Who Are We and Who Do We Want to Be?

Exploring the Professional Identities of Clinical Psychologists

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Statement of Originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance in preparing this thesis and sources have been acknowledged.

Samantha Schubert

15th June 2023

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Authorship Attribution Statement and List of Publications and Awards

This is a thesis with publications. At the time of submission, Chapters 3, 4 and 5 were published in peer reviewed journals and Chapter 6 had been submitted for publication and was under review. The chapters are presented in APA format. No changes to content have been made with the following chapters reflecting the versions published in peer review journals. For this reason, each chapter is presented as per the preference and focus of distinct academic journals.

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Name	Date

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Professor Caroline Hunt	15th June 2023
_____	_____
Name	Date

Thesis Abstract

The professional identities of clinical psychologists refers to their sense of self as a professional and enables them to make sense of who they are and want to be as clinical psychologists. My overall research aim was to explore the professional identities of clinical psychologists using a social constructionist framework and qualitative research methods. Study 1 involved an exploration of the transformation of professional identities of clinical psychologists, psychologists and psychiatrists implementing Open Dialogue in a public youth mental health setting. Open Dialogue is a social network model of mental healthcare service delivery that diverges from the medical model dominating Western mental healthcare services. The results indicated that clinicians' professional identities – including those of clinical psychologists – impacted their willingness and ability to implement mental healthcare service models that align with reform priorities. On this basis, the research shifted to explore the professional identities of clinical psychologists more broadly. Study 2 involved a scoping review of the literature exploring clinical psychologists' professional identities. Findings demonstrated clinical psychologists' professional identities are integrated with their personal identities, intersect with other identities, and change over time. The scoping review also revealed that educational settings are formative in shaping professional identity construction, with Studies 3 and 4 then focussing on the process of identity construction during clinical supervision interactions within a university clinical psychology training clinic. Study 3 explored identity construction during supervisor-initiated interrogations in supervision and found that supervisors approached interrogations from either a quality control or reflective frame, and that how supervisors approached interrogations influenced and constrained what identities trainees constructed for themselves. Study 4 focussed on supervision encounters in which clients were positioned as fragile (unable to manage distress), which was found to co-occur with clinical psychologists claiming identities as responsible for containing distress.

The findings were interpreted as demonstrating how sanctioned ways of knowing are perpetuated through supervision and how paternalistic clinical discourses (that do not align with mental healthcare reform priorities) can be perpetuated. Overall, this research highlights the importance of clinical psychology being aware and intentional in fostering professional identities of its members that enhance clinical practice and align with directions in mental healthcare service delivery. Recommendations for the profession, researchers and educators are provided.

Thesis Outline

Chapter 1: General Introduction

Statement of problem, significance of research, approach to this research, author reflexivity and research journey, and overview of the current research.

Chapter 2: Theory and Literature Review

Overview of theorising on identities in the literature and current research, and literature exploring professional identities across other healthcare professions and within psychology.

Chapter 3: Transformation to Professional Identity and the Implementation of Open Dialogue (Study 1)

Empirical study exploring changes to professional identity amongst clinicians implementing Open Dialogue in a youth mental healthcare setting.

Chapter 4: Scoping Review (Study 2)

Scoping review of the literature exploring the professional identities of clinical psychologists.

Chapter 5: Interrogations in Clinical Supervision (Study 3)

Empirical study exploring interrogations in clinical supervision encounters and the implications for clinical psychology trainees' identity construction.

Chapter 6: Fragilising Clients in Clinical Supervision (Study 4)

Empirical study exploring supervision encounters in which clients are positioned as fragile and the implications for clinical psychology trainees' identity construction.

Chapter 7: General Discussion

Importance of this research, revisit of aims and approach, reflections and considerations for the profession, educators and researchers, limitations and strengths, and final thoughts.

Contents

List of Figures

List of Tables

Chapter 1: General Introduction

1.1 Statement of Problem

Our identities are essential in determining who we are and want to be. Our sense of who we are as a member of a profession, or our professional identities, provides the cornerstone for the values, attitudes and behaviours we bring with us into our professional roles (e.g., Rees & Monrouxe, 2018). Recognition of professional identities as a foundational element of being a member of a profession by researchers and educators has led to the increased exploration of professional identities across a range of healthcare professions including medicine (e.g., Monrouxe, 2009), nursing (e.g., Hercelinskyj et al., 2014), counselling (e.g., Moss et al., 2014), and other allied health professions (e.g., Hammond et al., 2016), yet this remains comparatively underexplored within clinical psychology. Emerging research within clinical psychology suggests non-conflicting and optimal professional identities may be associated with professional development (Knoetze & McCulloch, 2017), well-being and reduced burnout (Turnbull & Rhodes, 2019), traits associated with enhanced clinical effectiveness including genuineness and tolerance of uncertainty (Salter & Rhodes, 2018), and is facilitated through education practices including clinical supervision (O'Donovan et al., 2011). Moreover, evidence suggests that how clinical psychologists understand themselves and their roles has implications for clinical service delivery and their capacity to align their work with new directions and reforms in mental health services (e.g., Cooke et al., 2019; Tickle et al., 2014). Thus, whilst professional identity is not an established research field within clinical psychology, it is pertinent to a range of prominent contemporary professional issues. Moreover, exploring the professional identities of clinical psychologists is important in the context of widespread divisions within the profession (Chang et al., 2008; Johnstone, 2010; discussed further on page 26 of current

thesis) that contributes to a turbulent professional landscape within which clinical psychologists must navigate who they are and who they are becoming.

The overall purpose of this research is to explore the professional identities of clinical psychologists. Largescale and longitudinal evidence confirms that the primary activity of clinical psychologists is conducting therapy (Norcross & Karpiak, 2012), and thus this research focusses on exploring the professional identities of clinical psychologists in clinical contexts. This research addresses and explores the following research questions:

RQ1: What is the nexus between clinical psychologists' professional identities and the implementation of new models of mental health care?

RQ2: What is known about the professional identities of clinical psychologists and what is the quality of the available literature?

RQ3: How and in what ways are clinical psychologists socialised into acquiring professional identities in educational contexts?

In answering the above, this research adopts a social constructionist approach to understanding identities (see 'Disentangling Identities in the Present Research' section in Chapter 2, page 63 for a comprehensive overview of how identities are understood in this research). The aim is to produce considerations for the profession, researchers and educators to guide and support the professional identity construction of clinical psychologists. The broader hope is that these insights will allow the profession to critically consider where it is and wants to be, and how it might intentionally support tomorrow's clinical psychologists to become clinicians whose professional identities contribute towards the realisation of high-quality mental healthcare service delivery.

1.2 Contextualising this Research

Our ways of understanding ourselves and the world are historically and culturally specific (Burr, 2015). How we come to understand ourselves and our identities has a social

origin; we come into the world and inherit meaning and concepts (all through language) that form the foundations from which we craft our identities. Thus, we make sense of ourselves through the cultural lenses bestowed upon us (Crotty, 1998). If all forms of knowledge are historically and culturally specific (Burr, 2015), then any exploration of clinical psychologists' professional identities must be situated within an understanding of the profession more broadly within which clinical psychologists themselves are situated. This section therefore provides an overview of the profession of clinical psychology and its development in an Australian context, and discusses topical issues and trends within the profession.

1.2.1 History of Clinical Psychology as a Profession

A *profession* is an occupation with a specialised interest and body of knowledge that provides an intellectual base for practice and for which the profession claims executive control (Lancaster & Smith, 2002). Professions were once defined functionally according to specific traits, but have increasingly been understood as the social processes through which a group with a shared collective interest acts to ensure a monopoly over knowledge and resources in a way that ensures social respectability and upwards mobility (Macdonald, 1995). It is easy to take for granted the existence and influence of professions without considering their monopoly over knowledge and resources, and thus their privilege and power in shaping how societies operate. Further, it is easy to overlook how professions achieve this; that is, how they make special claims to knowledge and resources, and the continuous implications for maintaining or redefining *how things are done* (Macdonald, 1995). The profession of clinical psychology and its history set the stage on which people come to be clinical psychologists, and thus influences how they come to position and understand themselves as clinical psychologists.

The origins and survival of clinical psychology – as with any profession - lie in establishing an area of knowledge which those in the profession can isolate and establish special claim to (Macdonald, 1995). Clinical psychology emerged from the broader profession of psychology and has subsequently demarcated itself as a specialty professional domain of psychology (Lancaster & Smith, 2002; Routh, 2000). Clinical psychology's efforts to establish a distinct identity for itself, and in doing so to create a boundary between its expertise and tasks distinct from psychology more broadly, are evident in the profession's history.

Clinical psychology emerged out of psychology in the late 1800's in America. During this time and up until World War II, clinical psychology sought to establish itself firmly as a science and clinical psychologists were predominantly involved in psychometric testing (Chang et al., 2008). Following World War II, however, there was increasing recognition of post traumatic stress reactions in returned veterans, with clinical psychologists increasingly trained and working within veteran psychiatric hospitals to provide psychiatric services to meet the increased demand for mental healthcare professionals (Albee, 1998). Subsequently, training programs adjusted to focus on mental health assessment and treatment (Humphreys, 1996; Miller, 1946). This post-war transformation was not universally agreed upon, however, and the role of clinical psychologists had no general consensus with many arguing for a renewed focus on psychotherapy less influenced by psychiatric models (Chang et al., 2008; Humphreys, 1996). Since this time, clinical psychology has experienced rapid growth and with this has come some fragmentation around the identity of the profession (Lancaster & Smith, 2002). The divisions and debates within the profession that have led to this fragmentation are discussed further on in this section (see section on 'Divisions and Debates' later in this chapter, page 26).

1.2.2 Clinical Psychology in Australia

Much of academic psychology in Australia was imported from Britain, Germany and America, and initially resided in philosophy departments (Taft, 1982; Taft & Day, 1988; Turtle, 1985). By the 1920's Australian psychology became heavily influenced by medicine and teaching, with undergraduate psychology degrees emerging during this time (Taft & Day, 1988). As in Europe and America, World War II led to a rapid growth of psychology, with the Australian post-graduate courses emerging in the 1970's (Taft, 1982). Since this time, psychology has become increasingly specialised within Australia, with clinical psychology now a distinct and specialised area of endorsement. Today, becoming a clinical psychologist in Australia requires eight years of specialised university education and training, and endorsement in the specialty area of *clinical* psychology by the Psychology Board of Australia (The Australian Clinical Psychology Association, 2022). Clinical psychology in Australia now positions itself as a science-based profession with the highest level of education and training in mental health, and with expertise in psychological problems and disorders (The Australian Clinical Psychology Association, 2022). Clinical psychologists are now positioned as highly specialised providers of mental healthcare clinical services in Australia (Jackson et al., 2021).

1.2.3 Current Trends in Clinical Psychology

Current trends within clinical psychology provide insight into the broader context in which clinical psychologists develop their professional identities. These trends encompass the theoretical models endorsed within the profession as well as the day-to-day trends illustrating the typical profile and experience of being a clinical psychologist. Dominant ways of knowing within the profession, survey studies of the profession itself, personal accounts detailing the lived experience of becoming a clinical psychologist, and an overview of the

divisions and debates within the profession are provided below to shed light on the current professional landscape of clinical psychology.

1.2.3.1 Ways of Knowing: Science practitioner model

Sanctioned ways of knowing within a profession communicate the values, truths and accepted ways of understanding the world within any professional group. Psychology as a broad discipline has modelled itself upon the natural sciences and adopted an objectivist framework (Burr, 2015; see page 34 for a definition of objectivism and a discussion about its constraints as an epistemological perspective). At the 1949 Boulder Conference the *science practitioner model* was endorsed as the primary training model for clinical psychology specifically (Raimy, 1950). The Boulder Conference was convened by the American Psychological Association to review the training of clinical psychologists amidst concerns about the lack of standardisation across an increasing amount of clinical psychology training programs. This endorsement of the science practitioner model led to an emphasis on rigorous scientific and research training in conjunction with explicit clinical training experiences (Furtaw, 2004), and remains highly influential as the foundation of the profession today. One implication of the model is that the training of clinical psychologists requires a competency based framework that reflects (and assesses skills in) the integration of research and clinical practice (Shapiro, 2002). This suggests the attainment of core competencies endorsed by the science practitioner model are a pivotal axis on which clinical psychologists are assessed (Australian Psychology Accreditaton Council, 2019), and thus likely play an important role in how clinical psychologists understand their professional identities. However, as in medicine, there is some recognition that the attainment of competencies alone as it currently stands is insufficient for the education and training of clinical psychologists (Berenbaum et al., 2021; Patel et al., 2022; Rodolfa & Schaffer, 2019). It has been recognised that therapists - including clinical psychologists - make decisions based on more than scientific or technical

knowledge alone. For instance, the concept of the 'reflective practitioner' by Schön (1983) - a notion that recognises the highly complex and reflective processes surrounding clinical decision making - is now widely embraced within clinical psychology despite a slow uptake given the profession's objectivist approach and focus on behavioural sciences (Bennett-Levy, 2003; Burgess et al., 2013; Lavender, 2003). This reflects a greater appreciation of other ways of knowing within the profession, although the science-practitioner model remains the predominant pillar on which the profession rests itself and attests to the privileging of scientific ways of knowing within the profession (Australian Psychology Accreditaton Council, 2019).

1.2.3.2 Who We Are and What We Do: Survey studies of the profession

Ways of knowing endorsed by the profession do not shed light on *who* clinical psychologists are and *what* they do. Much of the research investigating how clinical psychologists understand themselves involves large scale self-report surveys akin to a profiling of the profession. Nevertheless, these studies illuminate collective trends that influence how clinical psychologists make sense of themselves in their roles. Survey based studies exploring the characteristics and self-perceptions amongst clinical psychologists are wide-spread and have been conducted in countries such as the USA (Norcross & Karpiak, 2012), United Kingdom (Nel et al., 2012), Ireland (Carr, 1995), Canada (Hunsley & Lefebvre, 1990), South Africa (Manganyi & Louw, 1986) and Australia (Byrne & Davenport, 2005; Byrne & Reinhart, 1990). The largest of these is a longitudinal survey-based study of clinical psychologists that has chronicled the transformation of members of the American Psychological Association's Division of Clinical Psychology every ten years since the 1960's (Norcross & Karpiak, 2012). Norcross and Karpiak (2012) describe the rapid growth and change within the profession since World War II, with the following increasing between 1960-2010: the number of females (increasing from 16% to 32% with subsequently greater

numbers of females than males), racial or ethnic minority members (increasing from 2% to 9%), the number of institutions granting doctoral degrees (increasing from 103 to 153), employment in private practice (increasing from 17 to 41% alongside a decrease in employment in hospital and outpatient mental healthcare settings from 45% down to 10%) and cognitive and behavioural theoretical orientation (increasing from 8% to 46% alongside a decrease in psychodynamic or eclectic orientations from 71% to 30%). Whilst representative of American division members only, these shifts reveal collective trends amongst clinical psychologists amidst a transforming profession and shed light on the changes taking place within the profession that are similar in an Australian context (Byrne & Davenport, 2005; Mathews et al., 2010). In Australia, there is an increasing presence of women (now representative of the majority) and people of minority identities (although they continue to remain under-represented), and a shift out of public mental healthcare settings and into private settings with a trend towards scientific-based cognitive or behavioural orientations (grounded in natural sciences that privilege objectivist paradigms) (Byrne & Davenport, 2005, Matthews et al., 2010).

1.2.3.3 Becoming a Clinical Psychologist: Personal accounts

Ways of knowing and large-scale surveys shed light on general, collective trends but are silent on the individual experiences of clinical psychologists themselves. Yet clinical psychologists are increasingly self-authoring and publishing reflections of their own professional identity formation in the context of training (e.g., Avivi et al., 2015; Kottler & Swartz, 2004; Prajapati, 2019; Yancy & Hadley, 2005), personal suffering (e.g., Blake, 2015; Murray-Swank, 2019; Nash & Chapman, 2019) or in the context of navigating gender, disability, age, ethnicity, race and cultural identity alongside becoming a clinical psychologist (e.g., Blake, 2015; Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009; Hurd, 2016; McGowen & Hart, 1990; Pearlstein & Soyster, 2019; Prajapati, 2019).

Accounts of the experiences of navigating challenging personal circumstances in the context of developing an identification with the profession attest to the inseparable interplay between personal and professional identities. Questions around self-disclosure, and difficulties admitting to needing support emerge (e.g., Blake, 2015; Murray-Swank, 2019; Nash & Chapman, 2019). A picture arises in which difficulties admitting to experiencing personal hardship and locating support culminates in these issues being navigated secretly and behind closed doors, with calls for the profession to more openly acknowledge the vulnerability of its members (e.g., Nash & Chapman, 2019). In addition, clinical psychologists with minority identities not well represented professionally are increasingly articulating the complexities of navigating integration of these identities into their identities as clinical psychologists (e.g., Blake, 2015; Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009; Hurd, 2016; McGowen & Hart, 1990; Pearlstein & Soyster, 2019; Prajapati, 2019). Experiences as trainees being trained within systems and institutions that disregarded other cultural and indigenous knowledges in favour of white, Eurocentric perspectives have been destabilising and harmful for clinical psychologists who do not identify as white (Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009; Prajapati, 2019). Trainees describe feeling conflicted about their professional identities in the context of diverse racial identities because of Eurocentric perspectives that are blind to culture and race and thereby promote covert and overt racist attitudes (Davidson & Patel, 2009; Prajapati, 2019; Wood & Patel, 2017), with more experienced clinicians describing the transformative albeit challenging experience of progressively integrating their racial and professional identities (Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009). Other experiences of needing to navigate older age and motherhood (Hurd, 2016) or the intersection of multiple minority social identities (Comas-Diaz & Weiner, 2011) attest to the difficulties of entering and being within a profession where one's identity does not fit the perceived dominant identity.

Collectively, these lived experience accounts offer an insight into a deeply personal, nuanced, and complex process of identifying oneself as clinical psychologist in the context of other wider social and personal identities. These personal accounts illuminate the possible challenges of entering a profession where elements of one's personal identity are not well represented. The increasing emergence of this literature suggests a complex and nuanced process of professional identity formation amongst clinical psychologists eager to discuss issues pertaining to their professional identity development.

1.2.3.4 Divisions and Debates: Clinical psychology's 'identity crisis'

The increasing personal accounts of professional identity formation shed light on the variability in how people experience and understand the process of *becoming* and *being* a clinical psychologist. Not all clinical psychologists ascribe to a single shared understanding of the profession or themselves as members within it. Like many professions, clinical psychology has its own divisions, debates and uncertainties (Chang et al., 2008), and these divisions and debates encompass part of the broader context in which clinical psychologists must navigate their professional identities.

Much of the debate is traceable to the profession's history and concerns the role of clinical psychologists, relationship to psychiatry and the role of biology in understanding distress (Johnstone, 2010). As described above, the profession's underpinnings in the science-practitioner model remain divisive for some. Whilst the model is supported by many (e.g. Baker & Benjamin Jr, 2000; Shapiro, 2002), there has been some contention regarding the use of psychiatry's medical/biological model to explain distress (e.g. Albee, 2000) and a perceived divide between research and practice in that much research is seen as inapplicable to real-world clinical practice by trainees and those new to the profession (Shapiro, 2002). Amongst those contesting the future of the profession, far- and wide-ranging topics for debate abound. The literature spans ongoing disputes about the role and scope of clinical

psychologists (e.g. Chang et al., 2008; Wollersheim & Walsh, 1993), relationship to other specialty domains within psychology (e.g. Lancaster & Smith, 2002; Ogunfowora & Drapeau, 2008), relationship to psychiatry (e.g. Johnstone, 2010), diagnosis (e.g. Pilgrim, 2000), involvement in social justice and political issues (e.g. Kakkad, 2005), prescription privileges (e.g. McGrath et al., 2004) and core competencies (e.g. Pachana et al., 2011). Wider 'culture wars' about alignment to particular theoretical orientations and treatment types amongst therapists (Nocross & Lambert, 2011), including clinical psychologists, have also resulted in an overemphasis on difference rather than similarity (Markin, 2014).

These debates within clinical psychology come at a cost (Johnstone, 2010). Clinical psychologists must navigate how they understand themselves in their roles within a professional landscape in which ideas about the profession itself are contested. Depending on how one relates to these issues, implications for professional identities arise. For instance, a clinical psychologist whose values are incongruent with a biomedical approach to understanding mental health may face the dilemma of compromising or avoiding work in settings where this approach is dominant (e.g., inpatient wards) to navigate any dissonance between their personal and expected professional identities (Johnstone, 2010). Indeed, psychologists working in psychiatric settings have reported moral distress when one's personal values are compromised by expectations of them as professionals in these settings (Austin et al., 2005). The implications of these divisions extend further when appreciating that non-conflicting professional identities amongst professionals supports any profession to present a clear, distinct and valuable image of itself externally. Clinical psychology's identity confusion has been linked to public perceptions of the profession as non-specific, non-scientific and non-essential (Hartman et al., 2016), with confused public perceptions about the work of clinical psychologists (Dempsey, 2007; Wollersheim & Walsh, 1993).

The unhelpful polarisation characterising these debates and lack of opportunity to dissent on professional issues constructively has the potential to generate frustration, demoralisation and confusion amongst clinical psychologists (Gelsthorpe, 1997), impinges upon how clinical psychologists make sense of their roles and obligations (Johnstone, 2010), and ultimately has potential to interfere with the provision of quality clinical service delivery. Recognition of these dangers has led to calls for clinical psychology to intentionally consider how it positions itself in relation to these matters (Dempsey, 2007; Hartman et al., 2016; Johnstone, 2010).

1.2.3.5 Concluding Remarks

How we understand ourselves and the world cannot be divorced from historical, social and cultural contexts (Burr, 2015). Clinical psychology's recent albeit significant history has laid the foundations for dissenting perspectives across a range of professional issues. This, in turn, contributes to a perplexing professional environment that clinical psychologists must navigate to make sense of who they are. Appreciating the relatively recent albeit turbulent history of the profession alongside trends in privileged ways of knowing, personal accounts of the experiences of developing professional identities, and debates within the profession, all set the scene for understanding the wider context in which clinical psychologists make sense of who they are as professionals.

1.3 Significance of this Research

The rationale for exploring the professional identity of therapists – including clinical psychologists – typically asserts that professional identity serves as a stable frame of reference from which therapists make sense of their work and their lives (Friedman & Kaslow, 1986). Within clinical psychology specifically, the *being* of a clinical psychologist is cited as being as important as the *how to be* a clinical psychologist (Knoetze & McCulloch, 2017; Regas et al., 2017; Salter & Rhodes, 2018; Woodward et al., 2015), with the primary

task of conducting therapy considered inseparable from the personal characteristics and inner experiences of clinical psychologists themselves. Expanding upon this, this research proposes that researching the professional identity of clinical psychologists may be imperative on four grounds: to improve clinical psychologist's wellbeing, to enhance therapeutic effectiveness, to ensure the profession's perceived legitimacy, and to enable mental healthcare system reform. That is, professional identity is relevant both at the individual level of experience for clinical psychologists and clients, and at a wider societal level. This section considers why a better understanding of clinical psychologists' professional identities is necessary by drawing on a range of literature across different disciplinary and philosophical perspectives.

1.3.1 Improving Therapist Well-being

Research reveals the early stages of becoming a therapist are anxiety provoking as novice therapists grapple with complexities of forming a sense of oneself as a therapist (Rønnestad & Skovholt, 2013). Such findings have been replicated within clinical psychology (e.g. Eckler-Hart, 1987; Knoetze & McCulloch, 2017; Woodward et al., 2015). Early career disillusionment is common and over the entire professional lifespan, therapists must grapple with the complexities of progressively integrating their personal and professional identities (Rønnestad & Skovholt, 2013). With optimal development, satisfaction as a therapist is thought to derive from integration of these identities to achieve a non-conflicting sense of self (Rønnestad & Skovholt, 2013).

On this basis, this research presupposes that how clinical psychologists understand their professional identities will have implications for issues pertaining to well-being, burnout, and resilience. Indeed, research investigating burnout suggests that maintenance of psychologist's professional identities strengthens resilience and professional functioning (Rupert & Kent, 2007; Turnbull & Rhodes, 2019), and that stable and accepting professional identities may contribute towards clinical psychologist's professional development and well-

being (Woodward et al., 2015). Australian psychologists experiencing burnout attribute this to high expectations of an 'ideal self' as a psychologist, and report reflection on identity and modification of expectations of oneself as critical for burnout recovery (Turnbull & Rhodes, 2019). Further, in the field of medicine professional identity has been found to be negatively correlated with burnout in longitudinal studies of doctors (Monrouxe et al., 2017). These findings provide a convincing link between how clinical psychologist's make sense of their professional identities and their wellbeing.

1.3.2 Enhancing Clinical Effectiveness

Who therapists are – the personal personas of therapists – is increasingly attracting the attention of those interested in understanding therapeutic change (Rønnestad & Skovholt, 2013). This is because client outcomes are partially attributable to therapist characteristics and therapeutic relationship quality (Castonguay & Hill, 2017) which raises pivotal questions regarding what characteristics determine effective therapists (Bennett-Levy, 2019). Therapist attributes such as genuineness and empathy are associated with better outcomes (Elliott et al., 2011; Kolden et al., 2011). Though due caution prevents definitively concluding effective therapists are empathic and genuine because of client variables independent of the therapist that can impact outcomes (Wampold et al., 2017), the attributes of empathy and genuineness have been correlated with solid therapeutic alliance building skills in a recent meta-analysis (Nienhuis et al., 2018), and positive alliance-outcome relationships are a consistent finding in reviews of this topic (Flückiger et al., 2018; Flückiger et al., 2012; Horvath et al., 2011; Norcross & Wampold, 2011). Effective therapists also have sophisticated interpersonal skills and express professional self-doubt (Wampold et al., 2017). Further, research exploring the characteristics of master therapists have revealed the prominence of personal characteristics such as genuineness, embracing of complexity and humility (Skovholt & Jennings, 2016);

characteristics supported by the integration of personal and professional identities (Rønnestad & Skovholt, 2013).

