviewing if any further action is needed.

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

The interview schedule has received input and consultation from two qualified clinical psychologists who identify as having experience of accessing mental health services. Participants from the study may be involved in the analysis process if they have consented to this. For example, they may be asked to comment on their summary stories to confirm that these are an accurate representation of their experiences.

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

The study is a DClinPsy thesis, submitted as a requirement as part of the lead researcher's doctorate in clinical psychology. The findings will be presented to stakeholders and trainee clinical psychologists at Lancaster University's DClinPsy programme. A summary of the project findings will be provided to participants, if they have opted in to receive this.

The project may be of relevance to members of LUPIN (Lancaster University Public Involvement Network), and the findings will be submitted as a presentation during a LUPIN steering group meeting if members felt that this would be appropriate.

The results of the research may be submitted for publication in an appropriate academic journal, and the results may be submitted for consideration as a poster presentation at the BPS DCP (British Psychological Society, Division of Clinical Psychology) Annual Conference in Spring 2020, or at another appropriate conference, e.g. an In2g8mentalhealth conference.

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

In question 14b, the procedure is outlined for ensuring that appropriate information has been gained from the participant in the event of any information shared which leads the interviewer to be concerned that the participant is at risk of harm to themselves or is potentially engaging in clinical practice which is unethical or unsafe. The lead interviewer is due to ask participants for their address and their current workplace. However, these are sensitive pieces of information, and which may discourage participants from taking part in an interview, or may set a tone of interrogation and judgment in the interview which could affect or limit participants' responses, or cause potential distress to participants. The lead researcher has discussed this dilemma with supervisors, and has agreed to ask for the committee's views in how to proceed to balance the need to have enough information to follow safeguarding procedures if necessary, against creating a supportive and encouraging framework for the interview to take place.

SECTION FOUR: signature

Applicant electronic signature: M. Rhinehart Date 25.06.18

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

Project Supervisor name (if applicable): Dr Suzanne Hodge Date application discussed 22.06.18

Submission Guidance

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

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to **Diane Hopkins by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

  a. existing documents/data only;
  b. the evaluation of an existing project with no direct contact with human participants;
  c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>**

Research Protocol

Studies suggest that clinicians working in mental health services may be at a high risk of experiencing mental health difficulties, such as compassion fatigue (Figley, 1995), burnout (Volpe et al., 2014), depression (Volpe et al., 2014), and suicidal ideation (Meltzer et al., 2008). A recent survey of psychological practitioners in the UK suggested a high prevalence of experience of mental health difficulties in clinicians working in this area (British Psychological Society [BPS], 2017a). However, detailed evidence on the mental health of mental health practitioners is sparse and predominantly based on small, self-selecting samples (Tay et al., 2018). In addition, it can be difficult to examine for two reasons. Many studies focus on clinicians' experiences of accessing personal therapy (for example, Norcross & Guy's 2005 review), which although a useful indicator of psychological distress, may not necessarily indicate mental health difficulties as many professions require practitioners to access their own personal therapy (for example, BPS, 2017b) or clinicians choose to access therapy for personal or professional growth (Daw & Joseph, 2007). It can also be difficult to consider causality, i.e., whether mental health difficulties are as a result of the pressure and vicarious trauma linked to working in mental health services (Cooke & Watts, 2016) or if experience of mental health difficulties is a motivating factor for entering a mental health profession (Barnett, 2007).

Data on UK-based clinical psychologists' experiences of mental health difficulties is limited, and much of the information is drawn from unpublished theses (for example, Aina, 2015; Bailey, 2007; Davidson, 2013). Clinical psychologists are suggested to be particularly vulnerable to experiencing psychological distress due to the therapeutic requirements of their role (Stevanoic & Rupert, 2004), and more recent studies have begun to explore the extent to which trainee and qualified clinical psychologists experience significant levels of mental health distress (for example, Charlemagne-Odle et al., 2014; Hannigan et al., 2004). Recent studies suggest that approximately two thirds of trainee and qualified clinical psychologists surveyed identified as having experience of mental health difficulties (Grice et al., 2018; Tay et al., 2018).