This complex literature has culminated in recommendations to further research the entire person of therapists, including how they understand themselves, to make sense of this aspect of therapist functioning (Rønnestad & Skovholt, 2013). This research responds to such recommendations, albeit from a different theoretical perspective (see section on 'Epistemology and Theory' later in this chapter, page 34), and considers the professional identities of clinical psychologists as inherently linked with their understanding of who they are and how to behave (which ultimately establishes the quality of clinical care).

1.3.3 Ensuring Professional Legitimacy

Whilst separate constructs, there exists an interdependence between clinical psychologists' own perceptions of their professional identities, the identity of the profession broadly, and how the public and external bodies perceive the identity of the profession (Dempsey, 2007). The perceived legitimacy of clinical psychology within society is not fixed but rests on the profession meeting the needs and expectations of society in what can be conceptualised as the 'social contract' between clinical psychology and society (Macdonald, 1995). Yet, the identity of the profession is less than clear and not uniformly agreed upon (e.g. Dempsey, 2007; Hartman et al., 2016; Johnstone, 2010; Lancaster & Smith, 2002). It has been suggested that an ambiguous professional identity amongst clinical psychologists and the profession itself risks the demotion of the profession to the sidelines of healthcare systems (Hartman et al., 2016). Further, public perceptions of the profession as ambiguous or non-essential have been implicated in reduced funding for clinical psychology services (Hartman et al., 2016).

Clinical psychologists play a critical role in mental healthcare services, yet their expertise is underutilised within the Australian mental healthcare system (Jackson et al.,

2021). If clinical psychology is to be considered an integral part of the mental healthcare system and services funded accordingly, it is imperative that clinical psychologists individually, and collectively, develop clear professional identities that allow for the communication of a unified and valuable professional identity to the public.

1.3.4 Enabling System Reforms

One of the most critical ways in which clinical psychologists' professional identities matter pertains to the nexus between their understanding of themselves, their ways of working, and to what extent these ways of working align with healthcare system reform priorities. Identities are constructed within institutional sites that have historical ways of doing things; how we understand ourselves and who we are within these contexts often aligns with and perpetuates *the way things are* (Monrouxe, 2010). Who clinical psychologists understand themselves to be as actors within mental healthcare systems is both a product of, and in turn influences, mental healthcare systems themselves. The United Nations has increasingly demanded a human rights-based global agenda for advancing the right to mental healthcare (United Nations General Assembly, 2020), and mental healthcare systems globally and within Australia are transforming towards a focus on promoting personal recovery over clinical recovery to align with this (Commonwealth of Australia, 2013; Le Boutillier et al., 2015). The former emphasises agency, participation and empowerment, whilst the later emphasises symptom reduction (Slade, 2009). Australia's *Fifth National Mental Health Plan and Suicide Prevention Strategy* (Commonwealth of Australia, 2017) and NSW's *Living Well: A Strategic Plan for Mental Health in 2014-2024* (NSW Mental Health Commission, 2014) both commit to recovery-oriented approaches. However, initial evidence indicates clinical psychologists experience discomfort and challenges in working in recovery-oriented ways stemming from perceptions of their roles and values that conflict with institutional demands (e.g., Cooke et al., 2019; Tickle et al., 2014). Separate research also suggests that

therapist's theoretical orientation and approach are related to personal identity and personality traits (e.g., Arthur, 2001; Heinonen & Orlinsky, 2013).

Taken together this suggests that i) clinical psychologists experience challenges implementing mental healthcare reforms that are at least partially attributable to their perception of professional identity, and ii) clinical psychologists' ways of working, and consequently their readiness or ability to align with reforms, are likely influenced by variables related to identity. For clinical psychologists as providers of mental healthcare services to act as enablers for mental healthcare reforms, a deeper understanding of how they perceive themselves in their roles is required. This knowledge is necessary for appreciating the opportunities and barriers that clinical psychologists' professional identities pose for mental healthcare system reforms, and knowing how to support them to develop professional identities that facilitate reforms.

1.3.5 Concluding Remarks

For better or worse, our professional identities matter (Rees & Monrouxe, 2018). Clinical psychologists perceive themselves and their work through the prism of their own identity. How else could it be? As humans we see ourselves and what we do through our own perceptions of the world. For clinical psychologists, it would seem that perceptions of one's professional identity has implications for wellbeing, effectiveness, the collective identity and perceived legitimacy of the profession, and possibility of implementing mental healthcare system reforms. Collectively, this suggests supporting the professional identities of clinical psychologists is important on both ethical and practical grounds.

Clinical psychologists do not develop a professional identity in a vacuum, however, and clinical psychology has a tumultuous history that sets the stage on which clinical psychologists make sense of who they are. This history has formed a professional landscape characterised by divisions that question and de-stabilise the identity of clinical psychologists.

With professional identity increasingly recognised outside of clinical psychology as a pivotal aspect of being a healthcare professional (Hoeve et al., 2014; Monrouxe, 2010), clinical psychology has much to gain and learn from other healthcare professions with much more established literature. This research is therefore focussed on exploring how clinical psychologists understand and construct their professional identities, how they can be supported to develop optimal professional identities, and why this might be of relevance for the delivery of mental health clinical care.

1.4 Approaching this Research

At every point through a research process – in developing research questions, designing research, and in our observing, interpreting and reporting – we inject a host of assumptions (Crotty, 1998; Denzin & Lincoln, 2011). This is irrespective of whether these assumptions are made explicit or not. Assumptions about what we know, how we know it and what status can be ascribed to it (epistemology) have significant implications for the theoretical perspectives and research methods used (Crotty, 1998). Adequate coherence between epistemology, theory and methods is a fundamental feature of high quality social research (Crotty, 1998; Denzin & Lincoln, 2011). This section begins by outlining the epistemological and theoretical position of the present research and is followed by a discussion about the methodologies used. Finally, a critical and reflective discussion about my personal position and approach to the present research is provided for the purposes of transparency and accountability.

1.4.1 Epistemology and Theory

The epistemological grounding of any research determines what knowledge is possible and legitimate (Maynard, 1994). Unpacking and clarifying epistemological assumptions thus becomes necessary to sensibly ascertain and interpret research findings. The two main epistemological perspectives of knowing are objectivism and social constructionism (Crotty,

1998). These epistemological perspectives can be conceptualised as representing different viewpoints through which we might examine the same phenomena (for instance, identities). Objectivism emphasises an *objective* truth that can be known, exists outside of the human mind, and can ultimately be discovered. Social constructionists, in contrast, assume that knowledge and meaning are *created* rather than discovered.

1.4.1.1 Epistemological Position: Social Constructionism

This research adopts a social constructionist epistemological position (Burr, 2015; Burr & Dick, 2017; Crotty, 1998). An objectivist approach was considered unfit for exploring the ambiguous, idiosyncratic, and uncertain phenomenon of identities. Social constructionism rejects the existence of an ultimate truth, and instead asserts that all knowledge is *constructed* in and out of interactions with others through the use of language (Burr, 2015; Crotty, 1998). Our knowledge of the world does not necessarily reflect the true nature of the world but rather is a product of how the world is represented through language (Burr & Dick, 2017). For instance, prior to humans on earth, many would assume that volcanos existed in a physical sense yet there was no one present to *interpret* them as what we have linguistically labelled 'volcanoes' and thus no *knowledge* of volcanoes. For social constructionists, knowledge and meaning making is born out of the interplay between people and the world around them through language.

There is no one theory that adequately captures social constructionism (Burr, 2015). Rather, social constructionist theorising shares certain characteristics: a critical stance towards taken for granted knowledge, historical and cultural specificity, and assumptions that knowledge is created and sustained by social processes, and that knowledge and action go together (Burr, 2015). Social constructionism invites us to be critical of the idea that our observations of the world (and ourselves) unproblematically reveal its nature to us. Knowledge and ways of understanding are understood as specific to cultures and historical

periods, and thus we cannot assume *our* ways of understanding are any more *true* than others. Diverse perspectives eliminate the possibility of one true or valid interpretation; they may be more or less convincing or useful, but not more or less true (Crotty, 1998). In turn, each of these constructions or ways of knowing invites a different kind of action. How we understand the world and ourselves has direct implications for how we act.

Social constructionist approaches can be broadly split into *micro* and *macro* approaches (Burr, 2015). From a *micro* perspective, multiple versions of the world and our identities are always possible in interaction with others, and thus the only reality we really have access to are particular instances of talk. The focus is on using conversational analytic techniques to explore naturally occuring interactions in specific contexts (Burr, 2015). For instance, a micro approach would involve a close examination of how language is used between two people talking about volcanoes; the focus would be on who is speaking and the minutae of language to investigate what is happening in that particular interaction (without making any broader claims about what is real or true). On the other hand, a *macro* approach would be more critical and involve rejecting the idea that language is neutral and unproblematically reflects reality. Language would be seen as an ideological practice that influences and constructs how the world is seen (Benwell & Stokoe, 2006). Thus, in macro approaches there is an explicit political agenda and raising of awareness about how ideological frameworks shape language use. In doing so, macro approaches explicitly deal with issues such as power and social structure (Benwell & Stokoe, 2006). Although this perspective also emphasises the analysis of talk and language, it views this as an expression of wider historical, political and ideological context. So, from a macro perspective, analysing talk between two people about volcanoes might involve researchers considering what political and power relationships are created and re-created by talking about volcanoes in a particular way.

Both micro and macro approaches have been critiqued as inadequately conceptualising the relationship between the individual and society - and in doing so losing the *person* or the *self* - albeit in different ways (Burr, 2015). Micro approaches have been critiqued for losing the person behind the discourse; the micro text analysis and close analysis of language loses the person that *uses* language. Macro approaches, on the other hand, have been critiqued as tending towards the 'death of the subject'; the person becomes a passive and agentless outcome of wider social processes (Burr, 2015). Taking seriously these criticisms, the question becomes one of direction: do individuals determine society or does society determine individuals? Burr (2015) convincingly recommends that social constructionists conceptualise a dual relationship of influence operating in both directions: human beings continuously constructing the social world, which then becomes a reality to which they must respond (e.g., Davies & Harré, 1990; Berger & Luckmann, 1966). Such a perspective enables the person to be both agentive and also constrained by the social world (Burr, 2015). This perspective foreshadows later discussion about symbolic interactionism (see next section on 'Theoretical Position: Symbollic Interactionism') and the understanding of identities I have adopted within this research (see 'Disentangling Identities in the Present Research' section in Chapter 2, page 63).

Social constructionism is a term used within psychology to explicitly demarcate an epistemological stance which deviates from the predominant objectivist approach (Burr, 2015). The merits of adopting a social constructionist approach within psychology lie in challenging taken for granted assumptions of complex phenomena such as identities (Burr, 2015). When the tenets of social constructionism are contrasted with objectivist perspectives in psychology there are important implications. For instance, whilst psychology often relies on drawing inferences based on observable (measurable) data from primarily experimental methods (from which truths can be inferred), social constructionist's emphasis on the

construction of knowledge through language (and an acknowledgement of the myriad of possibilities this entails) shifts the focus to understanding the *processes* through which knowledge and ways of understanding are constructed and reproduced through talk. The search for one *valid* interpretation or *fact* therefore becomes redundant. General descriptions of human behaviour also become problematic if all knowledge, and thus ways of acting based on knowledge, are situated within historical and cultural contexts.

When it comes to understanding identities, there are marked differences across these perspectives (as discussed further on in the 'Theorising about Identities' section in Chapter 2, page 54). Briefly put, whilst objectivist-informed psychological theories emphasise the stable and internal existence of our identity, social constructionists relocate our identities from inside people's heads into the interactional space between people. This shift moves the focus of the research from structures to processes; the focus of inquiry is less concerned with the nature of people themselves and more with exploring *how* knowledge and ways of understanding are created (Burr, 2015). All of this means that an understanding of language as a means of expressing internal states within psychology from an objectivist perspective is replaced with an understanding of language as a form of social action; when we talk, we construct new meaning and subsequently construct the world as we know it. By adopting a social constructionist perspective, many of the assumptions in objectivist-informed psychological approaches are questioned and challenged.

1.4.1.2 Theoretical Position: Symbolic Interactionism

The epistemological position informs the theoretical position of any research and the use of methodology (Denzin & Lincoln, 2011). Symbolic interactionism (Blumer, 1962; Mead, 1934) is a theoretical perspective consistent with social constructionism (Crotty, 1998) that is used within the present research. Fundamental to symbolic interactionism is the understanding that people construct their own and other's identities in everyday interactions

(Mead, 1934). Symbolic interactionism transcends the problematic dualisms evident in strict macro versus micro social constructionist approaches by conceptualising the individual and society as interdependent and inseparable; each is created through interaction and understood in terms of the other (Burr, 2015). From a symbolic interactionist perspective, the self does not exist independently of society but is made possible only through social interaction. It is the distinctly human capacity for language that allows us to internalise social interactions and reflect on them, which simultaneously influences and constructs our broader social world. Thus, the mind and consciousness are accounted for; as we acquire language we can engage in and reflect on social interactions. A circular process arises in which the individual and society arise from one another, rather than being conceptualised as two pre-existing entities. It is in and out of the *interplay* between human beings and their world that both consciousness and society are constructed. In this way, the *micro* social constructionist focus on the specifics of language use by the individual (i.e., human agency) is accounted for alongside the *macro* social constructionist focus on broader discourses that shape and constrain us (i.e., wider social forces that impinge on and constrain human agency) (Benwell & Stokoe, 2006; Burr, 2015).

1.4.2 Methodology

Different ways of viewing the world necessitate different ways of researching the world (Denzin & Lincoln, 2011). Different research methods (that is, the practical steps employed when conducting research) assume different *ways of knowing.* These different ways of knowing rest on epistemological assumptions about what can be known and how (Charmaz, 2014; Crotty, 1998). Generally, quantitative and qualitative research approaches align with differing epistemological perspectives, and in the goals of research and ways to achieve these goals (Cleland, 2015). Quantitative approaches generally emphasise objective observation, measurement and description of fixed phenomena, with a focus on prediction

and causal explanation that aligns an objectivist epistemological position (Charmaz, 2014; Cleland, 2015). In contrast, qualitative approaches - when aligned with a social constructionist epistemological position - are concerned with how the social world is interpreted, understood, experienced and produced (Cleland, 2015). One single reality is not thought to be able to be measured directly as all knowledge is a construction and is therefore relative and multiple.

1.4.2.1 Qualitative Design and Methodological Implications

Embracing a social constructionist perspective requires research aims and practices that focus on language and process (Burr, 2015). The qualitative research methods used in the studies that follow were considered most consistent with social constructionist stance and the exploratory nature of this research. Stemming from this there are a number of implications for the present research:

Researcher presence: Assuming that knowledge is co-constructed between people through language requires accepting that researchers have an inherent influence on research processes and findings (Burr, 2015). Whilst an objectivist perspective considers this as 'bias' and something that can and should be avoided, a social constructionist perspective considers researcher presence as an inescapable part of the research process and something to be transparently accounted for. The task of the researcher becomes one of acknowledging and working with their intrinsic involvement to ensure the integrity and trustworthiness of findings (Burr, 2015). This is achieved through researcher values including researcher reflexivity, coherence between epistemology, theory and methods, and humility when presenting truth claims.

Reflexivity: Reflexivity functions to situate any research within an established context, and examines the position, perspective and presence of the researcher and research processes (Harper, 2003). Reflexivity draws attention to the fact that any account of an event or

perspective is both a description *and* an enactment because of the constitutive nature of language (Burr, 2015). This requires attending to both *what* is said and *how*, as well as the function or consequences of talk. Further, reflexivity requires acknowledging that social constructionism itself is just as much a social construction as any other form of knowledge (Burr, 2015). Consequently, researchers are required to address their part in the research process and the influence of this (Sherrard, 1991).

Ontology (truth claims): A social constructionist perspective requires recognising that 'facts' are never impartial (Burr, 2015). *All* knowledge gathered through *any* research is constructed (Crotty, 1998). Facts or knowledge are the product of a particular question being asked, and the questions asked derive from particular assumptions themselves. Thus objective and fixed truth claims become meaningless, and reliability and validity become inappropriate criteria through which to judge the trustworthiness of research (Burr, 2015; Crotty, 1998; Taylor, 2001). The current research findings are therefore put forward lightly and tentatively, with a focus on ensuring trustworthiness, rigour, relevance and usefulness (Taylor, 2001).

Alignment (ontology, epistemology, theory, methodology and axiology): Alignment between ontology (assumptions about what is real), epistemology (assumptions about what can be known), theory (principles or ideas used to understand phenomena), methodology (approaches to research) and axiology (researcher values) are critical in all research (Carter & Little, 2007; Crotty, 1998). The social constructionist epistemological stance underpinning this research has guided the selection of theory, research questions, methods and presentation of findings across chapters that follow. Different theorising on identities – all consistent with social constructionism and symbolic interactionism - have been utilised as conceptual lenses through which to explore professional identities across the different studies included henceforth (Cleland, 2015).

Each of the implication described above are carried forward throughout the remainder of this thesis. They have been outlined explicitly to assist the reader in understanding how and why the research is presented as it is. Across all chapters, I have attempted to account for my presence upon the research itself using reflexivity, carefully considered how findings are presented, and made attempts to ensure alignment as described above.

1.5 Author Reflexivity and Research Journey

Reflexivity is used in social constructionist research to acknowledge the impact of the researcher's personal and political views on the research process, the reality that social constructionist research is itself a construction, and the influence of context on how research unfolds (Burr, 2015). My hope is that in critically reflecting on a) aspects of who I am and how I believe this has influenced this research, b) how this research is a construction in and of itself, and c) the context and journey through which this research evolved, that the reader will be more informed and able to critically analyse for themselves the findings of the present research.

I have learnt that no research is neutral. When researchers assume neutrality they reproduce dominant and established ways of knowing (Volpe et al., 2019). Further, *who I am* has inherently shaped the focus, methods and findings of this research. For this reason, I begin by stating who I am upfront - prior to any research being presented - so that readers can judge the findings of this research from a contextualised and informed perspective.

1.5.1 Author Position

I am a female, white, middle class, able-bodied Doctor of Philosophy (Clinical Psychology) student in my mid-30's at the University of Sydney. In addition to my PhD, I work as psychologist in a public hospital where I coordinate a clinical team that provides services to people in suicidal crisis. I commenced both the PhD and this work at the time of the outbreak of the COVID-19 pandemic. Prior to this, I worked primarily in mental

healthcare system reform policy roles and in international development focussed on supporting people with psychosocial disabilities achieving inclusion in countries across Asia and the Pacific. Both what drew me to – and grew throughout – this work was a keen interest in trying to support mental healthcare systems and services to better cater for people who experience disadvantage and distress.

Being white, middle class and able-bodied has afforded me many opportunities that enabled me to pursue this interest. Being white, middle class and female also means that I represent the majority in clinical psychology (Norcross & Karpiak, 2012). This means that I am blind to the experiences of those in our profession whose identities fit outside of the hegemony. I have no insight into the experience of becoming a clinical psychologist as a black man with a disability, for example. There is no way that I can speak to these experiences. I have tried – where I can – do adopt a critical perspective on issues such as power and the reproduction of privileged ways of knowing. In hindsight, I wonder if I could have done this more effectively (as discussed in the 'Limitations and Strengths' section in Chapter 7, page 265). Nevertheless, I hope that in being transparent about my own identities I make visible the limitations of my perspective. It is just one perspective (albeit informed by the perspective of supervisors involved in the research).

My keen interest in system reforms is something that I bought with me when I returned to clinical work and study. This was my primary motivation for completing a PhD: a desire, fundamentally, to think how the profession can play a role in supporting mental healthcare services to better cater for those experiencing distress. There is a plethora of policy guidance and research arguing for changes in mental healthcare systems and *what* these changes should look like (e.g., NSW Mental Health Commission, 2014). Yet *how* these changes occur – the day-to-day interactions and ways of doing things that need changing – are often the stumbling blocks of realising reforms. The ambiguous and nebulous mental

healthcare *system* that needs reforming is, in fact, made up of people. *We* are the system. Therefore, if we as clinicians are willing and capable of change, then the system will change. Of course, we are also shaped and constrained by the broader political and social structures in which we operate, but I see it as ineffective and fatalistic to assume this means change is not possible. I have no doubt that the links I make in this research between professional identities and mental healthcare system reforms are influenced by my interest and past work experience in this area.

Further, working in a suicide service during a pandemic and whilst completing this PhD raised pertinent questions about the professional identities of clinical psychologists. It is a particularly unique experience to be faced with a person experiencing extreme distress during a time in which the world makes no sense. Most often, people's distress is understandable when you appreciate their lives and the hardships they must or have had to overcome. And at times, circumstances that make their lives difficult cannot be changed. As the months and years went by with me alternating my days between work at the hospital and completing this research, I became increasingly curious about how I understand *who I am* and *what my role is* in relation to these people. I became interested in thinking about *how* and *why* I see my role in working with people in suicidal crisis in a certain way, and critically reflecting on how helpful this is (or is not). As this progressed, I became adamant that this research be of clinical and practical relevance, and not just an academic or theoretical exercise. The more I reflected on these issues, the more energised, curious and willing to reconsider my role I became. I initiated discussions in the hospital with other clinical psychologists and clinicians who met such conversations with equal measures of curiosity, enthusiasm, relief and concern. They appeared to be conversations clinicians are wanting to have.

1.5.2 Is This Just Another Construction?

Just as *who I am* has influenced this research process, this research process has also re-constructed who I understand myself to be as a clinical psychologist and offers new ways of understanding the professional identities of clinical psychologists more broadly. These ways of knowing are, themselves, a construction (Burr, 2015). In designing and conducting this research exploring clinical psychologists' professional identities, I have, paradoxically, contributed towards constructing a way of understanding of clinical psychologists' professional identities. This is neither bad nor good. It is just so. Although I do acknowledge that my biases and blind spots as mentioned above will surely have influenced this particular construction. What is put forward in this research is not the only possible truth: it is one reading of the data and must be interpreted as such. Having said this, I intentionally drew upon a diverse range of methods, disciplines, theoretical perspectives and data sources (the four methods of triangulation in qualitative research; see Denzin, 1978) in an attempt to increase the trustworthiness of this research.

1.5.3 An Unexpected PhD: Research focus, supervisors, theory and methodology

This research did not begin as a PhD. It arose out of a Masters project exploring the implementation of Open Dialogue – a more recent model of mental health service provision that seeks to promote personal recovery and a rights based approach to mental health care – in a public youth mental health service (Study 1, Chapter 3). My prior work experience in international mental healthcare system reform had exposed me to Open Dialogue, so when an opportunity arose to explore the implementation of this model of care in a youth public mental healthcare setting, I arranged for this to be the focus of my Masters thesis. What became evident was that clinician's professional identities were interrelated with their willingness and capacity to work within mental healthcare settings in ways that align with reform agendas, and that this varied across professional disciplines. This was a new

perspective from which I had not considered mental healthcare reforms: clinicians are a crucial part of realising reforms yet often overlooked. It was from here that this PhD arose and shifted towards a broader focus of exploring the professional identities of clinical psychologists.

The evolving nature of this PhD is reflected in the supervision, theoretical lens and methodologies used. The first empirical study exploring the implementation of Open Dialogue was supervised by a Professor of Nursing (NB) and Associate Professor of Clinical Psychology (PR; noting that PR did not go on to be involved in the supervision of the subsequent research). As described above, it became clear after this study that the professional identities of clinical psychologists was worthy of exploration. At this point the Director of the Clinical Psychology Unit at Sydney University and a Professor of Clinical Psychology (CH) became the primary supervisor of this research given her experience and expertise within the profession. Under the supervision of CH and NB, I then conducted the scoping review exploring the professional identities of clinical psychologists (Study 2, Chapter 4). Simultaneously, I was reading extensively and widely across different disciplines, and it became evident that the exploration of professional identities is substantially more developed in nursing and medicine than it is in clinical psychology. I contacted a Professor of Healthcare Professions Education (LVM) who has experience researching professional identities within medicine and invited her to come on board as a supervisor of this research (which she agreed to). This resulted in an interdisciplinary supervisory team with perspectives from clinical psychology (CH), nursing (NM) and medicine (LVM). As the research team evolved, so did the ideas for the direction and focus of this thesis.

Healthcare professionals are increasingly work in interdisciplinary settings (Best & Williams, 2019) and interdisciplinary research is considered the gold standard. As knowledge in healthcare and scientific disciplines advances, researchers have become increasingly aware

of the need to link disciplinary fields to more fully answer critical questions and facilitate the application of knowledge in specific areas (Aboelela et al., 2007). All supervisors were actively involved through the research process, resulting in a continual process of challenging one another's taken-for-granted assumptions. Through this process, my exposure to ways of understanding the world and identities expanded my thinking and theoretical perspective.

Over time, my thinking became more informed and I became aware of the implications of adopting a social constructionist epistemological perspective. This was worlds away from the objectivist perspective that defined my science-based education previously and with which I began this research journey. Over time, the lens through which I viewed the world and this research changed: the *truth* became neither possible nor relevant, understanding the messy process of living and transforming identities increasingly seemed richer and more useful, and I became more critically engaged and interested in issues of power and the ways in which ways of knowing are reproduced. Trying to over-simplify the nature of our identities for the benefit of a neat and concise research thesis seemed inadequate (at one point I entertained the idea using a grounded theory approach to 'model' professional identity!). This research became about delving into the differences, divergences, and the way people's identities change: it is here that people *become* and *change* who they are. This evolution in thinking influenced the research questions I began asking and the qualitative methods most suitable for answering those research questions. This resulted in a shift towards examining in-situ identity construction (Studies 3 and 4, Chapters 5 and 6 respectively) with a critical eye on how institutions and contexts influence this process. My hope is that understanding this process will mean researchers, educators and the profession more broadly will be better equipped to support the construction of tomorrow's clinical psychologists' professional identities.