Although evidence suggests that occurrence of mental health difficulties amongst clinical psychologists may be high, disclosure and openness about these difficulties is low (Grice et al., 2018). Stigma linked to mental health difficulties is high amongst the general population (Corrigan & Watson, 2002), and also high amongst practitioner psychologists (Cain, 2000). This could be due to an environment which suggests that it isn't acceptable to need personal support as a psychologist (Charlemagne-Odle et al., 2014) and an implicit belief that in order to practise, one must be "mentally healthy" (Davidson & Patel, 2009). Studies have suggested that psychologists can develop dualistic perspectives on wellness and wellbeing (Good et al., 2009), with clinicians positioning themselves within an 'us' and 'them' dichotomy as a protective strategy (Maccallum, 2002), thus creating an internal barrier to disclosing any experiences which might place them within the 'other' group. Tay and colleagues (2018) suggest that the culture within mental health services may strengthen this false dichotomy by perceiving clinicians as "mentally resilient".

In recent years, there have been occasional published accounts of clinical psychologists speaking publicly about their experiences of mental health difficulties, such as Emma Harding (2010), Jamie Hacker-Hughes (2016), and Rufus May (2000). Other accounts have also been published, however many of these remain anonymous for fear of experiencing stigma (for example, Anonymous, 2016). It is interesting to note that all the published accounts are from experienced, qualified psychologists, potentially suggesting that individuals at the pre-training and trainee stages of their career may feel higher levels of stigma in disclosing experience of mental health difficulties. This may be particularly true for trainee clinical psychologists who frequently experience 'imposter syndrome' (Jones &

Thompson, 2017), which is linked to high levels of self-doubt and feelings of inadequacy, potentially adding an additional barrier to disclosing anything which may be perceived as a ‘weakness’.

The dichotomy of ‘us’ and ‘them’ within mental health services can create particular difficulties for clinicians who identify as belonging to ‘both groups’ (Oakley, 2016). Most individuals hold multiple identities, for example many people may separate their personal and professional roles, however, holding multiple identities with the potential to feel as though they are in conflict with each other may result in psychological distress from the strain of separation or concealment of a part of one’s identity (King, Reilly & Hebl, 2008). Concealment of a part of one’s identity may also leave an individual feeling inauthentic in their identity. Individuals who engage in self-concealment may be less likely to seek psychological help (Vogel & Wester, 2003), or may struggle to recognise when they are experiencing difficulty. The high level of stigma within mental health professions may lead clinicians to actively conceal their identity as a service user in order to avoid stigma or being seen as unfit to practice (Pope & Tabachnick, 1994). Good and colleagues (2009) support this suggestion, proposing that whilst many individuals may experience denial and shame over seeking help, this may be magnified in psychologists where feelings of shame may impact on the personal and professional aspects of their identity. This barrier is significant as clinical psychologists are required to recognise and acknowledge signs of ill health and take any necessary actions to manage their own distress (BPS 2009; Health and Care Professions Council [HCPC], 2015).

Whilst much of the literature focuses on the challenges and stigma associated with being a service user as well as a clinician, there is emerging evidence that there may also be positive benefits. When considering the clinician’s experience of delivering therapy, personal experience of mental health difficulties may enhance a clinician’s understanding of their clients' experiences, such as an appreciation for the level of commitment and energy required to engage in psychotherapy (Adame, 2011; Oates, 2017). A power differential is inherent within a therapeutic alliance, however personal experience of occupying the role of a client may encourage clinicians to be more aware of this imbalance when they are in the role of therapist, and to try to avoid behaviours which further this imbalance. Clinicians have reported feeling more compassionate and understanding towards clients as a result of their own personal experiences (Richards et al., 2016), positioning this as a unique set of resources and knowledge (Schiff, 2004) and the narrative of the 'wounded healer' posits a framework which may encourage the practitioner to utilise their own experiences of mental health difficulties to help others (Gilbert & Stickley, 2012). Whilst there is debate within different disciplines over the value and purpose of self-disclosure by a therapist within a therapeutic intervention, clients generally report thoughtful self-disclosure as helpful and powerful (Hanson, 2005; Ivey & Phillips, 2016). Clients' experiences of self-disclosure appear to support the suggestion that personal experience of distress can enhance empathy and understanding, reflecting that "they've been there, they know" (Lewis-Holmes, 2016). However, research into clients' experiences of self-disclosure is currently in its infancy, suggesting a need for clinicians to remain cautious and thoughtful about the purpose and use of self-disclosure (Gilbert & Stickley, 2012; Henretty & Levitt, 2010).