1.6 The Current Research

This thesis is comprised of a literature review, scoping review and three empirical studies which were completed between 2018 and 2022. The order of the empirical chapters and scoping review in this PhD correspond to the real life unfolding of this research. The evolution of this research journey is touched on in the preamble at the beginning of each chapter to shed light onto the thinking that influenced the focus of the research as it progressed.

1.6.1 Literature and Theory Review: Identities and professional identities

Theorising on i*dentities* underpins any conceptualisation of the construct *professional identities*, which explains why the literature is reviewed in this order (see 'Theory and Literature Review' in Chapter 2, page 53). Reviewing the literature for this thesis spanned a vast range of topics, disciplines and theoretical perspectives, and it became evident that a) the literature on identities is vast, complex and contested, and b) the research base exploring professional identities is more advanced and sophisticated in other healthcare professions than in psychology. For this reason, an overview of theoretical perspectives from which identities can be explored is provided with a clear description provided of how identities are understood in this research. The literature from medicine, nursing and counselling pertaining to professional identities is then reviewed before discussing the relevant literature in psychology to shed light on insights psychology can take from other professions in expanding its research in this area.

1.6.2 Study One: Implementation of Open Dialogue

In 2018, I undertook training in Open Dialogue delivered by The Centre for Family Based Mental Health Care at St Vincent's Hospital, Sydney alongside other clinical psychologists and clinicians working in a public youth mental health setting in New South Wales, Australia. Between 2018-2019, I interviewed 10 of these clinicians (clinical

psychologists, psychologists and psychiatrists) using a semi-structured interview protocol to explore their professional identities and how these were transformed through the process of implementing of Open Dialogue (Chapter 3). The two aims of this study were to: 1) Examine the professional identity of clinical psychologists, psychologists and psychiatrists in inpatient and community settings, and 2) Explore how clinical psychologists, psychologists and psychiatrists responded to or have been impacted by training and the initial implementation of Open Dialogue. One of the main findings of this research was that clinicians' identities had distinct characteristics across professions, and that their willingness, comfort and ability to implement new ways of working were inextricably linked to their professional identities. This research was conducted under the supervision of my initial Masters supervisors NB and PR. As described earlier, this project then evolved into a PhD exploring the professional identities of clinical psychologists specifically given the clear relevance that better understanding this topic has for the profession and reforms in mental healthcare systems more broadly.

1.6.3 Study Two: Scoping review

Between 2019 and 2021, I undertook a scoping review of the literature exploring the professional identities of clinical psychologists (Chapter 4). I conducted this study under the supervision of CH and NB who became the primary and secondary supervisor for my PhD respectively. This review was deemed necessary given the absence of an established or well-developed research area within clinical psychology, and the broad and heterogeneous nature of the research available. The review sought to answer two broad questions: 1) What is known about the professional identities of clinical psychologists? 2) What is the quality of the literature available? Due to the nature of the research, this review synthesised findings from qualitative empirical papers and included a consultation with practicing clinical psychologists to verify the findings. The review sought to provide recommendations for educators,

researchers and clinicians. I also took the opportunity to systematically evaluate the quality of the literature available.

The scoping review made it clear that the available research in clinical psychology had numerous issues with quality, and that the research was far less developed than in other healthcare professions. This is consistent with reviews of the professional identity literature in healthcare professions (Cornett et al., 2022). The research in clinical psychology required improved methods and theorising on identities, and I believed there were things to be learn from these other healthcare professions. I returned to the literature in these disciplines and at that point LVM came on board as a supervisor in 2021. At this point, I was encouraged to delve further into the theorising surrounding identities and develop a more nuanced understanding of social constructionist theory and methods. It became clear that research methods that shed light on the *what* as well as the *how* of professional identity formation were most fruitful. The finding in the scoping review that education plays a formative role in influencing the construction of clinical psychologists' professional identities, alongside an increased focus on the *process* of professional identity construction in interactions, influenced the focus of the final two studies.

1.6.4 Study Three: Interrogations in clinical supervision

The final two studies (Studies 3 and 4) both sought to explore the in-situ professional identity construction of clinical psychology trainees during supervision interactions, albeit with a different focus and using different theoretical frameworks and methodologies. In 2022, I audio recorded live supervision interactions between trainees and supervisors in a trainee clinic which comprised the data for studies 3 and 4 (Chapters 5 and Chapter 6 respectively). Both studies explored how and in what ways supervision impacts the professional identity construction of clinical psychology trainees and sought to do so in a theoretically informed way using sophisticated qualitative research methods.

Study 3 (Chapter 5) sought to answer the following research questions: 1) What occurs during supervision interactions that may have implications for the construction of trainees' professional identities? 2) What is the nexus between these interactions and the wider institutional context? 3) How are the professional identities of trainees created and constrained within these interactions? Supervisor initiated interrogations in clinical supervision were identified as key interactional sites impacting trainee professional identity construction. The transcripts of supervision sessions were analysed using an interdisciplinary approach to discourse analysis (Burr, 2015; Lakoff, 2015) guided by a distinct set of theoretical frameworks including framing (Goffman, 1974), positioning (Bamberg, 1997; Bamberg & Georgakopoulou, 2008) and impression management (Goffman, 1959). The findings from this study highlighted the ways in which supervisors approached interrogations (i.e. frame) influenced the identities that trainees claim for themselves (i.e. positions), and that trainees used a range of strategies to portray themselves in a desirable way (i.e. impression management). From a broader perspective, these results demonstrate the ways in which supervision interactions within educational institutions shape and constrain the ways in which clinical psychology trainees come to understand themselves in their roles.

1.6.5 Study Four: Fragilising clients in clinical supervision

Study 4 (Chapter 6) shifted to focus on the identities constructed for *both* clinical psychology trainees and clients in every-day supervision interactions. This shift reflects an understanding that the identities we claim for ourselves (as clinicians) are inherently intertwined with how we understand the other (our clients); that is, we define ourselves in relation to the other (Schrewe et al., 2017). Therapists exist because clients do. The research questions guiding the analysis included: 1) How are therapists and clients positioned in clinical supervision interactions in training settings? 2) What is the consequence of constructing the identities of therapists and clients in these ways? 3) What does this reveal

about the professional identities therapists are socialised into claiming from a broader perspective? Coding the transcripts revealed recurring interactions in which clients were positioned as being fragile (unable to manage distress), which I then analysed using a positioning analysis (Bamburg, 2020). Positioning analysis is particularly helpful in that it allows for both a close analysis of language and examination of broader discourses. The study demonstrated how when clients are positioned as fragile, trainee clinical psychologists are positioned as being responsible for managing or containing this distress. These findings were interpreted as demonstrating how fragilizing clients can result in clinicians claiming professional identities that perpetuate paternalistic models of clinical care, as well as demonstrating how established and sanctioned ways of *knowing* and *being* as a clinical psychologist are perpetuated through supervision interactions.

1.6.6 General Discussion: Considerations for the profession, researchers and educators

In the discussion (Chapter 7), having summarised the main outcomes and findings of the research as a whole, I offer a series of reflections and considerations for the profession, researchers and educators. I also explore the limitations and strengths of the present research before offering some final reflections for moving forward. Throughout the discussion, I maintain a critical perspective that invites thoughtfulness and ongoing conversation. This is intentional. In a fast-paced world with increasing pressure to provide and accept simple solutions (which are assumed will resolve complex issues), I have deliberately tried to steer away from simplistic – and ultimately unhelpful – solutions (Ajjawi & Eva, 2021). Instead, I have favoured developing a richer and more fruitful understanding of the issues surrounding clinical psychologists' professional identities.

Chapter 2: Theory and Literature Review

This chapter outlines relevant theories pertaining to identities (psychological, social and discursive) and clarifies the theoretical perspectives and key assumptions about identities underpinning the present research. The literature exploring professional identities across other healthcare professions (nursing, medicine, and counselling) is then reviewed with consideration given to what clinical psychology might learn from these professions. The intention is to illuminate the breadth across and within professions in which professional identities have been understood and researched, alongside a consideration of the critiques of the existing literature so that clinical psychology might learn from these. Finally, a brief summary about relevant literature in psychology is reviewed to assist with clarifying how related albeit different theoretical concepts are understood across disciplines. This chapter concludes with a consideration of what has been covered so far before laying the scene for the empirical chapters that follow in the present thesis.

2.1 Identities

Understanding *professional identity* first requires clarification of the construct *identity* more broadly (Monrouxe, 2016). Attesting to the importance and relevance of the topic, theorising about identity has a long history across disciplines and encompasses a vast range of theoretical nuance (Côté & Levine, 2014; Schwartz et al., 2011). A tendency for disciplines to view identities within their own discipline-specific parameters has subsequently resulted in a proliferation of vastly divergent theorising and literature on the topic. A selective review of the literature is provided to display the diverse and complex ways in which identities are understood. The chosen theoretical position and assumptions about identities adopted within this research are then clarified.

2.1.1 A Word on Words: Identities and discourse

An initial disclaimer on language and terminology is required. The use of the plural *identities* henceforth (with the exception of reference to theories that conceptualise *identity* as a singular construct) reflects an acknowledgement that we do not possess one, single, uniform identity (Benwell & Stokoe, 2006). Each of us occupies a range of identities; we are complex beings who embody multiple identities. This is in keeping with the social constructionist perspective underpinning this research (see 'Epistemology and Theory' section in Chapter 1, page 34). The use of the term *discourse* henceforth falls within two categories: both to understand *talk itself* and as well as the idea of *wider narratives* or *established truths*. In this research, I use the term to refer to the latter; discourses are understood as a dynamic and public understanding that revolves around certain topics (e.g. gender, class) and can be internalised by people (Davies & Harré, 1990).

2.1.2 Theorising about Identities

Over the years, theorists have taken their ideas about identities from a range of paradigms (Monrouxe, 2010). There exists significant theorising on identities from the psychological, social and discursive traditions (Côté & Levine, 2014). This literature is vast and complex; fundamentally representing different perspectives of the same phenomenon (Monrouxe, 2016). These different perspectives vary in the *emphasis* they place on the psychological and/or social aspects of identities and processes through which identities are transformed. Indeed, the chorus of voices theorising on identities is rapidly increasing and becoming ever more complex, muddled and difficult to stay appraised of (Smith & Sparkes, 2008). This section first outlines the relevant literature across these perspectives with increasing detail provided as the theorising becomes more sophisticated and relevant to the present research, before then turning to the dominant theorising that informs this thesis. This

is provided with an acknowledgement that theorising about identities is largely Eurocentric, which represents a significant shortcoming (Côté & Levine, 2014).

2.1.2.1 Psychological Theories: Identity as a product of the self

"*The sense of identity provides the ability to experience oneself as something that has continuity and sameness"* – Erikson (1950)

Psychological theories (e.g. Erikson, 1994; Marcia, 1963, 1966) typically locate identity (singular) internally and assume it is a unified construct that is formed within the individual, and can be accessed consciously (Benwell & Stokoe, 2006; Côté & Levine, 2014). There are a range of psychological perspectives on identity that prevents providing a unified psychological theory of identity (Côté & Levine, 2014), though a common feature across them is the emphasis on the individual (Monrouxe & Rees, 2015). Marcia (1963, 1966) proposed eight chronological stages of identity development, with Erikson (1994) building upon this and proposing that our identity develops in stages with a particular focus on 'ego identity'. Whilst the role of social settings in identity formation are acknowledged within psychological theories, this perspective emphasises identity as an internal and cognitive structure (Monrouxe & Rees, 2015). Further, whilst fluctuations in identity are accounted for, these theories generally assert one's identity is largely stable once formed (Côté & Levine, 2014).

Psychological theories have been critiqued as lacking a sufficient theoretical base and inadequately accounting for wider influences on identity formation (Côté & Levine, 2014). Whilst these theories often situate identity within some kind of social context, more recent and radically socially oriented understandings of identity assert that identities are *defined by*, or a *product of*, the social world (Benwell & Stokoe, 2006). The view that identity is stable and internal has been supplanted by the notion that identities are multiple, and a product of intersubjective and external social processes (Monrouxe, 2010).

2.1.2.2 Social Theories: Identities as a product of the social

"One cannot be a self on one's own" – Taylor (1989)

Social theories (e.g. Tajfel, 1982; Tajfel & Turner, 1979; Roccas & Brewer, 2002; Turner et al., 1987) understand identities (multiple) as intersubjective instead of subjective (individual); rather than identities residing entirely in the consciousness of autonomous individuals, identities are defined primarily by virtue of membership within or identification with particular social groups (Benwell & Stokoe, 2006). As with the psychological theories of identity, there are a range of theories that fall within this domain (Benwell & Stokoe, 2006; Monrouxe & Rees, 2015). Social Identity Theory (SIT) (Tajfel, 1982; Tajfel & Turner, 1979) suggests that our identities derives from membership within social groups; we categorise ourselves and others into groups (creating 'ingroups' and 'outgroups'), determine how compatible we are with a group, and then compare other groups to our own to enhance self-esteem. Despite SIT being influential, this perspective has been critiqued for treating identities purely as cognitive, pre-discursive and essentialist (Benwell & Stokoe, 2006). Social Identity Complexity Theory (Roccas & Brewer, 2002) extended upon SIT to propose distinct ways in which identities are navigated (intersection, dominance, compartmentalisation and merging) when we perceive ourselves as belonging to multiple social groups (Roccas & Brewer, 2002). Again, this theory has been critiqued as being pre-discursive and there is little consensus regarding the relation of multiple identities to each other (Sedikides & Brewer, 2015). Finally, Self Categorisation Theory (Turner et al., 1987) was also developed as a conceptual extension of SIT to shed light on the *processes* involved in group identification; it explores the cognitive process through which people come to identify with a particular group, and how when this occurs the person is more likely to adopt the norms of the group.

Collectively, these social theories of identities paved the way for future theorising on identities and remain influential within multiple disciplines including psychology (Benwell & Stokoe, 2006). A key tenet of these theories is that identities are an *outcome* of cognitive processes (rather than being central to cognition as in psychological theories), and for this reason these theories have been accused of suggesting that identities exist dormant within people and are 'switched on' in the presence of others (Benwell & Stokoe, 2006). This has resulted in a backlash within psychology and sociology against the notion of an internal identity (Benwell & Stokoe, 2006), giving rise to interactional and discursive theorising on identities that emphasise identities as being continuously constructed and re-constructed in interactions through discourse. Rather than providing a *theory* that defines or explains identities per se, this theorising offers a different *perspective* or *lense* through which to understand identities.

2.1.2.3 Discursive Perspectives: Identities as co-constructed

> *"Human selves and their identities are not sedimented … but are constituted as properties only in and through the forms of human subjectivity that arise from and inform participation in relationships"* - Williams (2000)

Interactional and discursive theorising about identities is influenced by social constructionism and reject assumptions that identities pre-exist in the mind (Monrouxe & Rees, 2015). Understanding the social constructionist underpinning of these perspectives is essential for making sense of them. Social constructionism views knowledge (including our understanding of ourselves) as created and co-created through language in interaction with others (see 'Epistemological Position: Social Constructionism' section in Chapter 1, page 35). Identities are not viewed as a fixed reality but as coming into creation and evolving in relationship with others. There is a reciprocity in which the self is both the origins and result of interaction with others (Gergen, 2009).

There is variation across these interactional and discursive approaches: they range from embracing weak to strong tenets of social constructionism (Monrouxe & Rees, 2015) and differ to the extent that they align with *micro* or *macro* social constructionist thinking (micro and macro approaches are described below as well as in the 'Epistemological Position: Social Constructionism' section in Chapter 1, page 35). Yet what fundamentally unites them is the assumption that identities are relational, constructed through language in interaction with others, and are context dependent (Monrouxe & Rees, 2015). Thus, theorising about identities looks somewhat different from this perspective; rather than *theories* that define or explain identities per se, this perspective emphasises different approaches or *lenses* through which identities and the process of identification can be examined (Monrouxe, 2016). Each lens scrutinises how identities are constructed through language from a slightly different viewpoint. Put differently, these approaches share a focus on the role of language and interactions as the site for *identity work*, yet differ in the way they investigate language and interactions as means of exploring identities (Benwell & Stokoe, 2006). For this reason, this section includes additional information on the research implications for exploring identities through each of the interactional or discursive lenses.

2.1.2.3.1 Identities as Discourse

"Identity is performed, constructed, enacted or produced, moment-to-moment, in everyday conversations" - Benwell and Stokoe (2006)

Discursive approaches to understanding identities grew out of discursive psychology (Edwards & Potter, 1992), and view language as mediating, influencing and constructing our experiences and ways of perceiving the world, others and ourselves. The emphasis within a discursive approach is on language; language and discourses are both *constructed* (in that peoples' use of language is constrained and limited by what they know and shaped by discourses available to them) and *constructive* (in that assumed truths and discourses are

continuously being re-created through our use of language) (Benwell & Stokoe, 2006). Discursive approaches to understanding identities are varied, complex and expanding, yet can be broadly categorised into *micro* and *macro* approaches (Burr, 2015). Put simply, micro approaches view knowledge as constructed within everyday talk in interactions; there is no broad truth (that exists independt of the interaction) and all we can know is what is said in any given interaction. A micro approach involves close analysis of specific instances of talk, how it is used and to what effect (e.g., conversation analysis methods). On the other hand, macro approaches – whilst still acknowledging the constructive power of language – consider knowledge as derived from wider social structures, social relations, and institutions. A macro approach therefore involves the analysis of talk with a view to critically expose and consider how certain knowledge or truths are being created and recreated through talk (e.g., critical discourse analysis methods). Increasingly social constructionist authors are arguing that micro and macro approaches should not be seen as mutually exclusive; there is no reason, in principle, that they should not be brought together (Burr, 2015). More recently, narrative theorists have begun to advance their theorising on identities in ways that allow for an integration of these micro and macro approaches.

2.1.2.3.2 Identities as Narratives

"Personal stories are not merely a way of telling someone (or oneself) about one's life; they are the means by which identities are fashioned" - Rosenwald and Ochberg (1992)

Narrative theorising on identities has rapidly evolved resulting in an increasing chorus of narrative researchers who are not in harmony (Smith & Sparkes, 2008). More recently, narrative theorists have drawn on social constructionism and discursive theorising on identities to suggest our lives are storied and that our identities are constructed through narrative: the self is produced and made coherent and meaningful through language and storytelling (Benwell & Stokoe, 2006; Denzin, 2000; Smith & Sparkes, 2008). Broadly

speaking, exploring identities through a narrative lens with a social constructionist orientation involves examining the kinds of stories narrators place themselves in, the identities that are enacted and claimed, and why narratives are developed in particular ways and in a particular order (Benwell & Stokoe, 2006). Smith and Sparkes (2008) placed perspectives on narrative identities along a continuum that varies according to whether the emphasis is on individual or social/interactional factors influencing identity construction. Perspectives emphasising the individual reflect traditional narrative approaches; it is assumed that narrators step outside of themselves, examine themselves, and reflect back a life story or internal understanding of who they are. The content of people's talk is analysed as if it were an unmediated and accurate reflection of their identity (Bamberg & Georgakopoulou, 2008). This 'big story' approach has been criticised as incomplete, decontextualised and non-analytical, and for disregarding the *process* of identity construction (Atkinson & Delamont, 2006; Bamberg, 2010; Mishler, 2006). Further across the continuum, narrative approaches conceptualise identities as *produced* or *constructed* in social interactions and are informed by social constructionist thinking. Thus, narrating or storytelling within a particular interaction becomes the site of interest (Smith & Sparkes, 2008). This 'small story' narrative approach (e.g., Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006; Watson, 2007) has re-defined *narrative*; the emphasis is on small moments of talk and how speakers (narrators) construct (narrate) identities for themselves in interactional spaces (Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006). Analysts explore how people use stories in every-day situations to create and perpetuate a sense of who they are (Bamberg & Georgakopoulou, 2008). Thus, the territory for inquiry shifts to the function of language in day-to-day interactions within which identities are constructed and can be approached from either a micro or macro oriented perspective. This approach is considered more analytic, rigorous and fruitful (Atkinson & Delamont, 2006).

The divide between big story and small story narrative research reflects a separation between researchers exploring neat *lived and told* narratives versus those exploring the messier business of *living and telling* (Georgakopoulou, 2006). With the increasing trend towards small story research informed by social constructionism, theorists have drawn on the concept of *positioning* (Bamberg, 2004b; Davies & Harré, 1990). Analysing interactions from a positioning perspective affords an exploration of how people position themselves as having a certain sense of self or identities, *and* how people are positioned by others or society (Smith & Sparkes, 2008). This perspective will be explored further on in this chapter but has been suggested as a promising avenue for synthesising micro and macro approaches to social constructionist research of identities because of the emphasis on close text analysis whilst considering the broader context (Burr, 2015)

2.1.2.3.3 Identities as Performative

"The self, then, as a performed character, is not an organic thing that has a specific location, whose fundamental fate is to be born, to mature, and to die; it is a dramatic effect arising diffusely from a scene that is presented, and the characteristic issue, the crucial concern, is whether it will be credited or discredited." – Goffman (1959)

Emphasis on the *performative* nature of identities highlights how we *present* ourselves to others using language, and in doing so, construct our identities (e.g. Goffman, 1959). In each interaction, we put on a *front* and portray a particular image of ourselves shaped by our perceptions of the situation in order to manage and maintain a desirable image of ourselves (Goffman, 1959). Thus, multiple identities are constantly being enacted (and thus created); as we interact with others we manage their impressions of us by putting on different fronts and presenting ourselves in particular ways to achieve our goals. Goffman (1959) explains that we are motivated to portray idealised images of ourselves and conceal aspects of ourselves that undermine this image. Goffman's work draws on symbolic

interactionism (see 'Theoretical Position: Symbolic Interactionism' section in Chapter 1, page 38), and builds from observations by Mead (1934) that we learn standards of behaviour by observing others and how they respond to us, developing responses designed *for others*, and integrate this into our own repertoire of actions and meanings. That is, we come to know the attitudes and behaviours expected of a person who occupies particular social positions within a community, and then act in ways according to this knowledge. For Goffman (1959), there is no single true identity behind these performances; our identities *are* these performances.

2.1.2.3.4 Beyond the Divide: Making sense of discursive theorising on identities

Disparate perspectives on whether identity is single or comprises multiple identities; individual or relational; stable or fluid; and discovered (and thus, pre-existing) or created means reconciling differences may not be possible nor necessary (e.g. Côté & Levine, 2014; Smith & Sparkes, 2008). Although some theorists have put forward integrated theories (e.g., Schwartz et al., 2011), these risk diluting and conflating concepts. Having said this, disparate perspectives outlined as distinct approaches above are not as boundaried as they appear. The edges are blurred and messy. Outlined briefly below are debates within the theorising on identities that are pertinent to the present research.

Objections to theories on identities exists both between social constructionist and psychological or social perspectives, as well as between social constructionist theorists themselves. An examination of the critiques reveals a certain irony. Early psychological theories were critiqued for over privileging human agency and inadequately accounting for interactional processes through which identities are formed (Côté & Levine, 2014). Subsequently, discursive theories arose to counter these criticisms but have since been accused of over privileging language as the site for identity construction and in doing so losing the subjectivity and experience of the actual person (Benwell & Stokoe, 2006; Burr,

2015). In moving so far from psychological accounts of person-hood, social constructionists themselves have landed into trouble when researching identities. Social constructionist theorists continue to disagree about the nature of the individual, and the relationship of the individual to society (Burr, 2015). Some theorists reject psychological processes entirely (e.g. Gergen, 2009), whereas others incorporate cognition and subjectivity into theorising on identities (e.g. Harré, 1997). Further, the disconnect between strictly micro and macro social constructionist approaches remains contentious (as discussed in Chapter 1, page 36). Both micro and macro approaches have been critiqued for losing the self, albeit in different ways: micro approaches over-privilege precise and specific analysis of language but risk losing the *self* behind the speaker (i.e., the inadequately account for the *user* of language), whereas macro approaches risk becoming deterministic (i.e., losing the person's agency) in over-emphasising the influence of wider discourses on identity construction (Burr, 2015). Thus, the social constructionist perspective poses a dilemma: do individuals agentively construct their identities through language, or is the construction of identities through language an inevitable product of wider social processes? Below I discuss the approach to researching identities in the present research that seeks to overcome this dilemma.

2.1.3 Disentangling Identities in the Present Research

This section details the theoretical underpinnings and assumptions pertaining to identities adopted henceforth. Within particular chapters, theorising on identities through various lenses that are consistent with a social constructionist perspective and the theoretical tenets of symbolic interactionism are incorporated to enhance particular studies and research designs. Such perspectives have been selected for their coherence with the epistemological and theoretical tenets of this research to provide a richer and fuller account of identities. Clarified below are assumptions about identities carried forward.

1.2.3.1 Identities: An interactional perspective

This research returns to symbolic interactionism as a way to reclaim the self and the relationship between the individual and society in a theoretically coherent way from a social constructionist perspective (Burr, 2015). Symbolic interactionism's value in understanding identities is the emphasis on the *interactional* nature of the relationship between an individual and society; it embraces micro and macro social constructionist approaches. There remains a place for a person's agency and subjectivity in constructing their identities within the social realm, as well as a recognition that the social realm and wider discourses within it constrain and limit this process. This research is therefore heavily influenced by discursive theorising on identities, without denying the role of psychological or social processes. This immediately disqualifies drawing on a particular *model* of identities and shifts the focus towards exploring the *process* through which identities are interactively constructed through language (Burr, 2015; Hacking & Hacking, 1999). In the present research, identities are understood to be actively negotiated within the social world through language; people are both agentive within *and* constrained by the social world in which they navigate and construct their identities. Such a perspective works at both the individual and structural level; it is assumed that people have the capacity to construct themselves and others *and* that power and societal discourses construct people (Burr, 2015). Who we are and our social worlds interact reciprocally.