Increased empathy and understanding may also transfer into systemic practices through strengthening compassionate, non-judgemental attitudes within staff teams, and sharing personal experiences of mental health difficulties may offer a powerful challenge to the 'us' and 'them' dichotomy within mental health services (Richards et al., 2016; Wasyliw, 2014) and also more widely within society (Pilgram, 2017). In a single study exploring colleagues' reactions to a practitioner's disclosure of accessing personal therapy, psychologists generally reacted positively and did not show any signs in feeling hesitant about referring clients to their colleague following the disclosure (Schroeder et al., 2015). Clinicians with experience of mental health difficulties have reported feeling more able to engage in positive social action at both an individual and a wider level (Richards et al., 2016) and have noted that their professional training has helped them to understand their own experiences of distress (Gilbert & Stickley, 2012).

A recent, emerging realisation of the prevalence of mental health difficulties in clinicians working in these services, along with increasing pressures within the NHS, has led to a focus on actively trying to reduce stigma around experiences of psychological distress and provoke a shift towards asking for support being viewed compassionately. Initiatives such as the Honest, Open, Proud pilot ("Honest, Open, Proud", 2017) and the In2gr8mentalhealth forum are both actively trying to reduce stigma around mental health difficulties within clinicians.

Although high reported levels of experience of mental health difficulties in clinical psychologists would suggest that these experiences may be more common than perceived, the concurrent high levels of stigma associated with these experiences may be a barrier to disclosure and help-seeking behaviour. This is potentially at odds with BPS (2009) and HCPC (2015) directives for psychologists to monitor their own mental health and professional impairment and suggests a need for studies to explore how clinicians navigate these experiences. Research published in this area has begun to consider the impact of clinical psychologists' own lived experience of mental health distress on professional roles; studies exploring the experiences of clinicians in navigating dual roles as service user and clinician are more limited. Richards and colleagues (2016) used discourse analysis to explore how mental health professionals from different disciplines constructed dual identities and found that participants often constructed separate identities as 'professional' and 'patient'.

However, many participants spoke about the value of an ‘integrated’ identity as being the most helpful approach, though participants recognized that this was difficult to achieve.

This study aims to build on Richards and colleagues’ 2016 study by utilising narrative analysis to explore participants’ journeys through negotiating and integrating dual identities. As this study is primarily focused on how participants view a series of experiences linked into a narrative, i.e., the development and negotiation of dual identities, rather than a single experience, narrative analysis offers an opportunity for an in-depth exploration and consideration of how participants view themselves within their story (Creswell, 2012). Identity development will be considered within a narrative theory (for example, Bruner 2004; Kirkman, 2002) as these theories suggest that identity is best understood as a process rather than a fixed construct. In addition, this study will focus on one specific professional group, which may be useful in order to place participants’ narratives within a similar context. This study may have relevance for clinicians with dual identities, training courses and supervisors in considering how these dual identities may be negotiated and supported.

Method

Participants

Participants will be recruited based on the following criteria:

Inclusion criteria

Participants will be a convenience sample of HCPC-registered clinical psychologists, with at least one year of employment as a qualified clinical psychologist. They will have been recently in employment as a clinical psychologist (i.e., in at least one role within the two years prior to taking part in the study), in order to talk about their experiences within a professional context.

Participants will identify as being a ‘service user’ or an ‘ex-service-user’ of mental health services. As a narrative approach will be used to explore how participants’ identities develop over time, self-definition as a ‘service user’ or ‘ex-service-user’ will be used as the primary criterion. The criteria for the service which participants have accessed is open to services based in the NHS, third sector, and/or private sector.

Between eight and 12 participants are intended to be recruited. As it is hoped that the findings of the study will be useful to other clinicians with dual identities, thematic narrative analysis will be used to explore themes emerging from the content of participants’ experiences (Lyons & Coyle, 2016; Riessman, 2008).

A small sample size has been chosen due to narrative analysis generating rich data, and so between eight and 12 participants should provide sufficient data for a detailed interpretative account, whilst allowing for the consideration of thematic saturation (Guest et al., 2006). Sample size in previously published narrative analysis studies exploring the development of identity have utilised a similar size (for example, Gravley et al., 2015; McKail et al., 2017).

Recruitment will take place nationally, and it is hoped that this will allow for a diverse range of experiences from a variety of locations within the UK, rather than from only one specific location.

Design

Semi-structured interviews will be conducted with participants to explore their experiences of navigating dual identities as service user and service provider. As the study is aiming to explore participants’ personal experiences that have shaped their identity over time, a narrative approach will be used to structure the interview as this approach will provide participants with the opportunity to talk about their experiences in a way which is meaningful to them, without imposing too much structure which might limit their responses.