1.2.3.2 Assumptions about Identities

Approaching identities from a social constructionist and symbolic interactionist perspective requires a discussion of both product and process (Hacking & Hacking, 1999); the product (our identities) is not inevitable or fixed but comes into being through situationally bounded interactions through which we come to understand ourselves (that is, a process of *identification*). Identities cannot be understood separately from the process of identification. This opens the door to a rich and complex theoretical space in which

assumptions about identities and the process of identification are more fruitful than a static definition of terms. First, it is helpful to clarify what this research assumes identities are *not*: identities are not singular, static entities that exist only internally within an individual's mind. Identities are not fully accessible to the conscious mind; whilst they can be *spoken about*, such accounts reflect, at best, aspects of one's identities of which one is aware, able to articulate, and willing or motivated to share (Mishler, 2006). I now review the assumptions about what identities *are* in this research. These assumptions are interrelated but have been delineated for conceptual clarity.

Identities are constructed: Our identities are constructed through language out of and within the discourses available to us within the social world (Bamberg, 2004; Burr, 2015). The construction of our identities is simultaneously determined by available discourses *and* emerges through our agentive interaction with these discourses; who we are is both determined and undetermined.

Identities are fluid: Identities change and transform temporally depending on the positions we take up in social interactions; it is the continuous and repetitious engagements we have in the social realm that become the source for a continuous sense of who we are – a sense of being the *same* in spite of continuous change (Bamberg & Georgakopoulou, 2008). Our identities are always moving, unequivocal and inconsistent across time and places (Bamberg, 2004a).

Identities are multiple: Although we experience ourselves from within a single body, and from this embodied centre of consciousness each of us experiences a singular point of view (Harré, 1991, 1997), there are infinite possibilities for how we can and do identify as we are forever in flux and changeable across time and space. As we engage in the social world, we present ourselves in ever-changing ways to the world amidst a range of discourses and truths (Burr, 2015).

Identities are contextual: Our identities do not exist within a vacuum; they are nested within situations and contexts. The ways in which a person identifies or enacts their identities is impacted by the particular time and physical setting, as well as the wider, multilayered and interwoven set of social structures, belief systems and social relations that surround a situation (Ashmore et al., 2004). Identities are therefore contextualised; we position ourselves – and display different selves - in different settings and in different company (Harré, 1997).

Identities are enacted: We enact our identities in the social realm. Human agency and insight mean it is possible for people to reflect on, communicate and *tell* others who they understand themselves to be, yet in doing this we inevitably enact and reconstruct who we are through the act of telling. Telling who we are is constrained to a person's awareness and willingness to share. When we speak about who we are, or when we speak *at all*, irrespective of whether it is about one's identities or not, always reveals aspects of the speaker's identity (Harré, 1997).

Identities can be conflicting: An inherent consequence of our multitude of identities is that they can easily and often do conflict (Costello, 2005). We can acquire beliefs about ourselves that are conflicting, and shift between ways of thinking about ourselves in different interactions with different people. Our identities can also conflict with situational or contextual demands, resulting in a need to realign and make coherent our perception of ourselves; that is, engage in 'identity negotiation' (Bamberg, 2004a).

1.2.3.3 Concluding Remarks

Evidently, our identities are not a clear, unequivocal, or straightforward matter. The concept is at once familiar yet fraught with complexities, and inevitably leads us to perennial questions around what it is to be human (Harré, 1997). Theorists from psychological, social, and discursive traditions offer vastly different ways in which we might understand and conceptualise our identities. In this research, I adopt a social constructionist perspective in

which identities are understood to be constructed and produced, moment to moment, in everyday conversation (Benwell & Stokoe, 2006). From this perspective, identities cannot be understood as an *entity* but are rather a process of *being* and *becoming*.

2.2 Professional Identities

Theorising on identities underpins how we conceptualise professional identities; after all, our professional identities are our identities as understood in professional contexts. Unsurprisingly, given the theoretical ambiguity surrounding the broader construct of identities, theorising and research exploring professional identities is equally vast and complex (Cornett et al., 2022; Snell, 2020). Across healthcare professions – in particular, nursing and medicine - the empirical investigation of professional identities has gathered increased momentum given the implications for the healthcare workforce at personal, interpersonal and professional levels (Cornett et al., 2022). Clinical psychology represents an exception. There is a comparative absence of research in clinical psychology exploring this topic, with the research instead typically focussed on related concepts such as professional development. For this reason, this section first reviews the literature exploring professional identities in other health care professions and considers what can be learnt from this literature for clinical psychology. A review of the literature in psychology and clinical psychology is provided, followed by a summary of what has been covered thus far before leading into the empirical studies of this thesis.

2.2.1 Literature on Professional Identity within Healthcare Professions

The professional identity literature in healthcare professions is predominantly qualitative, from the United States of America (USA), and is more advanced in nursing and medicine than other healthcare professions (Cornett et al., 2022). Although the research in allied health is comparatively poorly represented (Cornett et al., 2022), allied health focussed research into this topic is increasing (Snell, 2020). The well-established and increasing

research base exploring professional identities within nursing and medicine means there is much from which clinical psychology can learn. In addition, despite the literature being less well developed, counselling has a more established literature base comparative to psychology (Cornett et al., 2022), and offers some insights for clinical psychology from a mental health related perspective. Although the emphasis, theoretical underpinnings and scope of research varies between and within disciplines (Volpe et al., 2019), the focus is broadly on how individuals develop a representation of themselves within each profession. This section explores the literature from nursing, medicine and counselling, and elucidates insights that are pertinent to clinical psychology. The literature from nursing and medicine are provided first and in greater detail, with additional insights offered from counselling. This section finishes by outlining emerging criticisms of the professional identity literature arising out of recent literature syntheses before offering final conclusions.

2.2.1.1 Nursing

Professional identity research is more abundant in nursing than any other healthcare profession (Cornett et al., 2022), and is widely considered an essential aspect of being a nurse (Fitzgerald, 2020; Maree Johnson et al., 2012). Like clinical psychology, nursing has had to distinguish itself and carve out its own occupational field from medicine (Macdonald, 1995), and it has been argued that the profession has had ongoing struggles with cultivating a scientific and professional public image (Hoeve et al., 2014). With a historical emphasis on caring, the technical aspects of nursing are easily devalued (Macdonald, 1995). Beyond demarcating itself from medicine as a legitimate profession (Hoeve et al., 2014; Traynor & Buus, 2016), ensuring a strong professional identity is considered important for nursing to promote a clear public representation of itself (Hoeve et al., 2014), improve quality of care and patient outcomes (Maree Johnson et al., 2012; Rasmussen et al., 2018), ensure ethical practice (e.g. Crigger & Godfrey, 2014) and enhance nurse satisfaction and retention

(Hercelinskyj et al., 2014; Hoeve et al., 2014; Maree Johnson et al., 2012; Rasmussen et al., 2018). A weak professional identity has been linked to poor quality care, value dissonance and distress in nurses (Lyneham & Levett-Jones, 2016). Similar to nursing, clinical psychology has increasingly sought to differentiate itself from medicine and legitimise its own unique knowledge (Albee, 2000; Johnstone, 2010; Macdonald, 1995). This parallel in the socio-cultural and historical contexts of nursing and clinical psychology – without denying differences – mean there is much clinical psychology can learn from nursing.

Nursing researchers readily recognise the theoretical and definitional ambiguities surrounding professional identity (Fitzgerald, 2020). Reviews have described the theoretical underpinnings and use of the term by researchers as unclear (Fitzgerald, 2020; Hoeve et al., 2014; Rasmussen et al., 2018), with incongruous use of the terms identity and self (Hoeve et al., 2014; Maree Johnson et al., 2012) and conflation with process oriented terms such as professional socialisation (Fitzgerald, 2020). Notwithstanding these issues, professional identity has been defined within nursing as the *sense of self* that is derived and perceived from one's professional role (Maree Johnson et al., 2012); perceptions of what it means to *be*, and *act*, as a nurse (Rasmussen et al., 2018); and the integration of personal values, motivations of nursing, and the internalisation of the knowledge, skills and attitudes of nursing through professional socialisation (Hercelinskyj et al., 2014). Consistent across the nursing literature is an emphasis on *professional socialisation* as a means of understanding how nurses' professional identities develop (Johnson, 2012). Professional socialisation is understood to be a complex, interactive process in which the content of a professional role (knowledge, skills and behaviour) are learnt and which the vales, attitudes and goals integral to the profession are internalised (Goldenberg & Iwasiw, 1993). Generally, it is understood socialisation occurs through both explicit and implicit means, and often involves subtle coercive practices as novices transition into new cultural worlds and the practices sanctioned

within them (Traynor & Buus, 2016). There is notable variation, however, in whether and to what extent researchers link socialisation processes with professional identity formation, with suggestions the nursing literature would benefit from a shift away from an exclusive focus on socialisation to embracing identity formation (Benner et al., 2009).

The nursing literature offers less in the way of *models* of professional identity than in medicine (discussed further on in this chapter). The proliferation of primary literature has led to multiple reviews focussed on synthesising factors that influence nurses' professional identity without modelling professional identity per se (e.g. Hoeve et al., 2014; Maree Johnson et al., 2012; Mao et al., 2020; Rasmussen et al., 2018; Vabo et al., 2022; Valizadeh & Ghorbani, 2016). These reviews generally provide descriptive accounts of nurses' professional identities. For instance, Rasmussen et al. (2018) synthesised factors that influence nurse's professional identity into three interconnected categories: the self ("who I am"), the role ("what I do") and the context ("where I do it"). Alignment of these factors was associated with a strong professional identity, whereas misalignment was associated with stress and poor retention, and thought to negatively impact patient care (Rasmussen et al., 2018). Consistently, these reviews highlight the self and personal experiences as central aspects of nurses' professional identities, the fluid and constantly changing nature of identities, and the influence of context and socialisation processes on professional identity formation (Hoeve et al., 2014; Maree Johnson et al., 2012; Rasmussen et al., 2018). Although these reviews are fruitful in offering a broad perspective of nurses' professional identities, their descriptive nature means any guidance for educators and the profession remain speculative (Monrouxe, 2016; similar criticisms have arisen in medicine and are discussed further on in this chapter). Researchers are left to make vague recommendations and ultimately conclude that more information is needed about *how* socialisation processes shape

nurses' professional identities allowing for informed guidance for educators (Maree Johnson et al., 2012; Vabo et al., 2022).

Perhaps explaining the plethora of reviews focussed on nurses' professional identities, empirical studies exploring nurses' professional identities (predominantly relying on interviews and focus groups) are plentiful. Many are focussed on trainees and graduate nurses entering into the profession (e.g., Browne et al., 2018; Hunter & Cook, 2018; Marañón & Pera, 2015; Traynor & Buus, 2016; Walker et al., 2014), with the majority drawing on theorising relating to professional socialisation (Volpe et al., 2019). The majority of findings reveal how nursing students creatively take up, contest, negotiate and resist dominant practices and discourses in nursing in complex and nuanced ways as this socialisation process unfolds (e.g., Traynor & Buus, 2016). A repeated finding across these studies is the frequently distressing and anxiety-inducing disjunction between trainee expectations and clinical practice realities during initial workplace encounters (e.g., Hunter & Cook, 2018; Maree Johnson et al., 2012; Marañón & Pera, 2015; Traynor & Buus, 2016; Walker et al., 2014). The potential for existing personal values to conflict with the profession's values through socialisation processes, and the detrimental impact of this, is widely discussed in the nursing literature (Johnson, 2012). Nursing researchers have also emphasised the importance of the informal or hidden curricula that influence socialisation processes (Hunter & Cook 2018). A more in-depth discussion about the hidden curricula and impact on professional identities can be found later in this chapter (see page 77).

Expanding across the professional lifespan, researchers have also begun drawing upon *micro* approaches to social constructionist research and conversation-analytical methods to explore nurses' construction of professional identities in in-situ interactions (e.g., Benwell & McCreaddie, 2016; Samuriwo et al., 2021; Shakespeare & Webb, 2008). Researchers have explored the construction of nurses' professional identities in interactions with mentors (e.g.,

Shakespeare & Webb, 2008), interactions with other healthcare professionals in interprofessional contexts (e.g., Samuriwo et al., 2021), as well as interactions with patients (Benwell & McCreaddie, 2016). Researchers have also incorporated positioning theory and positioning analysis into these approaches to better understand in-situ interactions and how the contribute to the construction of professional identities (e.g., Phillips et al., 2002).

Perhaps more common, researchers have drawn upon *macro* social constructionist approaches to empirically explore the nexus between wider discourses within nursing and the influence of this on nurses' professional identities (e.g., Browne et al., 2018; Hallam, 2012; Jackson & Steven, 2020; Thompson & McNamara, 2022; Traynor et al., 2010a, 2010b; Traynor & Buus, 2016). For instance, gendered discourses pertaining to nursing being associated with caring and femininity (Browne et al., 2018) and idealistic discourses pertaining to what it means to be a 'good nurse' that conflict with the reality encountered in hospital contexts (Traynor & Buus, 2016) have been examined to better understand how nurses' professional identities are constructed within and contribute towards maintaining these discourses. Much of this research specifically focusses on novices and trainees entering into the profession (e.g., Browne et al., 2018; Traynor & Buus, 2016). Collectively, these studies reflect a willingness in the profession to critically examine how broader discourses within the profession are activated and maintained through socialisation processes.

The focus on training and education in the nursing professional identity literature means implications discussed largely centre on the role of training and clinical placements to adequately support nurses to develop positive and coherent professional identities (Cook et al., 2003; Crigger & Godfrey, 2014; Hercelinskyj et al., 2014; Maree Johnson et al., 2012; Maginnis, 2018; Rasmussen et al., 2018; Walker et al., 2014). Recommendations for educators to rethink and redesign curricula to embed a focus more explicitly on professional identity have arisen. Extending this, Crigger and Godfrey (2014) have attempted to outline a

comparison of teaching methods and content for various aspects of professional identity, yet they acknowledge that how little is known about *how* this process unfolds renders their suggestions speculative. Beyond education, recommendations have been made for deliberate efforts to enhance professional identity within workplace settings (Rasmussen et al., 2018), although there again remains an absence of guidance on how to operationalise this. Broadly speaking, empirical evidence and guidance on *how* to operationalise this guidance and what would be involved is lacking (Maree Johnson et al., 2012).

Clinical psychology can learn from the research available within nursing. Nursing's understanding of professional identity as a sense of self derived from one's work (Johnson et al., 2012), clarity in regard to why professional identity matters, and the emphasis on socialisation processes in professional identity formation are noteworthy. Drawing on professional socialisation theory has allowed researchers in nursing to better understand nursing education, transitional periods, and the role of placements and mentors on professional identity formation. Authors have utilised professional identity research to consider how institutionalised ways of talking move the practice of nursing towards patient-centred care reforms (e.g., Benwell & McCreaddie, 2016).

2.2.1.2 Medicine

Professional identity has long been recognised as fundamental to becoming and being a doctor (Monrouxe, 2010), and medicine has a well-established literature research base exploring the professional identities of doctors (Cornett et al., 2022). In medicine, this literature has evolved out of a recognition that an over-emphasis on professionalism and technical competence has been detrimental. Recognition that *becoming* a doctor is about more than technical skill and competence has resulted in a plethora of research, with problematic professional identities having now been linked with difficulties performing under

duress, reduced wellbeing, difficulties maintaining effective relationships, and unprofessional behaviours; all of which threaten quality clinical care (Mount et al., 2022).

Different researchers have drawn on a range of theories including social and discursive theories to define and explore professional identities (Monrouxe, 2016; Monrouxe & Rees, 2015); with different theoretical perspectives resulting in different research methodologies aimed at better understanding doctor's professional identities (Mount et al., 2022). Professional identity has been defined in medicine as how one perceives oneself as a member of the medical profession, based on one's attributes, beliefs, values, motives and experiences in relation to the profession (Rees & Monrouxe, 2018); and as the representation of self, achieved in stages over time, in which the characteristics, values and norms of the medical profession are internalised resulting in an individual thinking, acting and feeling like a physician (Cruess et al., 2014). Although some literature explores the experiences of practicing physicians (e.g., Chang et al., 2021), the majority – as is the case in nursing – is focussed on professional identity formation of medical trainees and interventions to support this process (Mount et al., 2022).

The professional identity literature in medicine can be broadly categorised in two ways: attempts to *model* professional identity and attempts to understand the *process* of professional identity formation. Attempts to model professional identity formation are more pronounced than in nursing, and tend to draw on social theories of identity in mapping out the ways that social contexts influence the profess of professional identity formation (e.g., Cruess et al., 2015; Goldie, 2012). Cruess et al. (2015) explain that professional socialisation influences and interacts with a person's existing personal identity in the formation of professional identity. Identity dissonance can arise when an existing personal identity is perceived as incongruent with professional norms and expectations. Cruess et al. (2015) emphasise the idiosyncratic nature of this process and the role of mentors and educators in

supporting identity construction. Similarly, Goldie (2012) draws on Social Complexity Theory (Roccas & Brewer, 2002) to emphasise the role of socialisation and the influence of medicine's norms and power hierarchies on individual professional identity construction, and how it is one's interaction with the profession that results in the internalisation of professionally sanctioned roles, norms and values. Both models acknowledge the importance of socialisation, the multiplicity of our identities, the highly idiosyncratic and continuously evolving process of professional identity construction, and shed light on the complex nature of this process. This research has shed light onto many aspects of medical students' professional identities, and yet what remains unclear is *how* this process unfolds. Research which *models* professional identity has therefore been critiqued for being unable to illuminate the *process* through which this unfolds, rendering recommendations for educators speculative at best (Monrouxe, 2016).

In comparison, social constructionist informed researchers explore the in-situ processes that influence professional identity construction (Monrouxe, 2016a). Here, identities are thought to be constructed and co-constructed through language. Researchers typically adopt either a *micro* social constructionist perspective (focus on minutiae of language) or a *macro* social constructionist perspective (focussing on broader discourses; see Chapter 1, page 36 for a distinction between micro and macro approaches). Drawing on micro approaches and conversation analytic techniques, researchers have examined interactions involving medical trainees to illuminate the moment-by-moment ways that their identities are negotiated in interactional spaces (e.g., Elsey et al., 2017; Elsey et al., 2013; Monrouxe et al., 2009; Rees et al., 2013; Rees & Monrouxe, 2010; Rizan et al., 2014). This research has spanned investigations of patient and clinician identities in patient-clinician interactions (Elsey et al., 2013; Elsey et al., 2017), explorations of how power is negotiated in interactions between students, patients and clinical teachers (Rees et al., 2013; Rees &

Monrouxe, 2010), as well as how medical students' identities are constructed in interactions between doctors and students in clinical settings (Rizan et al., 2014). Such research gives rise to a range of important guidance for educators (for instance, the importance of adopting a critical awareness on how their communication constructs power and impacts students' identity construction; see Rees et al., 2013; Rees & Monrouxe, 2010).

Approaching the research from a macro social constructionist perspective, researchers have explored dominant discourses that constrain the construction of medical students' professional identities, how this process occurs, and the impact of this (e.g., Bennett et al., 2017; Frost & Regehr, 2013; MacLeod, 2011; Monrouxe, 2009; Schrewe et al., 2017). For instance, discourses surrounding what it means to be a 'good doctor' impact students' journeys through medical school (e.g., Bennett et al., 2017; Monrouxe, 2009); they must navigate feelings of inadequacy (Monrouxe, 2009) and the complexities associated with coming into contact with competing discourses (Bennett et al., 2017; Monrouxe, 2009) as they develop a stance for themselves about what it means to be a doctor. Similarly, MacLeod (2011) demonstrated how discourses around 'competence' – recreated through the privileging of biomedical approaches and scientific knowledge – position students to display perceived desirable professional identities characterised by confidence and capability. The pressured environment of medical school with an emphasis on technical skill is directly seen to constrain and mould professional identities. Whilst the literature acknowledges that students have agency in negotiating their identities, there is an appreciation that some discourses are so culturally embedded that it seems exceptionally difficult for students to re-story them (Monrouxe, 2016). Finally, research by Cantillon et al. (2022) demonstrates that discourses are particular to specialty areas. That is, medical students negotiate their identities within the specific cultural words of medicine characterised by specialty-specific was of knowing, talking and being. Collectively, this research highlights how professional identity

construction is contextually bound and occurs within specialty specific cultural worlds, with the authors concluding that professional identity research must consider the specific contexts of disciplines and the specialty-specific discourses within them (Cantillon et al., 2022).

Consistent across the professional identity literature - irrespective of the theoretical and methodological approach - is an emphasis on the importance of *being* rather than *doing* as a doctor (Jarvis-Selinger et al., 2012); an emphasis that is now increasingly being reflected in medical curriculum reforms (Rees et al., 2018) in the context of longstanding concerns about the quality of post-graduate medical education (Cantillon et al., 2022). The aim is to assist students to discover who they are, who they are becoming and who they wish to become as doctors (Cruess et al., 2014; Jarvis-Selinger et al., 2012). Researchers have recommended professional identity be made an educational priority with staff made explicitly aware of relevant issues, trainees actively engaged in reflecting on their own identity construction, and educational institutions supporting interactions that optimally support professional identity formation (Cruess et al., 2019; Goldie, 2012). Recognition that professional identities are influenced by *hidden* curricula in addition to formal teaching experiences (Goldie, 2012), has highlighted the importance of appropriate interactions with educators and opportunities for trainees to make sense of emerging identities over and above formal curriculum content (Cruess et al., 2016; Goldie, 2012). Hidden curricula are the culturally acquired, unintended lessons that powerfully influence health professionals' values, beliefs, and behaviours (Chuang et al., 2010; Lempp & Seale, 2004; Raso et al., 2019). Recognition of the importance of hidden curricula has led to calls for educators to critically engage with the politics and cultural norms trainees are exposed to (e.g., Cantillon et al., 2022; Schrewe et al., 2017; Shaw et al., 2018), and more seriously consider how educational practices and institutional cultures in specific areas of medicine influence professional identity construction (Cantillon et al., 2022). A recent critical review of research that

focussed on interventions to support doctors' professional identity construction (Mount et al., 2022) found the majority of literature is focussed on undergraduate medical education and prioritises reflective writing which reflects an *individualist* approach to understanding identities (and insufficiently considers how socialisation processes influence identity construction). Mount et al. (2022) concluded that an unintended consequence of interventions that reflect an individualist approach to conceptualising identities is that cultural problems embedded in medicine are perpetuated and become burdens for physicians experiencing pressure to fit in to professionally sanctioned ways of being and doing things.

It is now widely recognised in medicine that becoming a doctor is as much about developing a professional identity as it is about acquiring technical competence (Monrouxe, 2010). More sophisticated understandings are emerging about precisely *why* professional identities are so important, with implications for physician wellbeing and burnout (e.g., L. Monrouxe et al., 2017; Winkel et al., 2019), patient care and alignment with reform priorities (e.g., Schrewe et al., 2017), ethical service provision and resisting hegemonic practices that violate moral codes (e.g., Shaw et al., 2018), critically engaging with taken for granted (and potentially unhelpful) professional norms (e.g., MacLeod, 2011), and addressing issues related to lack of diversity within the profession (e.g., Frost & Regehr, 2013). Moreover, Schrewe et al. (2017) demonstrated how one's understanding of patients through a biomedical lens in turn influences one's own professional identity as a physician; that is when clinicians come to understand their patients or clients through a biomedical lens they themselves participate in these discourses and acquire identities that perpetuate them. How physicians understand and care for their patients – and the extent to which this aligns with biomedical or other reform approaches in healthcare service delivery – is inherently interconnected with their *own* sense of professional identity.

Though there is still much that is not known about professional identity within medicine (Monrouxe, 2016), their headway in exploring professional identity offers insights for clinical psychology. The literature increasingly drawing on social constructionist approaches and theorising on identities (e.g. Cantillon et al., 2022; Frost & Regehr, 2013; Schrewe et al., 2017), allowing for a range of sophisticated qualitative research methods demonstrating the value of examining language and its role in professional identity formation (e.g., Chang et al., 2021), could assist in clinical psychology. In particular, utilising research methods that consider the nexus between professional identities and wider professional discourses and cultures (e.g., Cantillon et al., 2022; Frost & Regehr, 2013; Schrewe et al., 2017), would enable clinical psychology to better understand how power structures and professional truths influence professional identity formation which, in turn, impacts clinical service delivery. In medicine, research based on discursive theories of identity have proved powerful in making visible the processes through which people *become* healthcare professionals (see Monrouxe & Rees, 2015). This would enable clinical psychology not to repeat the same mistakes in conducting unsophisticated, small-scale studies that do not shed light on the *processes* through which professional identity is formed and therefore cannot provide meaningful recommendations for educators to nurture this process (Monrouxe, 2016). Like medicine, clinical psychology education emphasises competency and is established firmly on scientific knowledge. And yet, medicine demonstrates how an emphasis on identity theory can complement rather than replace competency-based discourses (Cruess et al., 2016; Jarvis-Selinger et al., 2012) and the value of expanding the emphasis from *doing* to *being* as a clinician (Cruess et al., 2014).