Participants’ responses will be analysed using a narrative approach, as this is a method which seeks to explore how meaning is applied to participants’ experiences (Finlay, 2011). Narrative analysis also considers the influence of culture and socio-political factors (Weatherhead, 2011), both of which may be linked to stigma and the development of identity (Abdullah & Brown, 2011). Narrative analysis is often used to provide a voice to silenced voices of excluded groups (Endo et al., 2010), which may include individuals with lived experience of mental health difficulties. As the development and negotiation of multiple identities is likely to change over time, narrative analysis offers an opportunity to explore the development of this, rather than focusing on a single experience (Creswell, 2012). Narrative analysis has been used in previous studies exploring identity development, for example, Burns and Bell (2011), and Kuper and Mustanski (2014).

Materials

The ‘lightly-structured’ interview schedule will offer participants the opportunity to tell their story without the researcher dictating or imposing a structure which might hinder participants’ responses (Willig, 2008). The schedule has been informed by previous qualitative studies looking at clinicians’ experiences of identity development (for example, Harvey, 2017; Tarik, 2017). See Appendix 2-A for full interview schedule.

The schedule has received input from two qualified clinical psychologists who identify as having experience of mental health difficulties and of accessing mental health services.

Procedure

Recruitment

Participants will be recruited through four avenues:

The study will be advertised on Twitter from the lead researcher’s account, which is a professional account. The link for the study will request that any potential participants contact the lead researcher’s university email account if they are interested in participating.

North-West Psychological Professionals Network (NWPPN) is a network representing psychological practitioners working in the North-West of England. The network will be contacted to ask if their members would be interested in participating. With their consent, details of the study will be sent to the NWPPN to be distributed through their mailing list. Potential participants will be directed to contact the lead researcher's university email account if they are interested in taking part in the study.

www.in2gr8mentalhealth.com is an online forum for clinicians who identify as 'dual status' (i.e., being both a clinician in mental health services and a service user). The study will be advertised on the forum using the lead researcher's account. Potential participants will be directed to contact the lead researcher via email if they are interested in taking part.

There are multiple groups on Facebook specifically for clinical psychologists working in the UK. The study will be advertised in these groups using the lead researcher's account. Potential participants will be directed to contact the lead researcher via email if they are interested in taking part.

When a potential participant makes contact, the lead researcher will be able to provide further information about the study and to answer any questions. If they are still interested, participants will be emailed a copy of the information sheet (Appendix 4-A) and a consent form (Appendix 4-B), which will be requested to be returned to the researcher prior to the interview taking place.

Interviews

Interviews will be conducted by the lead researcher and will take place at a mutually agreed location, or over the internet (i.e., using Skype), due to the potential wide-ranging geographical location of participants. Interviews are envisaged to take approximately 60 – 90 minutes.

Analysis

The data will be analysed using a narrative thematic analysis. The lead researcher will transcribe each interview, allowing the process of familiarisation and immersion to begin prior to analysis (Braun & Clarke, 2013). The researcher will begin by describing the interviews thematically, moving back and forth between the interviews and generalisations about them. This will lead the researcher into identifying major themes, without breaking down the text too much and losing a sense of the narrative within it (Reissman, 2008). Attention will be paid to the sequencing and progression of themes within interviews, and their transformation and resolution (Squire, 2013). Themes will be clustered into distinct categories, with some themes subsequently being divided into sub-themes. The analysis and themes will be discussed with the project supervisors in order to support validity. The analysis will aim to be conducted within the four key criteria for quality in qualitative research: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance (Yardley, 2017). In addition, participants from the study will be involved in the analysis process (if they have consented to this), by being asked to comment on their summary stories to confirm that these are an accurate representation of their experiences.

Dissemination

The findings will be presented to stakeholders and current trainees on Lancaster University's DClinPsy programme. The results will be submitted for publication in an appropriate academic journal, and the data may be submitted for consideration as a poster presentation at the British Psychological Society Division of Clinical Psychology's Annual Conference. The study may also be submitted for consideration as a presentation at a conference on dual identity organised by In2gr8mentalhealth. A summary of the project will be provided to participants, if they have opted in to receive this. In addition, the project may be relevant to members of LUPIN (Lancaster University Public Involvement Network), and the findings will be submitted as a presentation during a LUPIN steering group meeting if members felt that this would be appropriate.

Ethical concerns

Risk to participants

This study is aimed at exploring participants' experiences and is not anticipated to cause significant distress. However, there is a possibility that the topic of the interview could potentially be an emotive or difficult topic for participants to discuss. Particular care will be taken to ensure that participants are fully informed as to the nature of the study prior to beginning the interview (including on the information sheet) and will be made aware of their right to pause or withdraw from the interview at any point during the interview or within the two weeks following completion of the interview. Participants will be fully informed of the limits of confidentiality within the interview, including the researcher's duty to pass on any concerns about risk to self or unsafe/unethical practice. Participants will be debriefed at the end of the interview and will be given information on the information sheet about appropriate numbers to contact if they are experiencing distress following the interview.

During the interview, participants may discuss or reflect on examples from their clinical practice. Therefore, participants will be asked to maintain confidentiality during the interview through using pseudonyms when discussing any clinical examples and avoiding any potentially identifying information.

Participants will be informed that the interviewer will not be able to maintain confidentiality if any issues of significant risk or unethical practice are identified. Due to participants discussing their historical or current mental health difficulties, there may be limits to confidentiality both in terms of risk to self from participants and/or unsafe or unethical practice. If the researcher is concerned about a significant risk of harm, she will raise this with the participant and discuss the steps which will need to be taken, e.g., the participant to access support through his/her GP. The lead researcher will also discuss any safeguarding concerns with the project supervisors following an interview, including reviewing if any further action is needed.

Due to the personal nature of the content of the interview, it is possible that participants may feel keen to make sure that their story is 'heard' and represented accurately within the study. To support this, the lead researcher will write a summary story of each participants' narrative following transcription of their interview, which will be shared with the participant if they have consented to receive this. The participant will have the option of making any changes or suggestions to ensure that their story is an accurate representation of their experience, and that they can feel reassured that their narrative has been heard and 'protected' by the researcher.

Risk to researchers

Face-to-face interviews will involve the interviewer following Lancaster University's Lone Worker Guidance. This policy outlines the health and safety requirements where persons work alone and the implementation of safe working arrangements. The interviewer will provide her destination and name of the participant in a sealed envelope to a peer or colleague (e.g., another Lancaster DClinPsy trainee), along with an estimate time of return. The interview will then advise the peer upon her return. If contact is not made, the peer will attempt to contact the interviewer. If this contact is unsuccessful, the peer will open the envelope and contact the appropriate authorities, passing on the participant's name and destination.

Timescale

June - August 2018: Completion of ethics applications.

September – December 2018: Recruitment of participants and interviews. Write up introduction and method sections.

September 2018 – December 2018: Transcription of interviews

January – March 2019: Analyse data. Write up results and method sections.

May 2019: Project submission.

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Appendix 4-A – Participant Information Sheet

Exploring the experiences of clinical psychologists of negotiating dual identities as mental health service users and service providers.

My name is Molly Rhinehart and I am conducting this research as part of my studies on the DClinPsy programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?
The purpose of this study is to explore the experiences of clinical psychologists who identify as both a mental health service user and a provider of mental health services and their negotiating of these two identities. The study hopes to develop an understanding of how these identities develop over time, and some of the strengths and challenges in holding these dual identities.

Why have I been approached?
You have been approached because the study requires information from people who are working as a clinical psychologist in the UK and who have identified as also being a service user or ex-service user of mental health services.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part, and you will be able to withdraw at any point during the interview or up to two weeks following the interview.

What will I be asked to do if I take part?
If you decide you would like to take part, you would be asked to participate in an interview with the researcher, lasting for approximately 60 - 90 minutes. This interview may take place face to face in a mutually agreed location, or through Skype if this is not possible. The interview will be audio recorded, and I will analyse the interviews to see if similar themes emerge. Please note that if you chose to take part in the interview via Skype, it cannot be guaranteed that this method is completely secure.

As the focus of the project is on narratives of personal experience, I will be writing up a summary story of the information from your interview. If you are happy for me to do this, I will share this with you using Lancaster University's secure cloud storage, and ask for your feedback if the summary story feels like an accurate representation of your narrative, or if there is anything you would like to add or change.

Will my data be identifiable?
The transcribed version of your interview will be made anonymous by removing any identifying information, including your name and workplace. All documents (including scanned signed consent forms) will be password-protected and stored electronically on a secure drive (Lancaster University VPN).

Anonymised, direct quotes from your interview may be used in the report or a publication from the study; your name will not be attached to these. Audio recordings of the interviews will be deleted once they have been transcribed. All of your personal data will be confidential and kept separately from your interview responses.

There is a limit to the confidentiality provided in the interview. If what is said during the interview makes me concerned that you or someone else is at significant risk of harm, I will have to break confidentiality and speak to my research supervisors about my concern and report any concerns to an appropriate safeguarding team. Whenever possible, I will tell you if I have to do this.