2.2.1.3 Counselling

Counselling is a relatively new profession compared to medicine and nursing that is specific to mental health (Alves & Gazzola, 2011). Counselling, similarly to clinical

psychology and other healthcare professions, has struggled to establish a cohesive professional identity and distinguish itself from other helping professions (Mellin et al., 2011). Overlap with psychology is thought to have contributed to this (e.g., Alves & Gazzola, 2011; Gazzola & Smith, 2007; Mellin et al., 2011), and culminated in efforts to form a coherent and unified professional identity (e.g., Alves & Gazzola, 2011; Gibson et al., 2010; Moss et al., 2014). This perceived urgency to clarify a single, coherent, unified professional identity is thought to protect against issues of role confusion, conflict and the proliferation of professional stereotypes that devalue the profession (Alves & Gazzola, 2011; Mellin et al., 2011a; Mrdjenovich & Moore, 2004; Prosek & Hurt, 2014; Woo et al., 2014). Tensions regarding increasing pressure to integrate the medical model with counselling's traditional emphasis on holism and social justice (Gazzola & Smith, 2007) have also increased the motivation to develop a clear collective professional identity. As a more recent mental health profession whose work aligns with psychologists, this literature is reviewed – albeit briefly – which reflects the scope of literature available.

As in nursing and medicine, definitions and theoretical perspectives of professional identity vary across the counselling literature (Alves & Gazzola, 2011; Woo et al., 2014). The existing literature (e.g., Alves & Gazzola, 2011; Dollarhide et al., 2013; Gibson et al., 2010) often cites Nugent and Jones (2009) who conceptualised professional identity as the integration of professional training with personal attributes in the context of the professional community. More recently, counsellors' professional identities have been conceptualised as the product of personal attributes combining with professional training (Moss et al., 2014). In a review of the literature, Woo et al. (2014) found components of counsellors' professional identities are often assumed to include knowledge of counselling and its philosophy, expertise and knowledge of roles, attitudes towards the profession and oneself, and expected behaviours and interactions with other professionals. Finally, much of the literature refers to

the interpersonal nature of counsellors' professional identities; the counselling professional community in considered formative in shaping trainees' professional identities through socialisation processes (Gibson et al., 2010). This emphasis on socialisation is comparable - although not as abundant - as in nursing.

As in medicine, researchers have focussed on modelling professional identity with a focus on both trainees (e.g., Dollarhide et al., 2013; Gibson et al., 2010) and experienced counsellors (e.g., Alves & Gazzola, 2011; Moss et al., 2014). Much of this research is situated within counsellor development theory (Rønnestad & Skovholt, 2013), and comprises cross-sectional research attempting to develop models of professional identity across developmental stages (Dollarhide et al., 2013; Gibson et al., 2010; Moss et al., 2014). For example, Gibson et al. (2010) developed a temporal model of trainee professional identity formation in which trainees move towards internalised understandings, adopting internal responsibility for growth, and towards professional identity situated within the professional community. Moss et al. (2014), likewise developed a model of counsellor professional identity development emphasising a progressive shift towards realism, rejuvenation, and the merging of personal and professional selves into a congruent identity. Consistent across these studies there is a distinction made between transformational tasks (*what* needs to be accomplished) and transformational processes (*how* this occurs) as professional identity transforms, although the studies are primarily *descriptive.* What is notable about these studies is that they de-emphasise the multiplicity, variation and fluidity in counsellor professional identities, and result in similar difficulties moving beyond speculative recommendations for educators given their descriptive nature.

Nevertheless, as in medicine, recommendations for counselling education have been provided based on these models. Repeated findings that counsellors in training experience increased anxiety as they struggle to integrate personal and professional selves in developing

a professional identity (Auxier et al., 2003; Prosek & Hurt, 2014; Woodside et al., 2007) have resulted in recommendations for educators to more explicitly support professional identity formation, supervision practices, and the explicit normalisation of professional identity changes across the professional lifespan (e.g., Alves & Gazzola, 2011; Dollarhide et al., 2013; Moss et al., 2014; Owens & Neale-McFall, 2014). Yet, recognising the operationalisation of these recommendations is challenging and there is a clear lack of guidance on *how* emerging knowledge about professional identity formation in counselling might be applied.

Though counselling has work to do to enhance their understanding of professional identity (Woo et al., 2014), there are learnings for clinical psychology. There is a clear and unavoidable tension applicable to clinical psychology: a profession's desire to display and promote a coherent and unified professional identity to protect perceived legitimacy must be balanced with a recognition that identities – and the processes that influence identity formation – are far too complex to be reduced meaningfully to simplistic models. The distinction between *what* needs to be achieved as professional identity develops and *how* this occurs in these models, situating the research within theories of counsellor development (Rønnestad & Skovholt, 2013) and professional socialisation (Wenger, 1998), attest to the importance of clinical psychology remaining aware of and intentional about meaningfully addressing the ways in which social contexts shape professional identity formation. Counselling's need to draw on more sophisticated theorising about identities with empirical evidence about how to support its development (Woo et al., 2014) suggests clinical psychology would benefit from embedding future research exploring professional identity within a robust theoretical framework. This will be essential in answering questions about what works, for whom, and when with respect to supporting professional identity formation.

2.2.1.4 Critiques of the Literature

The recent proliferation of research exploring professional identities across nursing, medicine and counselling has given rise to a series of reviews of the literature (e.g., Cornett et al., 2022; Volpe et al., 2019; Wyatt et al., 2021). These reviews have raised concerns about the quality of the literature available. In particular, the literature has been critiqued for a tendency to be under-theorised (and where theories of identity are utilised these tend to be insufficient to account for the complexities of identities; Cornett et al., 2022) and for lacking a critical perspective that considers issues such as intersectionality and power (Volpe et al., 2019; Wyatt et al., 2021). An absence of meaningful consideration of how pre-existing aspects of a person's identity (race, gender, age, sexual orientation, socio economic status and so on) influence professional identity formation has led to claims that researchers are making erroneous assumptions about the professional identities being formed; that they are one of the hegemony - an upper middle-class white male (Vole et al., 2019). It has been argued that this blind spot and sociocultural bias perpetuates Eurocentric perspectives, and hence reviews have questioned the validity of the literature and its applicability to healthcare professionals from underrepresented minority groups (Wyatt et al., 2021).

2.2.1.5 Concluding Remarks

Professional identity research is well established in nursing and medicine, and to some extent counselling, and offers a plethora of guidance for psychology which is – by comparison – the healthcare profession with an underdeveloped literature base exploring professional identity (Cornett et al., 2022; Snell et al., 2020). Each profession has recognised professional identity as a pressing issue; whether at the level of the profession (e.g., to legitimise and differentiate one's profession), service (e.g., to promote ethical and quality service delivery) or individuals (e.g., to reduce burnout and promote wellbeing); it is widely agreed that professional identity matters. For all the same reasons, professional identity

matters in clinical psychology. Clinical psychology has a unique opportunity to learn from the mistakes and successes of other professions. The lack of sophisticated theorising on professional identity and empirical evidence regarding factors that influence it - both of which pose challenges for educators and workplaces in constructively engaging with professional identity (Johnson et al., 2012) - serve as a reminder for clinical psychology to ensure conceptual clarity and work towards empirically sound recommendations for researchers and educators. Specifically, constructionist-informed theorising that sheds light on the *processes* of identity construction – alongside a critical engagement with the existing literature and awareness of socialisation processes - appear promising. Reviews of the literature caution psychology to ensure future research adopts a critical lens and consider issues pertaining to power and wider social structures. Clinical psychology would be wise not to erroneously assume it is neutral and uninfluenced by such things.

2.2.2 Literature on Professional Identity within Psychology

Within psychology and clinical psychology, there is limited published research exploring professional identity. A recent review of professional identity literature in healthcare professions found only 3.75% is from psychology (Cornett et al., 2022), with another review finding psychology was the allied health profession with the least amount of literature exploring professional identity formation and professional socialisation (Snell, 2020). The reasons for this remain unclear. With respect to clinical psychology, the recency of the profession, determination to establish itself as a science (with a focus on empirical methods), and move towards privatisation (see ‘Contextualising this Research’ section in Chapter 1, page 18) may account for this. Since Chapter 4 includes a scoping review of the literature exploring clinical psychologists’ professional identities, this section focusses predominantly on literature outside of professional identity but nevertheless relevant to offer a broader perspective.

Discrepancies in how the term *professional identity* has been used in the psychology and broader mental health literature suggest it is often not used with the same theoretical understandings as in the other healthcare professions. Within the therapist and mental health literature, professional identity has been used synonymously or in close association with professional role or area of training (Alessi et al., 2016), theoretical orientation (Rihacek & Roubal, 2017), professionalism or professional behaviour (McKenzie & Cossar, 2013), professional development (Urban, 2013) or competencies (Kuittinen et al., 2014). Elsewhere in psychology, professional identity has been defined loosely as the conceptual representation of a person about their place in a professional group (Lozhkin & Shevchenko, 2018) or a combination of theoretical perspectives and career goals (Watts, 1987). Numerous unpublished dissertations have conceptualised professional identity as encompassing the developmental transition from student to professional (Fitzpatrick, 2005), the integration of the philosophies of a vocation into one's personality (Nolan, 2019) and the answer to the question 'who am I as a psychotherapist?' (Tsuman-Caspi, 2012). Where the term has been used more consistently as is understood in this research, the literature frequently refers back to the writings of Friedman and Kaslow (1986) and Bruss and Kopala (1993). Friedman and Kaslow (1986) described professional identity as providing the foundation from which therapists make sense of their work and the fabric of their lives, whilst Bruss and Kopala (1993) define professional identity as an attitude of personal responsibility, commitment to behaving ethically, and feelings of pride for a profession (Van-Zandt, 1990). Further, Bruss and Kopala (1993) expanded on the ideas of Friedman and Kaslow (1986) to argue that therapists' professional identities are exceedingly complex because they are inextricably tied to therapists' personal identities. This proposition that personal and professional identities of therapists are not separate arises frequently within the literature (e.g., Eckler-Hart, 1987; Rønnestad & Skovholt, 2013; Woodward, Keville, & Conlan, 2015). As with the other

healthcare professions, terminology and theorising surrounding identities is ambiguous and unclear; it is just that the research base in psychology has perhaps had even less opportunity to develop clarity around these issues.

Notwithstanding these issues, studies exploring professional identity formation amongst trainee and practicing psychologists and how to support it are increasing. It is noteworthy that much of this research is specific to other speciality areas of psychology including sports psychology (e.g., Quartiroli et al., 2022), counselling psychology (e.g., Gazzola et al., 2011) and educational psychology (e.g., Nastasi, 2000). When focussed on research specific to clinical psychology or psychology more generally, the quantity of research declines. A recent attempt to *measure* professional identity (and its relationships to other variables such as demographics, resilience etc.) amongst clinical psychology postgraduate students has emerged (Foo & Green, 2022). This reflects (although does not make explicit) a positivist way of theorising (and measuring) professional identity: it is assumed that students can numerically rate their professional identity on a scale which can then be tested for significance against other self-report variables. This contrasts with much of the research exploring professional identity reviewed earlier from a social or social constructionist perspective in other healthcare professions. Although Foo and Green (2022) did find a correlation between high student satisfaction, lower burnout, and lower engagement with being a "student" with higher professional identity scores, no other significant correlations between other variables (e.g., with age, motivation etc.) and professional identity were found. It is worth critically asking: what is being measured, what do these results *mean* for educators, and what are the implications? For instance, the results suggest that professional identity may be a facilitator of satisfaction and wellbeing, although what remains unclear is *how* clinical psychologists develop their professional identities or *what* is the nature or composition of these identities.

Separate still, despite a lack of clarity around the nature of the professional identities of psychologists and clinical psychologists, researchers have examined the use of a range of methods thought to influence professional identity formation. For instance, non-directive experiential groups amongst psychology trainees to promote professional identity development have been described (e.g. Amodeo et al., 2017; Di Stefano et al., 2019; Falgares et al., 2017). These groups involve educators supporting students to build skills by involving them in various activities and enabling them to reflect on such activities in groups (Falgares et al., 2017). Authors have reported these groups as effective in reinforcing identity and wellbeing (Amodeo et al., 2017), improving self-awareness (Di Stefano et al., 2019) and supporting psychology trainees to build more realistic visions of the profession's identity, and altered their sense of themselves personally and professionally (Falgares et al., 2017). It is thought these groups are effective because they increase reflective capacity and promote a more realistic and less idealised vision of oneself as a professional (Falgares et al., 2017). Other studies have explored how language use by learners in an online training forum influence trainees' professional identity (Perrotta, 2006) and how reflective journaling can support professional identity development in clinical psychology trainees (Knoetze & McCulloch, 2017). As noted by Mount et al. (2022), each of these studies is steeped in varying conceptualisations of professional identities and arise out of various theorising on identities (predominantly from an individualist perspective), which needs to be taken into consideration. Nevertheless, this research demonstrates increasing interest in professional identities within psychology despite the research being underdeveloped comparative to other healthcare professions.

2.2.2.1 Related Research: Professional development

Research exploring the professional development of psychologists – and therapists more generally – is widespread and shares some parallels with the professional identity

literature in other healthcare professions. Despite not being grounded in identity theory, this section briefly reviews this area of research to demonstrate parallels with the professional identity literature.

The professional development of therapists across various professional disciplines, including psychology and clinical psychology, has been widely studied (e.g., Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2013; Rønnestad et al., 2019; Skovholt & Rønnestad, 2003). Professional development refers to the changes in skilfulness, attitudes, cognitive capacities, and emotional and interpersonal functioning of therapists (Rønnestad et al., 2019). Much of this research comprises large scale qualitative studies exploring therapist development over time. For instance, the Minnesota Study of Therapist and Counsellor Development (Rønnestad & Skovholt, 2003; Rønnestad & Skovholt, 2013) analysed cross-sectional and longitudinal data from interviews from over 100 American therapists to model therapist development. The model proposes five stages of therapist development: novice therapist, advanced student, novice professional, experienced professional and senior professional. Although not approached through the lens of identity theory, parallels with the professional identity literature in the healthcare professions include: periods of heightened anxiety, self-doubt and anxiety as a student; a focus on socialisation and learning environments across developmental stages; disillusionment surrounding discrepancies between the self and perceived expectations of one's role; incongruency and progressive integration of personal and professional selves; humbling expectations of oneself and one's role; and navigating authenticity in relationships with clients. Rønnestad and Skovholt (2013) later developed ten key themes that spanned these phases, concluding that optimal therapist professional development involves a congruent integration of the personal and professional selves. In another large-scale study exploring therapist development, Orlinsky (2020) reported a significant intersection between therapists' personal and professional selves.

Notably, this study conceptualised professional identity as synonymous with *professional training (i.e. discipline)*. Nevertheless, whilst the focus is typically on the personal self within the therapist development literature, these studies reveal an increasing interest in exploring the personal self of therapists – including clinical psychologists.

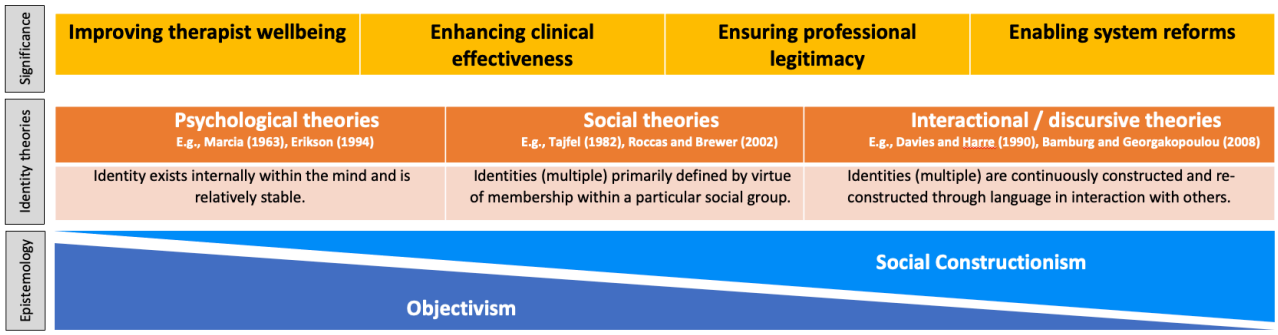
The literature exploring the professional development of psychologists and clinical psychologists specifically is less cohesive. The relevant literature ranges from a focus on professionalism and competency based development (e.g., Elman et al., 2005; Fouad et al., 2009) to an emphasis on personal-professional development (PPD; e.g., Gillmer & Marckus, 2003; Goodbody & Burns, 2011; Sheikh et al., 2007; Woodward et al., 2015), with reviews concluding the ‘ professional development’ of psychologists is a contested domain (Elman et al., 2005; Sheikh et al., 2007). Nevertheless, within clinical psychology, personal and professional development is increasingly being conceptualised as inextricably linked (Goodbody & Burns, 2011; Salter & Rhodes, 2018; Sheikh et al., 2007), which has led to increasing focus on PPD. PPD refers to the aspect of personal development that involves knowing oneself and understanding how one’s own experience shapes encounters with the world (Sheikh et al., 2007). A review of the vast and divergent PPD literature to develop a PPD model locates functions of PPD as developing self-awareness, resilience and professional effectiveness (Sheikh, 2007). A review of the PPD literature is beyond scope here although it is once again noteworthy that there is an emphasis on the *self* of clinical psychologists, with the research typically advocating for methods aimed at developing reflective practice to support the integration of personal and professional selves (Skeikh et al., 2017;, Salter & Rhodes, 2018, Woodward et al., 2015). With PPD dedicated to developing the capacity to reflect critically and systematically on the *self*, the link with professional identity or the *understanding of oneself as a clinical psychologist* is clear, despite inconsistent use of language around professional identity.

2.3 Summary: Where are we and where to from here?

It is clear that the professional identities of healthcare professionals – including clinical psychologists – matter (see Figure 2.1 for a graphical depiction of the discussion that follows). To summarise what has been discussed so far, the professional identities of clinical psychologists matter for improving therapist wellbeing, enhancing clinical effectiveness, ensuring the legitimacy of the profession itself, and enabling the realisation of mental healthcare system reforms (see 'Significance of this Research' section in Chapter 1, page 28). This final point is critical: Western mental healthcare services are under political and systemic pressures to reform the delivery of clinical care in ways that align with *person*-centered recovery-oriented approaches (Commonwealth of Australia, 2013; NSW Mental Health Commission, 2014). This shift away from privileging a medical model of recovery requires an equal shift in the way mental healthcare clinicians conceptualise *who they are* and *what they do*. Clinical psychologists therefore need to be supported to acquire professional identities that align with these reforms if they are to support the realisation of reforms on the ground in clinical care settings. A precursor to this is understanding more about clinical psychologists' professional identities and how they are constructed.

Figure 2.1.

Why Professional Identities Matter, Identity Theories and Epistemology



Note: Graphical depiction of a) why the exploration of clinical psychologists' professional identities matter, b) theories on identities, and c) epistemological approaches underpinning different theories on identities.

Nothing exists within a vacuum, however. The preceding chapters have explained how the professional identities of clinical psychologists are embedded within the unique historical, social, and cultural context of the profession itself. Although research exploring the professional identities of healthcare professionals is well established (for instance, in nursing, medicine and counselling); clinical psychology's history and development as a profession, sanctioned ways of knowing, and divisions and debates (as discussed in the 'Current Trends in Psychology' section in Chapter 1, page 21) all lay a unique foundation for understanding wider social and cultural factors that influence the professional identity construction of clinical psychologists.

As explained in Chapter 1, this research adopts a social constructionist epistemological position to pursue an investigation of clinical psychologists' professional identities. From this perspective, identities are understood as actively constructed through language in interactions with others in the social world (Burr, 2015; Benwell & Stokoe, 2006; see 'Epistemology and Theory' section in Chapter 1, page 34). Identities are multiple, fluid and contextual: we position ourselves in a myriad of ways across different times and spaces. More specifically, our professional identities – our understanding of *who we are* in professional contexts – are acquired and constructed within and through professional *socialisation* processes. Socialisation is an ongoing and complex process through which novices are exposed to clinical psychology's norms and values as they enter into the profession, and is a critical process underpinning professional identity formation (Goldenberg & Iwasiw, 1993; M Johnson et al., 2012). For this reason, the studies that follow pay close attention to socialisation processes and the role this plays in clinical psychologists'

professional identity construction. Further, the studies draw on a range of interactional and discursive theorising about identities as well as micro-oriented and macro-oriented approaches to answer the question: *'who am I and who do I want to be as a clinical psychologist?'*.

The four empirical studies that follow are presented in the order in which they were conducted. To briefly summarise, the first study explored the transformations to professional identity of clinician's implementing a recovery-oriented model of care (Open Dialogue) in a youth public mental health setting (Chapter 3). The results of this study indicated that clinical psychologists' professional identities are an important consideration in the implementation of reform-oriented models of care. From here, I conducted a scoping review exploring the professional identities of clinical psychologists as a launchpad for understanding the available literature and informing future research (Chapter 4). The review made it clear that theoretically informed research investigating the *how* and *what* of professional identity construction of clinical psychologists was necessary, alongside a recognition of the importance of education interactions as key socialisation processes which shape professional identity construction. I subsequently conducted two studies exploring interactions between clinical psychology trainees and their supervisors in an education setting. The third study explored interrogation interactions in supervision (Chapter 5). The fourth study explored interactions in which clients were fragilized and considered the implications for professional identity construction and the realisation of mental healthcare reform priorities (Chapter 6). Following these chapters, the General Discussion provides a critical reflection and perspective on 'where to from here' with recommendations for the profession, educators and researchers (Chapter 7).

Chapter 3: Transformations to Professional Identity and the Implementation of Open Dialogue (Study 1)

3.1 Preamble

It has been suggested that the professional identities of mental healthcare clinicians are of relevance for the realisation of mental healthcare reforms (see 'Enabling System Reforms' section in Chapter 1, page 32). This makes sense: a clinicians understanding of *who I am* is intimately interconnected with *what I do.* Extending this further, clinician's professional identities are likely to be of direct consequence for clinician's capacity and willingness to implement new mental healthcare service models, particularly when these models challenge or disrupt the status quo (and by extension, require different ways of *being* and *doing* from clinicians). This is the launching pad for the present study: an exploration of clinicians professional identities and how they were transformed by the implementation of a new model of mental healthcare within a youth mental healthcare setting.

This study relates to the first research question of this thesis (see 'Statement of Problem' section for thesis research questions in Chapter 1, page 18): what is the nexus between clinical psychologists' professional identities and the implementation of new models of mental healthcare? The research focusses on the implementation of a particular model of mental healthcare (Open Dialogue) which represents a shift away from a medical-oriented approach to mental healthcare towards a person-centered and recovery-oriented approach (and therefore aligns with reform priorities in mental healthcare settings). As will become clear, the findings indicated that clinical psychologists' professional identities were characterised by an emphasis on 'doing' (i.e., action oriented) and discomfort admitting to not knowing, and that this had implications for the implementation of Open Dialogue. Clearly, professional identities matter for the implementation of new ways of working that disrupt the status quo within mental healthcare settings.

At the initiation of this study (March 2018), this overall research thesis exploring the professional identities of clinical psychologists had not been contemplated. The study was instead focussed on the implementation of a new model of mental healthcare (Open Dialogue) in a multi-disciplinary team, as is typical in Australian community mental healthcare settings. Consequently, the sample includes clinical psychologists alongside psychologists (general registration) and psychiatrists. It is also notable that at this stage, I was less familiar with the complexities of social constructionism and unaware of the distinction between micro- and macro-oriented approaches to social constructionist research (see clarification about this distinction in Chapter 1, page 36). Although I do not use this terminology in the study that follows, I did nevertheless integrate an analysis of both conversational features (consistent with a micro approach) and broader discourses (consistent with a macro approach) within my analysis of discourse. Moreover, I relied on interview data as opposed to an in-situ examination of identity construction (an approach I only later became familiar with). I therefore acknowledge that the data analysed reflects that which participants were able and motivated to tell.

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Study Materials: Confirmation of approval from the University of Sydney Human Research Ethics Committee for this study and all study materials are provided in Appendix A.

3.2 Abstract

This study explored how psychologists and psychiatrists working in youth mental health services constructed their professional identities, and whether and how implementing Open Dialogue transformed these identities. Nine clinicians were interviewed after completing Open Dialogue training. Interviews were subjected to discourse analysis. First, we constructed two general pre-existing discursive professional identity positions: i) psychiatrists rhetorically distancing themselves from the medical model as 'fixers' of mental illness, and ii) psychologists and psychiatrists rhetorically embracing their personal identities. Second, participant's responses about implementing Open Dialogue revealed opportunities and discomforts, including: i) dialogical approaches offering psychiatrists an alternative identity to 'fixers', and ii) dialogical approaches generating discomfort at the risk of exposing participants own vulnerability. Participants identities comprised contrasting positions.

Transformations of Professional Identities: An exploration of clinical psychologists, psychologists and psychiatrists implementing Open Dialogue

3.3 Introduction

Open Dialogue is a resource-oriented model of therapeutic intervention which aims at mobilising the social networks of a person experiencing mental distress (Seikkula, 2003). The approach was developed in Finland with the substantial re-organisation of the mental health system leading to the articulation of seven principles: immediate help, a social network perspective, responsibility, flexibility and mobility, tolerance of uncertainty and dialogism (Seikkula, 2003). The first five principles relate to organisation of the mental health system and the final two to the therapeutic engagement. Despite some concern about the quality of the post-hoc evidence from the original Finnish studies given the lack of rigorous testing in randomised controlled trials (Buus et al., 2017; Freeman et al., 2018; Gromer, 2012), evidence for Open Dialogue is promising and growing. A recent large-scale retrospective register-based study found that young people experiencing distress who were exposed to Open Dialogue had fewer psychiatric emergency treatments and less use of general practitioner services over a ten-year period (Buus et al., 2019). Furthermore, the increasing evidence for Open Dialogue and the model's compatibility with a human-rights based approach to mental health (von Peter et al., 2019) is leading to the increased implementation of Open Dialogue internationally.

Open Dialogue represents a shift from the medical view of psychotherapy based on the *problem-diagnosis-treatment* model (Rober, 2017). The model conceptualises distress as being located within human relationships (Seikkula, 2003) and involves the facilitation of network meetings and requires therapists to adopt a non-directive stance (Buus et al., 2019). Therapeutic change is thought to take place in the relational space between those present through dialogue (Seikkula, 2003). The principle of dialogue requires the therapist to avoid

privileging one transcendental perspective and instead recognise 'truth' in multiple positions (Bakhtin, 1984). The purpose of the therapeutic encounter shifts from identifying one prevailing truth to ensuring the multiplicity of perspectives are heard. The multiple inner voices within each person or 'vertical polyphony', as well as the multiple voices between people or 'horizontal polyphony' (Haarakangas, 1997) become important components of generating new understanding. The principle of tolerating uncertainty is linked to 'not knowing' (Anderson & Goolishian, 1992) and requires therapists to suspend preconceptions to remain open to what the client as the expert in their own life is saying (Rober, 2005). Rober (2005) notes this position creates an obscurity about what therapists should do with their experiences and expertise. Rober (2005) asserts that whilst therapists must respect client's own expertise, their role is to be aware of and reflect on if and how their own inner conversations or experiences could enrich the therapeutic encounter. Therapy guided by the principles of dialogue and tolerance of uncertainty shifts the role of the therapist from one of identifying problems and making an intervention (Seikkula, 2011) to one of facilitating dialogue where new understandings can emerge (Anderson, 1997).

Emerging anecdotal evidence suggests Open Dialogue and dialogical approaches to therapy are difficult to implement for therapists yet may be transformative for therapists' identities. Limited research exists exploring the professional identity or 'self' of therapists and these concepts remain debated. The few but existing studies have investigated the professional identity of counsellors (Moss et al., 2014), psychologists (Rønnestad & T. Skovholt, 2003; Salter & Rhodes, 2018; Skovholt & Rønnestad, 1995), family therapists (Rober, 1999, 2005; Rober et al., 2008) and psychiatrists (Borchers, 2014). Consistent findings include the fluid nature of professional identity over time with a tendency to shift from a reliance on technical expertise to one's own experience, values and knowledge that

integrates professional and personal identities. Navigating expectations, acknowleding one's limitations and managing feelings of inadequacy are common experiences.

Papers exploring therapists being exposed to or working using dialogical approaches report i) difficulties for therapists to acknowledge the limit of their influence in controlling therapeutic change (Seikkula, 2011), ii) dialogical approaches requiring a unique way of thinking, doing and being by therapists in relation to themselves, clients, families, networks and colleagues (Brown et al., 2015; Rhodes, 2018; Seikkula, 2011; Stockmann et al., 2017), and iii) exposure to Open Dialogue suggesting substantial shifts in attitudes and approaches to clinical work by therapists (Brown et al., 2015; Rhodes, 2018; Seikkula, 2011; Stockmann et al., 2017). To date, however, no research has explored how exposure to and implementation of Open Dialogue shifts the professional identities of psychologists and psychiatrists.

Theoretical perspective

This study asserts that the 'self' is constructed, negotiated and continually altered through relations with others (Gergen, 2009). Social identities are not fixed but are constructed through people's active use of linguistic resources (Gee, 2004). In contrast to psychology's dominant cognitive paradigm in which talk is assumed to be based on innate and stable inner-representations of the world, discursive psychology (Potter & Wetherell, 1987) understands that 'reality' is actively and continuously constructed through language (Potter & Edwards, 1996). Access to reality is therefore achieved through investigating language (Gee, 2004; Potter & Wetherell, 1987).

Discourse Analysis is the study of how talk and text are used to perform actions (Potter & Wetherell, 1987). It studies how people use language to construct identities (Gee, 2004) and considers variations, gaps and inconsistencies as important as consistency. The focus is on analysing the discourse itself: *what* versions of reality people are creating and *how*

they do this (Potter & Wetherell, 1987). Because this study aimed to explore the discursive construction of professional identity of clinicians this analysis was considered appropriate. The discursive features used by participants were analysed to show how they produced and positioned their professional identities in the context of learning about and implementing Open Dialogue.

Aim

This study aimed to explore the different constructions of professional identity by examining participant's accounts of clinical work, their experience and perspective of being exposed to and learning about Open Dialogue, and their experience of implementing Open Dialogue.

3.4 Methods

Design

Semi-structured interviews were designed following interview outlines by Brinkmann (2015) and subjected to discourse analysis (Potter & Wetherell, 1987).

Study context

The study took place in Sydney in New South Wales, Australia. The Centre for Family-Based Mental Health Care have been delivering Open Dialogue training in various settings across the Blue Mountains, Sydney and Wollongong since early 2017. This involves a five-day experiential training preceded by five two-hour workshops. Participants were invited to participate in this study after their participation in one of these one-week trainings.

All participants work for the same local health district in either the community-based outpatient service or acute inpatient services provided for young people experiencing moderate to severe mental health issues. Psychologists (clinical psychologists and general psychologists) and psychiatrists were invited to participate.

Interviews and participants

Nine face-to-face semi-structured interviews were conducted between August and November 2018. All interviews were conducted by the first author except one conducted by the last author. Nine interviews was considered sufficient for discourse analysis. Five psychologists (three clinical psychologists and two general psychologists) and four psychiatrists were interviewed (two male and seven female; seven identified as Caucasian, one identified as Middle-Eastern and one identified as South-Asian; average age 44.3 years; average years since professional endorsement 14.8 years; average years working in mental health 17.1 years).

Interviews were restricted by participant availability and lasted between 45 and 69 minutes, with a total duration of nine hours and two minutes. All interviews were audio-recorded and transcribed verbatim by the first author with indications of basic interactions. A reflective diary was completed after transcribing each interview. The first author checked transcriptions against the original recordings for accuracy.

A test interview was conducted with a clinical psychologist from another health district who had attended the same Open Dialogue training. This interview was transcribed and analysed and participant feedback obtained. Based on this feedback, the approach used in the remaining nine interviews was more 'active' to enable greater flexibility (Brinkman & Kvale, 2014). The interviewer sought to activate narrative production from interviewees to answer the research question (Holstein & Gubrium, 1995). The style, pace and ordering of questions were modified to develop and support trust between interviewee and interviewer.

Interviewer position

Discourse analysis is not value neutral as researchers work with an outset in particular social and political values (McHoul & Rapley, 2001). Since meaning is inherently social and interactive, it is considered impossible to free interactions in interviews from factors that could be seen as contaminants (Holstein & Gubrium, 1995). Instead, interviews are viewed as

collaboratively constructed in which the interviewer seeks to gather information about what and how knowledge concerning a particular topic is constructed (Holstein & Gubrium, 1995). The first author was a clinical psychology Masters student at an Australian university with a professional background in mental health policy, human rights and community development.

Analysis

We used discourse analysis (Potter & Wetherell, 1987) to analyse the interviews and reveal dominant discourses and conversational structures. Whilst following Potter & Wetherell's (1987) ten-step discourse analysis approach, we followed some key tenets of Grounded Theory (Charmaz, 2006) to code interviews by constructing themes 'grounded' in the data. Themes *earnt* their way into the analysis through coding and memo writing. Initial line-by-line coding avoiding abstraction was used to ensure codes accurately reflect participant's views followed by focussed coding to categorise the most prominent codes. Theoretical coding related codes and allowed integration to reveal themes. Attention was paid not to apply a language of intention, motivation or strategies unless data existed to support these assertions. Memos were written to record major analytic themes and continually refined to produce the findings reported below. Finally, analysis of selected discourses explored how participants use language to construct positions of professional identity relevant to the research areas. The qualitative data obtained was rich and complex. What is presented is a small sample chosen to reflect the research question.

3.5 Results

Analysis was separated into two broad phases, including: pre-existing identity constructions prior to Open Dialogue training and the experience of implementing Open Dialogue in clinical work settings following training. In terms of the former, the analysis led to the construction of two general professional identity positions by participants, including i) psychiatrists rhetorically distancing themselves from the medical model as 'fixers' of mental

illness, and ii) participants rhetorically embracing the personal self as critical to their professional identities. After Open Dialogue training, participant's responses about integrating dialogical approaches into clinical work revealed opportunities and discomforts associated with how this impacted their identities, including: i) dialogical approaches offering psychiatrists an alternative identity to 'fixers' of mental illness, and ii) dialogical approaches giving rise to discomfort at the risk of exposing the vulnerability of participants.

Overall, participants' professional identities were polyphonic as they presented themselves by taking multiple and contrasting positions. The distinction between professional and personal positions became progressively less clear as interviews progressed. Participants described themselves as working with young people with moderate to severe mental health issues and high risk. Psychiatrists positioned themselves as holding technical expertise in systemic thinking and prescribing medication, and psychologists positioned themselves as holding technical expertise in psychotherapies. Participants positioned their current professional identities as diverging from the identities of their colleagues or wider profession, as well as from their own early career professional identities. Participants spoke of their difference or otherness. Further, participants presented unique and idiosyncratic accounts of their own professional identities continually evolving and in motion. The voices of the current iteration of the professional self and the past but newly trained professional self were often in tension. The analysis revealed that whilst most had implemented Open Dialogue sessions, participants often understood the implementation of Open Dialogue as the integration of dialogical ways of working into existing clinical practice.

Pre-existing Position One: Distancing oneself from the medical model as a "fixer" of mental illness

Participants spoke of weighty expectations imposed upon them to 'fix' or 'cure' mental illness. Psychiatrists positioned their identities as having been constructed by colleagues,

consumers and the system as medication prescribers. They expressed frustration and disdain with this perspective. Psychiatrists expressed a sense of inadequacy and having lost professional autonomy, and a constricted capacity to define one's self and work beyond the scope of medication. In response, psychiatrists distanced themselves from the dominant medical discourse of mental illness and referred to being guided by systemic frameworks. Some spoke of the profession's loss with new psychiatrists narrowly trained to understand distress as biologically based. Some psychiatrists spoke of themselves as a 'witness' to people's distress, and their role in sensitising families to their own capacity for healing.

Some psychiatrists spoke of the power imbalance between doctor and patient. They referred to their deep commitment to promote client dignity rather than pathologise distress but described challenges. Attempts to re-distribute power and respect voice could be surpassed where psychiatrists risked being held accountable for completed suicides by the Coroner's Court. The necessity for psychiatrists to have control and responsibility if they are held accountable in the instance of a client death emerged as a dilemma for prioritising service user voice and autonomy.

Participant 1 was a child and adolescent psychiatrist working full time in a community-based team. This participant gradually admitted to experiencing significant expectation to medicate and 'fix' young people in distress. They positioned themselves as working hard to resist these expectations; not on the basis of personal values but because of a clinical judgement that quick fixes are unrealistic.

In the transcript in Table 3.1, participant 1 invokes multiple voices to convey their position of being a doctor: the voice of the self as doctor (making clinical judgements about the utility of medication), voice of the outward facing self (aware of expectations of others), voice of the experiencing self (experiencing feelings of hatred) and the voice of a pathologizing system or society (as heard by the families with loved ones in distress). This

polyphony of voices highlights the complexity of their experience. This participant initially reported using a cognitive-behavioural model, but subsequently explained that they draw upon a wide repertoire of therapeutic approaches. When asked to explain their approach further they responded as transcribed in Table 3.1.

Table 3.1.

Interview Transcript from Participant 1

1	P1	So it is <u>really</u> varied (.) so it is a mixed bag. So I don't sort of adhere to a single model
2		of care really And it is usually >sort of a< (1.0) probably (1.0). Medication is definitely a
3		<u>pa:::rt</u> of what I do ↑ Because <u>I am</u> a <u>doctor</u> ↓ (.) So I am aware that often I am being
4		asked if other clinicians have a question about medication (.) But in my <u>own mi::nd</u> it is
5		actually a very small part (.) >of what I do< ↑
6	I	[yeah]
7	P1	So I mean I think (.) I guess (.) You know with all the young people I do my best to
8		work systemically (.) and (1.0) um:: (1.5) yeah (.) that is a big focus of care ↓. [So -
9	I	[when you
10		say medication is a <u>small</u> part of what you do and (.) a <u>large</u> part of what you do is
11		work systemically ↑ what do you mean by that? ↓
12	P1	(1.0) I think there's (.) when you're a doctor and you're asked to see the patient there is
13		this kind of sense of (.) it's kind of um (1.0) I think sometimes (.) there is an expectation
14		that you are going to <u>me::dicate</u> ↑(.) which I <u>ha::te (.) because it is almost like it is used</u>
15		like a [<u>ve:::rb (1.0)</u>
16	I	[mm
17	PI	Um
18	I	How do you mean? ↑
19	P1	Um (.) "the doctor will <u>me::dicate</u> <u>you</u>" (.) or (.) as in (.) you know (.) "there is something
20		dreadfully <u>wrong</u> with you and this is going to be the <u>cure</u>::" (.) or (.) "you are so severe
21		you <u>need</u> this" ↓ (1.0) Um (3.0) Or::: (.) >sometimes I think< there is expectation from
22		families that medications will (.) <u>fi::x</u> problems (.) when (.) >you know< they can be (.)
23		>they can actually be very <u>helpful</u>< but they are certainly not the be all and end all. ↓

Note: Conventions used in transcripts: (.) indicates pause < 1 second, (x.0) indicates pause in x seconds, = indicates latching between utterances, [indicates interruption – and] end of simultaneous speech, ::: indicates stretching of sound, @ indicates laughter, .h indicates audible inhalation, hh indicates audible exhalation, emphasis, "spoken quieter", >spoken quicker<, ↑indicates rising or falling ↓ intonational shift.

Participant 1 begins by stating the variability in their work and repetition of the extreme case "really" punctuates their point. Anticipating a query regarding the role of medication as a psychiatrist, they assert that medication is part of working "as a doctor" (line 3). In attaching their identity to the title "doctor" they ensure they do not stray from that professional title. This identity statement warns off potentially obnoxious attributions as they then minimise the importance of medication from their perspective in contrast to the perceived expectations imposed on them. In doing so this participant opens themselves to criticism but maintains the safety of being able to retreat to the position of "doctor". They introduce "working systemically" (line 8) as an alternative to medication. This participant clarifies by drawing again on the identity of being a doctor (line 12) and hesitates in their response (line 13), indicating contemplation and that what is to come is meaningful and considered. They pause briefly before addressing a matter they have alluded to: expectations of psychiatrists to medicate (line 14). The abrupt shift to the feeling of hatred this creates (line 14) and drawing out of the emotive word "hate" signals disdain. This participant justifies their stance by proposing that "to medicate'" is used as a verb (lines 14-15) and the prolonged emphasis suggests absurdity. When asked to clarify, they respond not with their own voice but by inciting multiple voices of someone or something uncertain (lines 19-21); perhaps the wider mental health system, society or colleagues in third person. Increasing pace and rapidly shifting between these voices, the cumulative effect is convincing and ensures the listener is less able to refute these claims. Their tone is one of mockery. The emphasis on "dreadfully wrong", "cure" and "need" suggest the toxicity of these voices. Pausing (line 21)

lowers the intensity and criticism, and they shift to another source of expectation to medicate: families themselves. Their tone changes and they repair their position by moderating themselves as indicated by false starts in their flow of language. Rather than asserting the voices of others, they speak only of their own thoughts here (line 21) and they propose a new position towards medication: *part* of the solution but not *the* solution.

In comparison to psychiatrists, psychologists began interviews by recounting their training in specific therapies they can *deliver*. As interviews progressed, a deeper and more uncomfortable uncertainty about their roles emerged. Psychologists spoke of anxiety about what it is they "do" or the expected function of their role. They described wanting to help (often by fixing) but needing to remind themselves of the limits of their influence. Many spoke of needing to continually remind themselves that, ultimately, families are their own agents of change. Instead of narratives of fixing, ideas of *relating to* and *being with* emerged as key aspects of their role.

Pre-existing Position Two: Embracing the personal self

Most participants positioned themselves as experiencing, suffering and experiential beings even prior to exposure to Open Dialogue. Their humanity and *sameness* with clients was portrayed as an inescapable and invaluable. Through use of the pronouns "we" and "us" they acknowledged that they, too, hurt when loved ones suffer and how their own well-intentioned efforts often exacerbate pain. Personal experiences were a source of empathy and connection. Many reflected on their personal experiences of distress or caring for loved ones.

The pre-existing and long-standing tension between the position of this experiencing, suffering and experiential therapist with the professional 'expert' position acquired during clinical training was described regularly. Participants described how practical, clinical experience led them to grapple with and reappraise their training where they felt pressured to limit the influence of the personal self on the professional self. This often led to questions of

expertise and an acknowledgement that whilst families are the experts in their experience, the place and role for participant's own knowledge, thoughts, and ideas became less certain. One clinical psychologist recalled how enforcing certain professional boundaries and insisting upon one's separateness from a client had led to damaging and devastating outcomes. They described feeling cruel and declared the hypocrisy in the profession proclaiming the impossible task of encouraging clinicians to prioritise therapeutic rapport whilst also insisting on maintaining a professional separateness. See Appendix A.7 (available as Supplementary Figure FI with online manuscript).

In summary, all participants positioned their professional identities as being *other* to what they considered the dominant approach in their profession. They defined themselves in *opposition* to something or someone else. For psychiatrists, there was a sense of distancing one's professional identity from the problematic over-medicalisation of human distress. Psychologists positioned themselves as experiencing a *sameness* with clients and in opposition to a perceived expectation to maintain strict boundaries and be personally removed from clinical work.

Implementing Open Dialogue: Opportunities and discomforts

When discussing the implementation of Open Dialogue and the integration of dialogical approaches into clinical work, participants identified both opportunities and discomforts. As part of othering themselves from their professions, participants saw working dialogically as an opportunity to work differently from colleagues and in ways aligned with personal values yet also identified discomfort with the approach. When discussing opportunities, feeling calmer, more authentic and able to be of more assistance to families without needing to take an 'expert' position were described. Acknowledging the rarity of simple, finite solutions to human distress alleviated participant's sense of inadequacy regarding their inability to eradicate suffering. This was true until hesitation or refusal to work dialogically prevailed

when concerns about managing risk or meeting administrative requirements arose within a risk averse mental health system. When discussing discomforts, participants reported uneasiness with dialogical approaches in situations of perceived high risk and concerns about such approaches revealing the limitations of their technical knowledge and thus exposing participant's own vulnerabilities.

Opportunities. All clinicians identified opportunities in working dialogically including enhancing self-reflection, workplace relationships and clinical work. Participants unanimously spoke about how their own personal and embodied experience of encountering Open Dialogue facilitated a deeper self-reflection and deepening of relationships with colleagues, which left many clinicians contemplating what a dialogical approach could offer clients. They described re-connecting with their initial motivations for becoming therapists. Dialogical communication with colleagues emerged as improving relationships and fostering a supportive team culture. Some clinicians reflected on incorporating elements of dialogical listening exercises into team meetings. One senior consultant psychiatrist spoke of the devastation experienced by clinicians when a client completed suicide and how staff well-being had not been adequately addressed. The psychiatrist facilitated an Open Dialogue meeting with staff described as being profoundly healing.

Clinically, participants reflected on instances where working dialogically resulted in valuable but unexpected clinical information emerging. This was attributed to increased self-awareness about how participants can unintentionally steer therapeutic conversations and a resolve to be less directive. One psychiatrist recalled working with a suicidal adolescent and his parents, and the therapeutically counter-productive pressure he perceived to get the boy to report no risk. Shifting the therapeutic goals to focus on strengthening the family relationships to ensure the adolescent could approach his parents during times of high suicidality produced better therapeutic outcomes.

Psychiatrists identified dialogical approaches as offering an alternative to medication and reducing their own anxieties about being identified as medication prescribers. Psychiatrists uniformly expressed frustration around navigating expectations to 'fix' human distress. Their identities shifted from one of resisting the perceptions of others as medication prescribers to one of embracing the role of facilitating dialogue as part of their professional identities. See Appendix A.8 (available as Supplementary Figure F2 with online manuscript).

Participants, particularly the psychologists, identified dialogical approaches as a means through which they could prioritise *being with* clients and relating more authentically. Dialogical approaches offered opportunities to embrace a shared *sameness* with clients. The approach was seen to offer a way of working with clients that de-constructed the pretence of *separateness*; rather than seeing clients as pathologically unwell and in need of acting upon, they were seen as fellow humans in distress. Whilst all participants articulated opportunities in working using a dialogical approach, there were initial reservations and almost all participants expressed concerns about the feasibility of dialogical approaches within the current system.

Discomforts. Some participants described the exposure to a dialogical approach as frustrating or felt their expertise was being threatened, and all participants identified perceived internal and external barriers to working dialogically. Managing risk emerged as a significant perceived barrier. Almost all psychiatrists positioned themselves as being ultimately responsible and accountable for client deaths. Personal reflections of devastation after watching colleagues deemed accountable for deaths by the Coroners Court were anxiously recalled. One senior psychiatrist deemed that responsibility must be accompanied with authority; how can a psychiatrist be held responsible for a death without the authority to take control over the situation when they judge it to be life-threatening? The tension between balancing this responsibility with a commitment to prioritising the voice, autonomy and

choice of clients produced a dilemma. An incongruence between professional values when working within a system described as needing ‘scape goats’ was upsetting. The realities of managing these risks was interspersed with vulnerable reflections of personal heartbreak after losing clients to suicide.

Participants detailed how a dialogical approach necessitates a willingness to be vulnerable which felt professionally discouraged. Limitations in how much participants feel able to display vulnerability in their work emerged as a key barrier, particularly for psychologists. Most participants recognised and valued their vulnerability as humans – with fears, pains, wishes and desires – and embracing this emerged as a desired opportunity but also a key barrier to working dialogically.

Participant 4 is a clinical psychologist working in the community-based team who positioned themselves as a confident cognitive-behavioural therapist. Progressively, this participant revealed their own anxieties and disclosed a desire to work dialogically. Acknowledging families as experts in their own lives and requiring therapists to be 'present’ for clients in a deep, qualitative way that requires genuine vulnerability were described as important. Prior to the transcript in Figure 2, participant 4 had reflected on feeling vulnerable when working dialogically. Responding to a question about whether they believed the vulnerability served a therapeutic purpose in sessions they replied as seen in Table 3.2.

Table 3.2

Interview Transcript from Participant 4

1	P4	↑ I mean I think it is (.) a hard thing for people to sit with (.) the >kind of< uncertainty of
2		"we don't know" or "we are not going to fix it" (.) um (.)
3	I	The clinicians? Or =
4	P4	= Yeah the clinicians doing that (.) and that makes us look very vulnerable ↓ and I don't
5		think we like that at all (.) like (.) to not have the answers:: ↑(.) is (.) crazy (.) like that is
6		not what we are there for ↓ (1.0)
7	I	Mm:: (2.0)
8	P4	↑ It is like saying "oh:: I don't really know @ what I am doing" you you know (.) but
9		like it makes sense (.) because they do know:: ↑ (.) they are the best person in that
10		position to know (.)↑ than us (.) but (1.) yeah (1.0) ↑ It is admitting that we don't know @
11		(.) but we don't like to think that we don't know.
12	I	So it is admitting really rather than (.) it doesn't change anything =
13		= yeah (2.0) It is being vulnerable (.) acknowledging that we aren't >you know< (1.5)
14		perfect either (2.0)

Note: Conventions used in transcripts: (.) indicates pause < 1 second, (x.0) indicates pause in x seconds, = indicates latching between utterances, [indicates interruption – and] end of simultaneous speech, ::: indicates stretching of sound, @ indicates laughter, .h indicates audible inhalation, hh indicates audible exhalation, emphasis, "spoken quieter", >spoken quicker<, ↑indicates rising or falling ↓ intonational shift.

Participant 4 collectively identifies themselves with other clinicians and splits the therapist self into that which is vulnerable and a more defensive or protective self that denies this vulnerability. They begin confidently then pause and hesitate (line 1) before invoking the voice of themselves and the voice of other clinicians admitting to not having answers or not being able to "fix" (line 2). They situate themselves collectively with other clinicians using the pronoun "we" (line 2) which warns off potential judgement being able to be directed solely at them. This participant re-emphasises this is not only what they personally do, but that the "clinicians" do it (line 3). Returning to include themselves in this category, they

admit that tolerating uncertainty is hard because it is very vulnerable (line 4). Their wording emphasises the potency of this vulnerability. Shifting, they confidently propose this as uncomfortable for clinicians and close down the possibility for exceptions emphasising "at all". Continuing to elaborate, they introduce not having answers (line 5). Intermittent pauses increase suspension before they highlight the extremity and absurdity of their argument through emphasis on "crazy". Justifying their stance and further emphasising the absurdity, they assert that admission of vulnerability isn't the expected function of clinicians (line 6). A longer pause leads them to re-visit their argument, but from a different angle (line 8). They make a mockery imitating the voice of a clinician admitting this not knowing and the impossibility of such admissions (line 8). Turning to explain this dilemma, this participant alludes to the position of families themselves as holding knowledge. In emphasising that they "do" know (line 9), this participant responds to an unsaid but present assumption that they "don't" know. This participant positions families as experts in knowing and hesitates before positioning them in an elevated position of knowing in comparison to clinicians. Pauses and hesitations indicate continued reflection and insights: it is the act of *admission* from clinicians of not knowing that causes discomfort (lines 10-11). This participant identifies themselves within this category, and in doing so admits their own discomfort with admitting to not knowing. A longer pause suggests deeper contemplation before locating language to express the essence of the core of the conversation thus far: vulnerability (line 13). They quickly explain themselves with some hesitancy and long pauses and identify what needs to be acknowledged by clinicians but appears almost intolerable: that they are not perfect either (lines 13-14). Use of the word "either" suggests a dropping of pretences of separateness between client and therapist; both are imperfect together.