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data.

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

What will happen to the results?
The results will be summarised and reported as part of my thesis and may be submitted for publication in an academic journal or as a poster presentation.

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

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part.

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

Where can I obtain further information about the study if I need it?
If you would like to take part in the study, or have any questions, please contact the main researcher:

Molly Rhinehart, Trainee Clinical Psychologist.
Division of Health Research, Lancaster University, Bailrigg, Lancaster, LA1 4YG.
Please email me on: m.rhinehart@lancaster.ac.uk

The project is supervised by:

Dr Suzanne Hodge, Lecturer in Health Research and Research Tutor.
Division of Health Research, Lancaster University, Bailrigg, Lancaster, LA1 4YG.
01524 592712
s.hodge@lancaster.ac.uk

Dr Hannah Wilson, Clinical Psychologist and Senior Clinician.
Central & West Lancashire Eating Disorder Service, Tudor House, 18 Euxton Lane, Chorley, Lancashire, PR7 1PS.
01772 647072

Hannah.Wilson@lancashirecare.nhs.uk

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

Professor Bill Sellwood
Tel: (01524) 593998
Programme Director
Email: b.sellwood@lancaster.ac.uk
Division of Clinical Psychology
Furness Building
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup
Tel: +44 (0)1524 593746
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

GP – Your GP will be able to signpost you to access relevant support if needed.

Samaritans – Provide 24 hour support, 365 days a year on 116 123.

MIND – Provide support Mon – Fri, 9am – 6pm on 0300 123 3393.

You may also wish to talk with your clinical supervisor about any issues raised during the interview, or contact your trust's employee wellbeing service.

Appendix 4-B - Consent Form

Study Title: Exploring the experiences of clinical psychologists of negotiating dual identities as mental health service users and service providers.

We are asking if you would like to take part in a research project exploring the experiences of negotiating dual identities as mental health service users and service providers.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Molly Rhinehart.

Please tick each statement

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

Name of Participant:

Signature:

Date:

Name of Researcher:

Signature:

Date:

Appendix 4-C – Letter to Ethics Committee

Study reference: FHMREC17104

8th August 2018

Prof Roger Pickup
Chair of the Faculty of Health and Medicine Research Ethics Committee
Lancaster University

Dear Professor Pickup,

Re: FHM Research Ethics Committee application for project titled: *'Exploring the experiences of clinical psychologists of negotiating dual identities as mental health service users and service providers'.*

Thank you for your feedback on my recent application. I have attached a file with the changes made and highlighted. I wanted to address a concern raised in your feedback letter relating to the use of Facebook for recruitment:

"Application section 3.4 – Use of Facebook is not advised, since Facebook rules mean that you can only use your own page and this is not a safe option for you".

Following discussion with my supervisor on the benefits and risks to using Facebook for this purpose, I would like to include this as a recruitment method for the following reasons:

- **Range in participant experiences.** The study is aiming to recruit participants from a range of sources to attempt to have a wide range of participant experiences, within a relatively small sample size. The use of Facebook will assist with this aim.
- **Mutual trust.** The lead researcher is a trainee clinical psychologist, part of the same professional group as potential participants (clinical psychologists), and is already a member of Facebook groups set up for clinical psychologists. I have posed questions and responded to previous posts in the group, using my existing profile. The use of this profile in recruitment will potentially be a stepping stone in building mutual trust between myself and a potential participant, a key goal in qualitative research.
- **Risk to researcher.** The use of a personal profile in recruitment for research naturally presents a potential risk of breach of privacy for the researcher. However, this will be minimized as the privacy settings on my account are set high in accordance with BPS guidelines on the use of social media, meaning no personal information will be viewable by potential participants. In the recruitment advert, participants will be directed to contact me using my university email address. If any potential participants contact through Facebook Messenger, they will be directed to contact me using my university email account, and no further contact will be made through Facebook.

Please could you let me know your thoughts on this proposal?

Yours sincerely,

Molly Rhinehart

Appendix 4-D – Ethics Approval Letter

Applicant: Molly Rhinehart
Supervisor: Suzanne Hodge
Department: Health Research
FHMREC Reference:
FHMREC17104

24 August 2018

Dear Molly

Re: Exploring the experiences of clinical psychologists of negotiating dual identities asmental health service users and service providers

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

As principal investigator your responsibilities include:

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

Please contact me if you have any queries or require further

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

Yours sincerely,

R·E·Case

Becky Case
Research Ethics Officer, Secretary to FHMREC