Participant 4 went on to identify a key reason for therapists steering away from positions of vulnerability was a discomfort in humility and admitting they are not always in

positions of knowing. Concluding the interview, this participant spoke of an emerging and deep sadness that their training, models and expectations had taken them further away from an approach of openness and curiosity.

In summary, psychiatrists identified dialogical approaches as offering opportunities to identify oneself beyond the role of 'fixer' of mental illness. For psychologists, dialogical approaches offered a framework for embracing their *sameness* with clients and relating in a deeper, more authentic capacity. Across professions, dialogical approaches alleviated participants' own discomfort and anxieties arising from perceptions of having been positioned by others as medication prescribers or experts whose role is to *act upon* people in distress. A discomfort with dialogical approaches exposing the vulnerability of participants emerged as a barrier. Vulnerability was described as the greatest strength and the greatest challenge. Dialogical approaches were seen as a way of enabling a deep connection but also risked exposing participants' imperfections and the limitations of professional expertise.

3.6 Discussion

This study examined the discursive constructions of professional identities by psychologists and psychiatrists, and explored how participants positioned the impact of learning about Open Dialogue on these identities. Participants often referred to the integration of dialogical approaches into their existing clinical work rather than the implementation of Open Dialogue as a model of care. They referred to being less directive, tolerating uncertainty and relinquishing the expert position. Analyses revealed two positions regarding the construction of professional identities and how working dialogically had shifted the construction of these identities. Participants distanced their identities from the medical model as 'fixers' of mental illness and embraced identities that privileged their personal and experiencing selves as therapists. Participants also spoke of dialogue as offering an

alternative to being seen as 'fixers' of mental illness but giving rise to discomfort associated with the risk of dialogical approaches exposing their own vulnerability.

Participants rhetorically positioned their current identities as being differentiated from past iterations of themselves and from their professional colleagues. Participants positioned themselves in relation to the *other* and often reacted to or countered how they perceived their identities were constructed by others. Their identities did not exist in isolation but were created in relationship (Bernasconi, 2012; Gergen, 2009) and there appeared to be differences between the professions of psychiatry and psychology. Psychiatrists' positioned their identities in reaction to perceptions of being seen as 'fixers' or medication prescribers. Psychologists positioned their professional identities as hinging on authentic, genuine relationships to counter perceived expectations to maintain unnecessarily strict boundaries which were perceived as potentially damaging. Inverting the typical process through which individuals create identities by othering and distancing themselves from minorities (Bernasconi, 2012), our participants othered themselves from dominant paradigms. construed as hypocritical, over-promising and ineffective. This construal revealed participant's dislike of the medicalisation of human distress and privileging of technical expertise. This othering from the dominant paradigm still functioned to manage anxiety and threat but acted to strengthen the position of participants as being valid or superior.

The polyphony and continual motion of all participant's identities was apparent in the rich and often contrasting utterances. Consistent with the dialogical nature of therapists as observed by Seikkula (2011) and Rober (2005, 2008), participants positioned themselves as a sequence of different thoughts reflecting a multitude of voices (Bakhtin, 1984). The participant's voices were a field of tension between different concerns (Rober, 2008). This polyphony (Seikkula, 2008) appeared to be in a continuous state of motion and re-creation; both at a broader level across people's careers and within the interviews. Participants used

rhetorical devices to reflect on the changes to their identities across time, possibly consistent with findings suggesting therapist identity formation is an evolving process (Friedman & Kaslow, 1986; Gibson et al., 2010; Rønnestad & Skovholt, 2003; Salter & Rhodes, 2018). Psychologists diverged from adhering to distinctions between the professional and personal self, with the two becoming increasingly synthesised as described in previous research (Friedman & Kaslow, 1986; Salter & Rhodes, 2018). Similar to findings by Salter and Rhodes (2018), psychologists appeared to be increasingly guided by their own internal dialogues. Expanding these findings, our results suggest that whilst identities change over time, this change is not towards a homogenisation of therapist internal dialogues, but towards a sensibility and coherence of multiple voices.

Through this process of evolving professional identities, tensions regarding how to synthesise what appeared to mirror Rober (2005)'s *experiencing self* and *professional self* were apparent. The multitude of therapist inner dialogues emerged as a clear source of anxiety; wanting to fix distress but knowing one's limitations. Participants spoke of grappling with who's (theirs or the clients) experiences to privilege in what appeared to be an attempt to locate a single truth. Rarely did this culminate in an acknowledgement of the capacity for multiple truths to exist and the role of the therapist in promoting dialogue where all these voices are heard (Anderson, 1997). As participants alternated between their own voices they generated new positions and reported surprise at their own sense-making in interviews. Never did this move participants towards a place of eliminating multiple perspectives, but often generated a new observer-style inner voice that could witness this tension. Participants were attending to their own here and now experiences of interviews and their own emerging self-talk and emotions (Rober et al., 2008). These conversations support observations that the generation of dialogue rests on difference and tension (Hermans, 2004) and that dialogue itself is a restless process (Pezzano, 2017; Rober, 2017).

The discomfort with privileging technical expertise and undermining families' own expertise was matched by a discomfort with admitting to a 'not knowing' position (Anderson & Goolishian, 1992). Willingness to admit to 'not knowing' was difficult in a risk-averse mental health system and risked exposing participants' own vulnerability. Whilst vulnerability was described as a necessary requirement for deep and authentic connection, the *admission* of vulnerability on this basis was perceived as unacceptable. Yet, adopting a 'not knowing' position appeared the only truthful option. The 'not knowing' position was both annihilating and necessary. Psychologists appeared motivated to free themselves from the inauthentic and unhelpful pretence of 'expert'. Yet, consistent with observations by Rober (2005), they confronted additional anxieties derived from an obscured view of the role of their own opinions, ideas and emotions. Beyond the suffering of client's evoking feelings of helplessness and inadequacy (Clance & Imes, 1978) and giving rise to fears within therapists of not being worthy of their positions (Rober, 2017), admitting to 'not knowing' gave rise to uncertainties about where to place their own internal experiences which, if exposed, could shed light on their own vulnerability. Such findings parallel the reflections of Rober and Seltzer (2010).

Participants positioned themselves as needing to differentiate their identities from a mental health system that *others* clients by pathologising distress and requires participants to *act upon* service users. Rober et al. (2008) noted how therapeutic contexts which avow expectations that therapists are helpful gives rise to prominent concerns for therapists about what they *do.* Our participants similarly experienced a pressure to be action-oriented. Psychiatrists felt compelled to medicate and eradicate risk whilst psychologists felt compelled to 'do' something to eradicate distress. Rober and Seltzer (2010) describe how action-orientation approaches can result in well-intentioned therapists becoming overly responsible and pushing for change whilst adopting subtle colonising positions (Rober &

Seltzer, 2010). This implicit loss of agency through institutional pressures and medicalised psychiatric discourse aligns closely with the experience of psychiatrists found by Borchers (2014). Perceived pressure to be action-oriented was felt to diminish the capacity to adopt dialogical approaches. Paradoxically, whilst wanting to push against the risk-averse system, participants appeared to find temporary relief in the system as a refuge from the anxiety of tolerating uncertainty. Similar to observations by Seikkula (2011), it appeared that participants experienced internal barriers in adopting dialogical approaches stemming from discomfort of tolerating uncertainty. Participant's own awareness of their personal challenges in maintaining dialogical approaches was a source of frustration and sadness.

As an alternative to othering, participants spoke of their sameness with clients. Participant's construction of their professional identities stemmed not only from technical knowledge, but from their emotive, relational and embodied experiences that they shared with service users. Consistent with the reflections of Rober (2017) and Rober and Seltzer (2010)**,** personal encounters with distress and suffering, as well as the embodied and felt experience of participating in a dialogical training, emerged as rich sources of empathy and motivation for working dialogically. Participant's positioned themselves as engaging with clients with their own mortality in mind in ways that avoided positioning themselves on the 'sane' side of the dialectic and clients on the 'pathological' side (Rober & Seltzer, 2010).

Validity in discourse analysis concerns coherence, participant's orientation, new problems and fruitfulness (Potter & Wetherell, 1987). This study revealed non-coherence between how participants see their roles. Psychiatrists faced greater challenges othering themselves from the medical model whereas psychologists experienced more apprehension about being action oriented and about conflicting perspectives on the benefits of a dialogical approach. Despite individuals conveying multiple positions, coherence was most strongly observed amongst participants within the same profession. Participant's orientations were strikingly similar in

terms of having a multiplicity of voices and identifying similar challenges with working dialogically. New problems identified in this research for further investigation concern clearly distinguishing the integration rather than implementation of Open Dialogue, and how integration efforts can shed light on and influence clinician discomfort. The fruitfulness of this study lies in its novel revelations about the construction of professional identities of psychologists and psychiatrists working in public mental health systems and the opportunities and dilemmas these clinicians face in adopting dialogical approaches. Additional potential limitations include the self-selecting and primarily Caucasian sample as well as the data coding being done exclusively by the first author. The reflective diary completed by the first author revealed striking similarities between the anxieties and discomforts of the first author and those of participants. The first author was deeply moved by the personal accounts of participants, and it is certain this sameness and sense of shared experience likely influenced the direction of interviews and the lense through which the first author coded the data. Consistent with a constructionist framework, paragraphs of text from all interviews were presented to the final author and analysed together to ensure the fullest exploration of interview data, contestation of ideas and systematic development of themes.

Conclusion

This study has shed light on how psychologists and psychiatrists working with young people construct their professional identities through othering themselves from dominant professional paradigms or discourses. Distancing oneself from the problematic over-medicalisation of human distress by psychiatrists, and aligning oneself with the sameness of clients in contrast to the expectations of the profession psychologists, emerged. Integrating dialogical approaches into existing clinical work gave psychiatrists an alternative therapeutic tool that expanded their professional identity from the ‘fixer’ of mental illness through medication, and offered a framework for participants to embrace their shared humanity with

clients. Yet this also risked exposing the limitations to professional expertise and thus vulnerability of participants. All participants embraced the model of Open Dialogue and incorporation of dialogical approaches into their clinical work but ultimately became constrained by systemic and individual barriers. Despite intention and commitment to this model of working, psychiatrists were constrained by the external legal and systemic processes around managing risk and administration. Psychologists were constrained by their own internal doubts about their utility and helpfulness upon admitting to ‘not knowing’ or the limitations of their professional expertise in creating change.

Chapter 4: Scoping Review Exploring the Professional Identities of Clinical Psychologists (Study 2)

4.1 Preamble

The findings from Study 1 confirmed the relevance of clinician's professional identities to their willingness and capacity to implement new models of mental healthcare service delivery that align with mental healthcare reform priorities. Even amongst clinicians who positioned themselves as unaligned with dominant medically-oriented approaches and who saw opportunities for improved clinical carer in dialogical ways of working, the implementation of Open Dialogue was threatening: potentially undermining professional expertise and requiring vulnerability (with the risk of exposing one's own limitations). For psychologists and clinical psychologists specifically, a focus on *doing* (i.e., an action orientation oriented around doing something to or for clients), intolerance of uncertainty and admitting to a 'not knowing' position were particularly challenging. Effectively, the results demonstrated that psychologists and clinical psychologists' ways of understanding *who they are* and *what they do* were barriers to the implementation of Open Dialogue. These findings tell us that the professional identities of clinical psychologists do matter for the realisation of mental healthcare reforms on the ground.

It was for this reason that the research then expanded to explore the professional identities of clinical psychologists more broadly. This first required a thorough understanding of the scope and quality of the existing research to inform future studies. This study therefore relates to the second research question of this thesis (see 'Statement of Problem' section for thesis research questions in Chapter 1, page 18): what is known about the professional identities of clinical psychologists and what is the quality of the available literature? In setting out to review the available literature, it became clear that the literature was vast, heterogeneous and varied in quality (as is explained further in this chapter). For these reasons, the scoping review ended up including qualitative literature and including a quality

assessment of included studies. The findings indicated that clinical psychologists' professional identities are interrelated with their personal identities, intersect with other identities and change over time. The findings also identified quality issues across the included studies.

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Study Materials: Supplementary materials for this scoping review are provided in Appendix B.

4.2 Abstract

Introduction: Our professional identity refers to our sense of *who we are* and *how we should behave* as professionals. Professional identities are developed through socialisation processes: established ways of knowing and doing are acquired and reproduced. The professional identities of healthcare professionals have implications for the realisation of healthcare reforms that require new ways of being and doing from clinicians. Tension and frustration can arise when professional identities are incongruent with reform directions. More knowledge is required about the professional identities of mental healthcare professionals – including clinical psychologists – so that they can be supported to develop professional identities that align with healthcare system reforms.

Method: We undertook a scoping review of existing literature. We aim to i) identify the relevant literature ii) review the literature quality iii) thematically summarise the literature findings iv) consult with clinical psychologists, and v) identify recommendations for research, training and practice.

Results: A systematic database search (PsycINFO, CINAHL, Scopus and Web of Science) identified 24 relevant published articles and dissertations. Quantitative studies were excluded due to their markedly different research focus. Included studies were independently reviewed and findings summarised. Findings were organised around three themes: 'integration of personal and professional identities', 'intersectionality' and 'changes in professional identity over time'. Research quality issues were identified. The trustworthiness of the findings was corroborated in consultation with clinical psychologists.

Discussion: Clinical psychologists recognise their professional identities as being interrelated with their personal identities and changing over time. They recognised professional identity as important yet inadequately considered in the profession. The research area is emerging yet remains under-theorised and requires improved research methodologies. Future theoretically-

informed research is required to build up a credible research base to better understand the development of clinical psychologists' professional identities so that this process can be facilitated to enable the realisation of healthcare reforms.

The Development of Professional Identity in Clinical Psychologists: A Scoping Review

4.3 Introduction

Embodying relatively coherent, shared professional identities across our own professional group facilitates accountability for the legitimacy and mandate of our profession as a whole within society: expediting collective understandings of *who we are* and *how we should behave* (Abrams & Hogg, 2006). Further, professional identities have a critical impact on political, social and healthcare advances and reforms (Cornett et al., 2022). Internationally, within healthcare services (including mental healthcare), there has been widespread criticism of paternalistic models of care and privileging *biomedical* views of recovery (Bayetti et al., 2017; Hardy et al., 2022; Jackson-Blott et al., 2019). In this vein, current *mental* health system reforms demand person-centred clinical care that promotes *personal* recovery: a radical shift in the way mental health services are delivered requiring an equally radical shift by mental healthcare professionals (Bayetti et al., 2017). However, healthcare professionals develop their identities through socialisation processes within institutional parameters (Monrouxe, 2016): neophytes are exposed to and go on to internalise and adopt institutional norms. In turn, they go on to enact and reproduce institutionally sanctioned ways of *being* and *doing*. This is problematic if *who I understand myself to be* within institutional norms – and the behaviours this generates – does not align with reforms and advances. In such situations, reforms will not be realised.

While we are beginning to establish how the development of professional identities occurs through socialisation processes – the *hows* of identity – the exact particulars of this process within and across healthcare professional groups are lacking (Bayetti et al., 2017; Gkiousias, 2021; Noble et al., 2019; Snell, 2020). Furthermore, it has been argued that there is sufficient difference across healthcare professions to warrant specific attention to disciplines (Snell, 2020) to better understand what this means politically and socially for each

healthcare profession (the *whats* of identity). For example, clinical psychologists are specialised mental healthcare providers in health settings specifically trained to assess, diagnose and treat patients with complex mental health difficulties. To realise the reform agendas in these contexts, we need to understand the intricacies around clinical psychologists' professional identities so they can be supported to develop identities that better align with the reform priorities set for the mental health services in which they work.

To begin this process of knowing, a knowledge synthesis approach was deemed the first step before embarking on knowledge translation or the development of new research. Although there have been several recent scoping reviews of professional identities across a range of healthcare professions exploring how healthcare professions conceptualise, operationalise, and assess professional identity formation (Bayetti et al., 2017; Best & Williams, 2019; Cornett et al., 2022; Gkiousias, 2021; Noble et al., 2019; Rasmussen et al., 2018; Snell, 2020; Toh et al., 2022; Woo et al., 2014; Wyatt et al., 2021), only two have focused solely on mental healthcare professionals (Bayetti et al., 2017; Woo et al., 2014), with clinical psychologists being notably absent. We aim to address this issue by undertaking a scoping review to address the following overarching research question "how and in what ways do clinical psychologists develop their professional identities?".

Reviews of Professional Identity in Healthcare Professions: What is already known

There have been a number of reviews over the past decade synthesising the increasingly available empirical literature exploring a range of healthcare professionals' identities (Bayetti et al., 2017; Best & Williams, 2019; Cornett et al., 2022; Gkiousias, 2021; Noble et al., 2019; Rasmussen et al., 2018; Snell, 2020; Toh et al., 2022; Volpe et al., 2019; Woo et al., 2014; Wyatt et al., 2021). Much of the literature within these studies originates from the USA, Canada, the UK and Australia (Best & Williams, 2019; Cornett et al., 2022; Gkiousias, 2021; Noble et al., 2019; Snell et al., 2020). Furthermore, the included studies

cover a range of healthcare professions across nursing, medicine, and other allied healthcare professional groups. Notably, however, within these syntheses there is a dearth of literature on psychology in general: Cornett et al. (2022) identify 6/160 articles, Best and Williams (2019) report on 3/19 articles and Snell et al. (2020) identify only 1/96 articles. Furthermore, there are just two syntheses specifically focussing on mental healthcare professions, namely psychiatrists (Bayetti et al., 2017) and counselling (Woo et al., 2014), although others did include articles with mental healthcare professions: 1/19 articles in the review by Best and Williams (2019) focussed on interdisciplinary mental healthcare teams and 9/92 in the Volpe et al. (2019) review involved counselling or psychology students.

Across the included studies in the reviews, the main impetus for studying professional identity arises from the remit of examining issues around political, social and healthcare reforms and advances (Bayetti et al., 2017; Best & Williams, 2019; Cornett et al., 2022; Gkiousias, 2021; Woo et al., 2014). This is both in terms of the *impact* of professional identity on reforms, as well as the role of professional identity in *adjusting* to reforms. This makes sense given that *who I am* as a member of a healthcare profession influences *what I do* in that role (Rasmussen et al., 2018).

Key rationales for the reviews themselves include identifying barriers and facilitators to identity development (Bayetti et al., 2017; Gkiousias, 2021; Noble et al., 2019; Rasmussen et al., 2018; Sarraf-Yazdi et al., 2021; Snell, 2020), the absence of minoritised physicians' professional identities (Wyatt et al., 2021) and curricular matters including conceptualising, operationalising and even assessing professional identity development (Volpe et al., 2019). Bringing these issues together, the importance of better supporting the development of professional identity over time - across all minority groups - and providing guidance to educators, is widely recognised (Bayetti et al., 2017; Cornett et al., 2022; Rasmussen et al., 2018; Sarraf-Yazdi et al., 2021; Snell, 2020; Toh et al., 2022; Wyatt et al., 2021). From these

reviews the message is clear regarding why such support is required: navigating identity changes over time is a complex process which, despite commonalities across healthcare professional groups, and those within such groups, is also radically different. By excluding certain groups (e.g. professional or minoritised groups) we necessarily only capture part of the story. Indeed, there is an increasing chorus of researchers critiquing the lack of diversity reflected in the 'data' on professional identities (historically comprising of white, male, and medical cultures) and the need for a critical perspective from researchers (Cornett et al., 2022; Mount et al., 2022; Volpe et al., 2019; Wyatt et al., 2021). One of these absent groups comprises mental health professionals, specifically clinical psychologists, which are the focus of this article.

Mental Health: The *development* of therapists

The dearth of professional identity literature in psychology might be due to variations in terminology, theoretical underpinnings, focus and research methodology. Such nuances muddy the waters when it comes to searching and synthesising the available literature. For example, where researchers in psychology have claimed to investigate *professional identity*, the term is frequently used as a *descriptor* label to indicate demographic data, activities, theoretical orientations, training, and selected attitudes. Such research acts towards the profiling of the profession (e.g. clinical psychologists are highly educated, increasingly working in private practice, engage in their own therapy, and share overlapping and distinct activities with counselling psychologists) (Byrne & Davenport, 2005) rather than exploring and offering insight into the *subjective sense of oneself* as a psychologist.

Outside the theoretical lens of *identities*, the exploration of therapist *development* – including the development of clinical psychologists – is well-established (Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2013; Rønnestad et al., 2019; Skovholt & Rønnestad, 2003). Here, research focuses on professional development. However, similar

constructs and concepts found in the professional identity literature are being used, despite drawing on different theoretical frameworks. Thus, research refers to changes in skilfulness, attitudes, cognitive capacities, emotional and interpersonal functioning, and *vocational identity* of therapists (Orlinsky & Rønnestad, 2005). For instance, the large-scale Minnesota Study of Therapist and Counsellor Development (Rønnestad & Skovholt, 2003; Rønnestad & Skovholt, 2013) led to a widely influential model of therapist development that describes features of therapist development resonating with the professional identity literature in other healthcare professions. This includes periods of heightened anxiety, self-doubt and anxiety as a student; a focus on socialisation and learning environments; and disillusionment surrounding discrepancies between the self and perceived expectations of one's role.

The Present Review

Having synthesised the published reviews of empirical studies exploring professional identity across healthcare professions and briefly touched on the therapist development literature, we move forward by undertaking a knowledge synthesis to better understand what is known about the professional identities of clinical psychologists. We aim to do this in a way that brings together a broad range of literature that is relevant to professional identity even if this is not made explicit.

Clinical psychologists are specifically trained to work in mental health contexts that are unique from other healthcare settings: patients can present with particularly complex and challenging behaviours and emotional distress which require specialised ways of working. Nevertheless, clinical psychologists are not the only healthcare professions to work in mental health settings: mental health nurses, psychiatrists, social workers and so on all work clinically in such settings. We expect this research will therefore offer a unique perspective relevant to these healthcare professionals. Since we know that the professional identities of healthcare professionals working in mental health settings are shaped by these contexts, and

that mental healthcare professionals are being asked to radically shift their ways of working to align with reform priorities, we need to better understand how and in what ways their professional identities develop so that we can support the realisation of these reforms. Exploring the literature on clinical psychologists' professional identities will move us one step forward in this direction by providing information on what is similar and different for a healthcare profession specifically trained to work in mental health settings and paving the way for future research.

Objectives

The aim of this study was to systematically review published and unpublished studies investigating the professional identity of psychologists and clinical psychologists working in clinical contexts. This study sought to i) identify the extent, range and nature of relevant literature ii) review the literature quality iii) summarise the literature findings, iv) consult with psychologists working clinically regarding the findings of the present review, and v) identify recommendations for research, training and clinical practice.

4.4 Method

We conducted a scoping review (Arksey & O'Malley, 2005; Levac et al., 2010) together with a quality assessment of papers (Blaxter, 2013), with reporting guided by the PRISMA extension guidelines for scoping reviews (PRISMA-ScR) (Tricco et al., 2018). Scoping reviews share similarities with systematic reviews with a shared focus on rigour, reproducibility and transparency, but differ in their purpose and aims (Peters et al., 2020). Whilst systematic reviews are indicated when the intention is to answer a specific research question or inform clinical decision making, scoping reviews are inherently more exploratory and indicated when mapping large, diverse and novel research topics (Peters et al., 2020; Pham et al., 2014). A scoping review was considered most appropriate given the complexity and novelty of this emerging research area in clinical psychology, as well as the method

allowing for a breadth of coverage across published and unpublished literature (Arksey & O'Malley, 2005). We chose to include a quality assessment as recommended by Pham et al. (2014) to identify the quality of the studies and inform future research. We adapted the six-step methodological framework described by Arksey and O'Malley (2005) as follows:

Step One: Identifying the Research Question

The overarching research question for the review is "how and in what ways do clinical psychologists develop their professional identities?" with the following sub-questions guiding our analysis:

Question 1: What is the scope of empirical research investigating the professional identity of clinical psychologists?

Question 2: What is the quality of this research?

Question 3: What are the key themes in the findings of this research?

Question 4: To what extent do the findings of this review align with the experiences of clinical psychologists? and

Question 5: What recommendations can be made for future research, training and clinical practice?

Step Two: Identifying Relevant Studies

Professional identity refers to a person's understanding of what it means to think, feel and act as a clinical psychologist, in terms of their attributes, beliefs, values, motives and experiences. This present review defines professional identity as the way in which a person understands who they are, who they are not, and who they want to be in a professional role as a clinical psychologist (Monrouxe, 2010; Monrouxe, 2016). We also consider professional identity as a *sense of oneself* in a professional role, continuously changing and renegotiated in interaction with others (Monrouxe, 2010; Monrouxe, 2016). Here, the concepts of self and identity are inter-related. All literature exploring the self, identity, professional identity

formation and professional development was included. The review only included studies with clinical psychologists or psychologists (no speciality indicated) working in clinical settings.

The key inclusion criteria were: i) research investigating professional identity, identity or self; or professional development with findings relevant to clinical psychologists' professional identity; ii) sample of at least fifty percent clinical psychologists or students undertaking clinical psychology training; iii) empirical studies; iv) published research articles or dissertations; and v) published in English.

Two strategies were used to identify relevant studies. First, a building block strategy was used to systematically search PsycINFO, CINAHL, Scopus and Web of Science. The first block included "professional identity OR professional identit*" OR "professional development AND ((identity or identities) OR (self or themselves))". The second block included "psychology OR psychologists OR clinical psychologists OR psychologist attitudes OR psychologist*". No country of publication or date restrictions were applied. This process identified a total of 3,241 references (see PRISMA flow chart in Figure 4.1). After duplicates were removed, 2,859 titles were included for further screening. Second, the building block strategy was supplemented with a citation pearl search (Pearce-Smith, 2014). This involved screening the reference lists of included papers and examining the first twenty identified relevant papers in the SCOPUS and PROQUEST databases. This was done to increase the precision and recall of the search. The search was completed in October 2020.

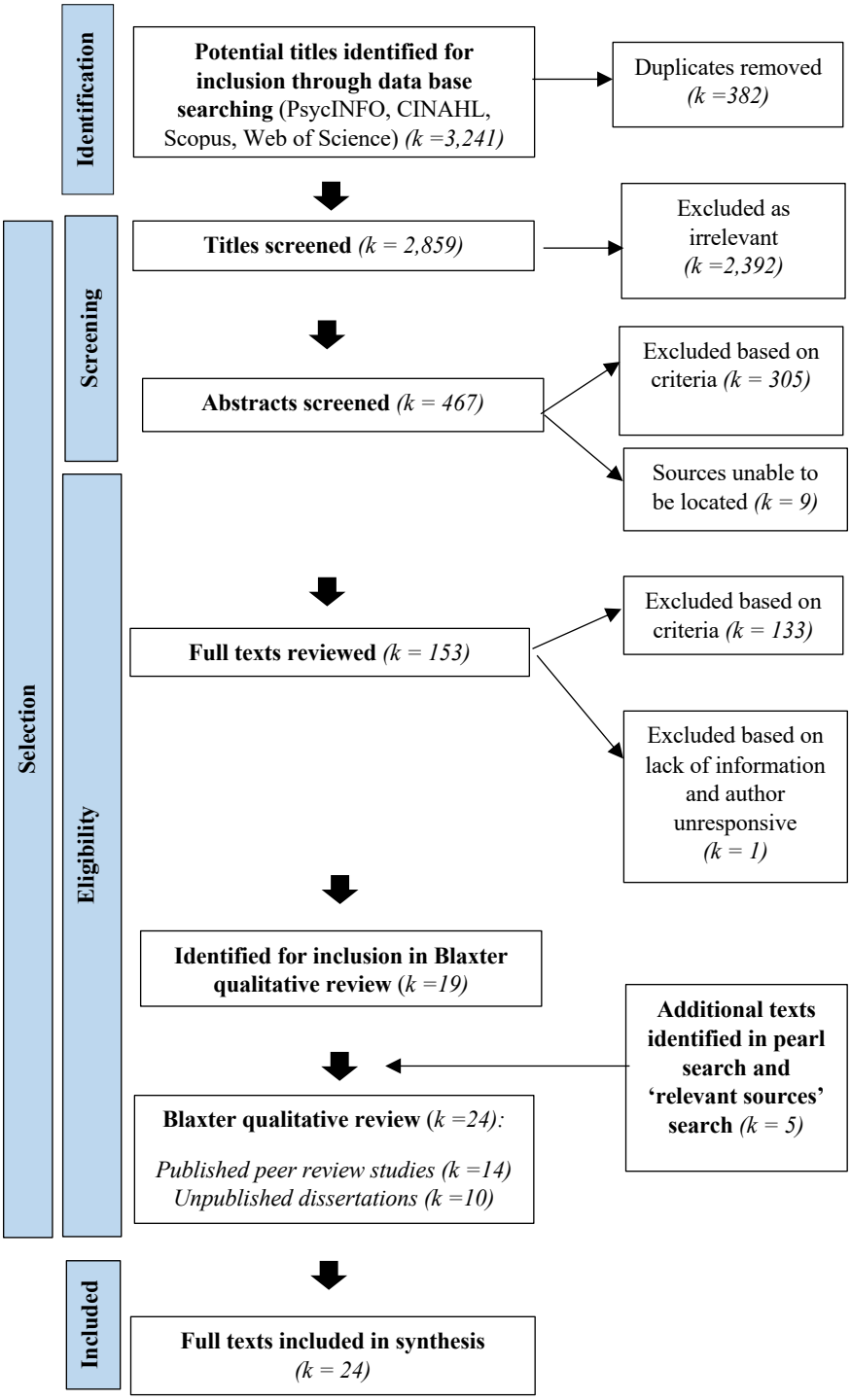
Step Three: Selecting Studies

Exclusion criteria included: i) conceptualisation of professional identity as comprising demographic details, theoretical orientation or competency; ii) exclusive and narrow focus on professional development; and iii) quantitative studies due to the fundamentally different research focus.

As depicted in Figure 4.1, the inclusion and exclusion criteria were applied progressively at the levels of title, abstract and full text review. The 2,859 titles were screened by author SS and subsequently 467 abstracts remained included. Over half of these abstracts (k = 240) were initially blindly double rated against the inclusion and exclusion criteria by authors SS and CH with good inter-rater reliability at 90 percent agreement. Disagreements were resolved by consensus. A third reviewer (NB) was consulted in cases without consensus. The remaining abstracts were reviewed by SS following this process except for nine abstracts that could not be located. This process identified 153 full-text studies that were further examined against the exclusion criteria by SS and 133 studies were excluded. Authors were contacted by SS when further information was required. One author was unresponsive resulting in the exclusion of that study. This strategy resulted in 19 remaining eligible studies. These 19 studies were used to conduct the citation pearl search that resulted in the inclusion of an additional five texts bringing the total to 24 studies.

Figure 4.1

PRISMA Flow Chart



Although quality reviews are typically not found within scoping reviews (Arskey & O'Malley, 2005), we chose to include a quality review in line with Pham, et al. (2014). Given the final selected studies were qualitative designs we used the 20-item Blaxter (2013) criteria for evaluating qualitative research (see Appendix B.1 for an overview of the 20-item checklist). These criteria reflect a wide array of areas that are relevant in the assessment of qualitative research, including methodological rigour (e.g., selection of participants, sensitivity of methods), quality of analysis (e.g., appropriate analysis, validity checks), presentation (e.g., distinction between data and interpretation, author positions), and ethics (e.g., ethical issues adequately considered). Each peer-reviewed article (k = 12) was reviewed independently by two authors who then compared appraisals. SS then independently applied the criteria to dissertations (k = 12).

Step Four: Charting the Data

The key elements extracted from each study were charted for analysis. See Table 4.1 for a condensed version of this charting outlining authors, context and relevant findings.

Table 4.1

Overview of Key Elements Extracted from Each Study

	Author and year	Context	Professional identity: key findings		Author and year	Context	Professional identity: key findings
1	Schubert et al. (2021).	Australia.	Personal self critical to professional identity. Evolves over time. Difficult admitting to vulnerability and relinquishing action orientation.	**13**	McMahon (2012).	Ireland.	Self-doubt associated with desire to be helpful and 'fix'. Varying abilities to integrate personal and professional identities.
2	Turnbull & Rhodes (2019).	Australia.	Burnout arising from incongruence between self-image and ideal self. Burnout recovery involved developing authentic self. Insufficient focus on identity in training.	**14**	Goodbody & Burns (2011).	United Kingdom.	Challenging integrating personal self in to therapy. Minority identities situate themselves in wider social contexts (discrimination). Majority identities describe linear and individualistic identity development.
3	Nolan (2019).	USA.	In-person intensives with mentors facilitated growth. Perceived sense of duty to present self as knowledgeable and compassionate.	**15**	Stolz (2009).	USA.	LGBTI psychologists vigilant about exposing identities. Integrating personal and professional identity fosters self-respect. Supervision
4	Odusanya et al. (2018).	United Kingdom.	Pressure to conform to white profession. Being black created dual identity. Integration of personal and professional identities over time.	**16**	Normoyle (2009).	USA.	Professional and personal identities can generate role conflict and distress. Overcoming adversity generates new professional identities.
5	Salter & Rhodes (2018).	Australia.	Integration of personal and professional identities. False professional persona developed in early career. Training insufficiently explored identity.	**17**	Baird et al. (2007).	USA.	Professional identity shaped by personal experiences. Experience of oppression enables recognition of self as oppressor.
6	Bentley (2016).	USA.	Clinical training disrupts identity. Personal history impacts identity as psychologist.	**18**	Daniel (2006).	USA.	Conflict between American professional identity and Indian identity. Acculturation. Integration of personal and professional identities over time.

			Integration of personal and professional identities over time.				
7	Delgado-Romero et al. (2017).	USA.	Integration of personal and professional identities over time. Navigation of personal and professional boundaries. Intersectionality.	**19**	Furtaw (2004).	USA.	Professional identity emerged from pre-existing personal identity and not sufficiently accounted for in training.
8	Knoetze & McCulloch (2017).	South Africa.	Training involves developmental identity transitions. High standards and perceived requirement to present self as 'professional'.	**20**	Motioke (2004).	USA.	Overlap of professional identities with race and ethnicity. Variation. Bicultural identities influence clinical work. Training inadequately considers these issues. Necessity of boundaries.
9	Hoffman (2015).	USA.	Non-linear professional identity development. Gender and masculine identities conflict with professional identity. Integration of personal and professional identities over time.	**21**	Maniss (1997).	USA.	Training accompanied by loss of sense of self and identity. Training generated fears of being exposed as inadequate.
10	Woodward et al. (2015).	United Kingdom.	Self-awareness facilitates integration of personal and professional identity. Results in increased flexibility, risk taking and displaying vulnerability. Profession intolerant of displaying personal self.	**22**	Barden (1995).	USA.	Supervision fostering integration of personal and professional identities. Results in greater awareness of true self and authenticity.
11	Barreto (2013).	USA.	Migration and culture shock disrupt sense of identity as a psychologist. Development of new professional identity alongside acculturation.	**23**	Eckler-Hart (1987).	USA.	Fear of exposure of imperfection generate protective false self during training. Integration of personal and professional identities in advanced students. Lifelong process facilitated by supervision.
12	Tsuman-Caspi (2012).	USA.	Training re-creates professional identity. Non-linear process. Optimal professional identity is self-congruent, strengths based and responsive.	**24**	Lev-El (1983).	USA.	Strengthened professional identity associated with well-being. Role conflict between professional identity and gender roles.

Step Five: Collating, Summarising and Reporting the Results

The results section includes an overview of the included studies, quality assessment of included studies, and thematic summary of findings. We conducted a thematic analysis (Braun & Clarke, 2006) and coded any findings relevant to professional identity (as defined in the present review) in the included studies. This involved familiarisation with the findings of included studies, generating initial codes for findings relevant to clinical psychologist's sense of self irrespective of whether authors interpreted their findings in terms of professional identity, collating codes into themes, comparing themes to the codes and findings in original papers for accuracy, and producing the final themes. We used an analytical memo writing process to support the thematic analysis given the breadth of theoretical perspectives and variations in the use of terminology across included studies. This allowed us to meaningfully collate and compare codes across studies by applying a higher degree of interpretation.

The authors acknowledge their own positions will have inevitably influenced the process of collating, summarising and reporting the results within this review despite attempts to be systematic, consider varying perspectives, and conduct a consultation to verify our findings. To improve the trustworthiness of the results we utilised two types of triangulation as part of our analytical process: investigator triangulation and theory triangulation (Carter et al., 2014). Specifically, interpretations of the results were compared across all investigators from different disciplines and theoretical perspectives. The first author identifies as female, white, heterosexual and is a recent graduate and PhD candidate in clinical psychology with a professional background in human rights and international mental health policy reform. The second author identifies as a male, middle-aged, white, and heterosexual university employed qualitative researcher with a professional background in nursing. The third author identifies as a female, white, heterosexual academic with a background in cognitive linguistics (psychology) and healthcare professional education

research. The last author identifies as a female, white, heterosexual senior clinical psychologist and academic with specific interests in the education, accreditation and regulation of the psychology profession. The authors identify as trauma-informed (SS), dialogical (NB and LVM) and cognitive-behavioural (CH) in their respective theoretical approaches. The triangulation of perspectives across investigators from diverse disciplinary and theoretical orientations was formative in producing new interpretations of the results, challenging individual investigator's assumptions, and ultimately impacted how the data was understood and analysed. This process was prioritised by the investigators to increase the validity of the results.

Step Six: Consultation Exercise

Levac et al. (2010) argue that the optional consultation step described by Arskey and O'Malley (2005) adds methodological rigour, and a recent review of consultations in scoping reviews argues they can be beneficial when used to genuinely activate discussions with stakeholders (Buus et al., 2022). An Australian-based consultation was included to confirm whether the findings of the present review align with psychologist's own experiences and to validate the findings. Ten practicing clinical psychologists, psychologists working clinically, and final stage trainees, were identified through professional networks and represented a range of gender identities (male, female, non-binary), sexual identities (heterosexual, LGBTI), racial or ethnic identities (white and non-white) and developmental stages (early career to senior). No person identified as having a disability. Those in the consultation were emailed preliminary findings and asked to provide feedback and recommendations on the results of the scoping review. Respondents were asked to comment on ways the findings of the review were similar and dissimilar to their experience. They were also given the opportunity to provide recommendations for research, training and clinical practice based on the results of the review. Respondents were given the option to discuss the results and the

consultation process in person, however all respondents chose to provide a written response. The findings from this consultation are reported within the results and considered further in the discussion.

4.5 Results

We begin our results section by specifically answering the first three research questions (RQs) identified above as follows, RQ1: What is the scope of empirical research investigating the professional identity of clinical psychologists? RQ2: What is the quality of this research? and RQ3: What are the key themes identified in the findings of this research? References to original studies within the results corresponds to the numerical system used to chart the studies (see Table 4.1).

Extent, Range and Nature of Reviewed Studies (RQ1)

The 24 reviewed studies were published between 1983 and 2020 with 12 peer reviewed publications and 12 unpublished dissertations. Of these studies, 14 (five peer reviewed publications) had research aims, which explicitly investigated professional identity (1, 3, 6, 8, 9, 10, 11, 12, 16, 18, 20, 21, 22, 24). In contrast, professional identity was identified in the findings in ten studies exploring areas such as lived experience of training or working, personal and/or professional development, and supervision. Ten studies focussed on participants in clinical training or recently graduated. All studies were qualitative with one utilising a mixed-methods design (4). Interviews were used for data collection in 21 studies whilst three studies analysed written text including published life narratives (7) or reflective journals (8, 13). Qualitative data analysis techniques varied with predominant methods including thematic analysis (k = 5), mixed (k = 5), interpretative phenomenological analysis (k = 4), narrative analysis (k = 3), phenomenological analysis (k = 2), discourse analysis (k = 1), grounded theory (k = 1), consensual qualitative analysis (k = 1), listening guide (k = 1), or unspecified (k = 1). The majority of studies were from the USA (k = 16), and remaining from

Australia (k = 3), UK (k = 3), Ireland (k = 1) and South Africa (k = 1). Ten of the USA based studies focussed on the experiences of clinical psychologists from minority groups or with diverse social identities (7, 9, 11, 15, 16, 17, 18, 20, 21, 24).

Quality Assessment of Reviewed Studies (RQ2)

The quality assessment of included studies is based on the 20-item framework developed by Blaxter (2013). Concepts related to identity or self were often under-theorised and definitions of terms were often not provided. Dissertations tended to have a stronger theoretical foundation relating to identities (e.g., 1). Many papers employed a snowball sampling technique without discussing the limitations. Clear theoretical rationales for sampling (e.g., 9) and discussion of sampling limitations (e.g., 17) were beneficial. Direct quotes were often not adequately contextualised, which rendered the quotes difficult to interpret. Longer and contextualised quotes (e.g., 1) increased the ability to judge the relationship between the data and researcher interpretations. Details about data collection (often semi-structured interviews) were scarce. Theoretically informed approaches to conducting interviews (e.g., 1) and interview details (e.g., 19) assisted the reader to judge the data quality. Methods were often reported abstractly without discussion of *how* methodological steps were operationalised, although there were some detailed descriptions that demonstrated methodological accuracy (e.g., 6). Reports of utilising reliability and validity checks (e.g., independent review and member-checking) were inconsistent and did not always describe the impact on the findings. Further, most studies described findings that were identified within the data yet occasionally findings appeared to be moulded to fit existing theoretical assumptions. When researcher interpretation was found in results sections it became unclear whether the participant or researcher perspective was presented. Discussions were not always theoretically informed. Divergent perspectives were not always considered but strengthened research when used judiciously to explore the data (e.g., 12).

Description of author positions were often absent, yet most common when authors disclosed minority identities related to the research area focus. Credibility was increased when researchers identified strategies used to minimise the impact of researcher positions on findings (e.g., 9). Our appraisal of ethical issues revealed that relationships between researchers and participants were rarely described.

In summary, this quality review process indicated a range of research quality issues that were variable across studies. Although each study displayed strengths and weaknesses, problems pertaining to the reporting of theory, qualitative research methods and analyses, and reporting of finding and interpretations, were most frequently identified.

Summary of Thematic Analysis (RQ3)

Findings were organised around three themes: i) integration of personal and professional identities, ii) intersectionality and iii) changes in professional identity over time.

Theme 1: Integration of personal and professional identities.

This theme relates to the relationship between personal and professional identities. All texts reported that professional identity was related closely to personal identity, with variations in emphasis, language and description of this relationship. Descriptions ranged from explicitly describing the evolution of professional identity from personal identity, characteristics or experience (2, 6, 7, 8, 10, 16, 17, 19, 20), the progressive integration or congruence between personal and professional identity (1, 4, 5, 6, 7, 8, 9, 10, 12, 14, 15, 16, 18, 19, 20, 22, 24), the indivisibility of personal and professional identity (10, 12, 16, 20, 23), or a combination of these descriptions. Where no explicit finding about this relationship was reported (11, 13, 21, 24), there was a focus on the personal self or subjective experience that indicated a clear relationship with professional identity.

Despite the clear interdependence of personal and professional identities, the necessity of maintaining separation between them was reported (2, 7, 12, 18, 19, 20).

Conversely, caution that boundaries also impinged on the expression of personal identity in a professional context and jeopardised authenticity was also described (1, 18). It appeared that it was precisely *because* personal and professional identities are so closely intertwined that separation and boundaries are required (12).

Challenging personal experiences were identified as formative in shaping professional identity and acted as catalysts for increased integration of personal and professional identities (2, 6, 7, 9, 10, 11, 14, 16, 18, 19, 20). Such experiences often increased resilience, empathy for clients, or clarity surrounding one's professional identity (1, 2, 6, 11, 19). Personal experiences were not always perceived as favourable, however. Reports of needing to conceal challenging personal experiences were described (2, 6, 10, 13, 18, 19).

Within this professional context, revealing human imperfection or vulnerability, or limitations in knowing, were experienced as anxiety provoking (1, 3, 13, 17, 18, 22, 23). In what seemed like a vicious cycle, this angst then further increased difficulty admitting to vulnerability, human imperfection or not knowing (1, 10, 13, 18, 21, 23). Reports of a perceived incongruence between self-perception and self-expectations of an ideal clinical psychologist were identified (2, 3, 5, 8, 10, 18, 19, 21, 22, 23), and were linked to suppression of personal aspects of the self, reduced flexibility and burnout (2, 10, 23).

The incongruence between perceptions of oneself *as is* and expectations of how one *should be* was described alongside high levels of self-interrogation (8, 13, 23), and perceived role expectations to be helpful, fix or perform (1, 13), or take the position of expert (1, 10, 13, 21). Role expectations in the face of vulnerability and imperfection, and attempts to hide this, generated fear of being found out as a fraud (1, 4, 10, 13, 21, 23). Explicit discomfort with adopting the role of expert was described (1, 13, 16), yet clinical psychologists perceived admission of not knowing or embracing uncertainty as challenging (1, 5, 10, 12, 13, 16).

In contrast, increased self-awareness was associated with subsequent acceptance of oneself *as is* as a therapist (2, 5, 10, 12, 16, 18, 22, 23) and an increased ability to integrate personal aspects of the self into professional identity (5, 9, 10, 12, 13, 16, 18, 22, 23). Valuing self-experience and a sense of authenticity was identified as important as professional identity developed (1, 5, 12, 14, 19, 22, 23). Clinical psychologists valued and prioritised integrating personal and professional identities (3, 6, 10, 12, 15, 18, 19, 24), and associated this with increased wellbeing, self-respect and growth (4, 10, 12, 15, 18, 24). In addition, enhanced confidence, and flexibility (5, 10, 12, 16, 23), sensitivity and insight (11, 20, 22), and expanded therapeutic effectiveness (2, 6, 11, 12, 15, 19, 20) were described.

Clinical psychologists did not understand their professional identities in uniform ways, however (1, 4, 10, 12, 13, 16, 19, 20, 22). There was striking variability, for example, in values, as well as perceptions of roles and goals, the relationship between personal and professional identity, and the influence of race or culture on professional identity (10, 12, 13, 19, 20). Further, individual participants saw themselves as comprising multiple, competing, or contrasting identities (1, 9, 11, 14, 18).

In summary, professional identity and personal identity were constructed as being inherently intertwined. This interdependence highlighted the need for boundaries between aspects of clinical psychologist's personal and professional selves. Challenging personal experiences were identified as formative in shaping professional identity, for better or worse. There was an overarching sense of how one 'should be' as a clinical psychologist which valued self-reliance and competence yet gave rise to feelings of anxiety and inauthenticity. Amidst these findings there was noticeable variation in how clinical psychologists understood their professional identities that highlights the idiosyncratic nature of professional identity.

Theme 2: Intersectionality.

This theme relates to wider master identities. Master identities are the relatively stable and unchanging aspects of a person's personal identity such as race, ethnicity, culture, gender, disability, sexuality, and age[36]. Master identities and how they are bound up with professional identity were discussed frequently within the literature and are therefore explored below. We use the concept of intersectionality to consider the meaning and consequences of master identities in relation to professional identity.

The integration of personal and professional identity was particularly nuanced when master identities were considered. Master identities shaped professional identity in complex ways (4, 7, 9, 15, 17, 18, 20, 21, 24). Navigating how to integrate master identities into professional identity was most explicit when people perceived themselves as a minority, often experiencing marginalisation or being 'othered' on this basis. Integration of minority identities into one's professional identity was described as necessary for promoting self-respect and cohesion of sense of self (4, 10, 15, 18). When minority identities were not able to be adequately integrated into professional identity this was reported as detrimental (4, 15, 18, 19, 20).

In keeping with the broader theme described above, the indivisibility of one's identity as a clinical psychologist from master identities was clear (4, 7, 10, 18, 20, 21). For example, the contribution of ethnic identity could not be disentangled from the broad experience of being a black and ethnic minority clinical psychologist (4).

Despite the priority for integration of these identities, there was also a need for separation between personal and professional identities, particularly where cultural identities conflicted with perceptions of Westernised clinical psychology (18, 20). Tensions between collectivistic cultural identities and perceptions of clinical psychology privileging individualism resulted in a clear separation of these identities across personal and

professional contexts (18, 20). Over time, these boundaries were replaced with a process of integration associated with reduced tension and cognitive dissonance (4, 18).

Personal experiences associated with particular master identities were reported as being formative in shaping professional identity and contributed to greater awareness of context and power differentials (7, 11, 14, 17, 18, 20). For example, whilst black female clinical psychologists foregrounded discussions about their professional identity development within dilemmas about navigating gender, class and ethnic identities, their white counterparts did not (14). The experience of being the cultural 'other' within a Western context was associated with an understanding of cultural issues and cultural competence (4, 7, 11, 18, 20).

More specifically, distressing personal experiences such as discrimination or oppression were reported as formative in shaping professional identity (7, 14, 17). Though challenging, these contributed to increased awareness and commitment to social justice or advocacy (7, 17) or limitations of the profession in terms of power and inequality (14, 17). Findings suggested that personal experiences of oppression might allow clinical psychologists to empathise with others' experience of discrimination (7, 17).

Minority identities were not always seen as beneficial for professional identity, however. A sense of being different led to an incongruence between how some clinical psychologists with minority identities perceived themselves and how they perceived they should be (4, 11, 14, 16, 17). For example, black and ethnic minority clinical psychologists were found to equate being a clinical psychologist with being a *white* clinical psychologist (4). This sense of difference was often associated with loneliness, isolation and anger (4, 9, 16, 17), and needing to prove oneself as worthy of being a clinical psychologist (4). This sense of difference often cumulated in the progressive integration of social and professional identities, and redefining what it means to be a clinical psychologist (4, 7, 9, 15, 17, 18, 20).

Various descriptions of role and identity conflicts between one's professional identity as a clinical psychologist with one's gender (9, 16, 18, 20, 21, 24), ethnicity or culture (4, 18, 20), age or life stage (9, 16, 24), or sexuality (15) were described. Role conflicts gave rise to dilemmas regarding whether to adapt and conform to the majority status quo or retain unique elements of one's minority identity and were particularly clear in the context of minority ethnic or racial identities, bi-racial identities or acculturation (4, 7, 11, 18, 20).

In summary, the relationship between professional identity and distinct master identities (race, gender and so on) was particularly nuanced when people identified as a member of a minority group. Although there were nuances and tensions associated with identifying both as a member of a minority group and a clinical psychologist, clinical psychologists from minority backgrounds were identified as being more empathic, culturally competent and aware of power dynamics when these tensions could be resolved. The results indicated people from minority groups face challenges in entering the profession, both in terms of assumptions about the profile of a 'typical' clinical psychologist as well as practices within the profession that are perceived as disrespectful or perpetuate inequality.

Theme 3: Changes in professional identity over time.

This theme relates to the *process* of professional identity formation over time. Clinical psychologists understand that their professional identities as continuously changing and being renegotiated (1, 2, 3, 4, 5, 6, 7, 9, 11, 12, 13, 14, 16, 19, 20, 22, 23). Possibly for this reason, multiple studies featured research questions pertaining directly to personal and professional development (2, 3, 5, 10, 12, 14, 16, 21).

Numerous studies indicated the training and early career period is a critical stage in the process of professional identity formation, and that this simultaneously comprises a period of rapid growth (2, 3, 6, 8, 9, 12, 16, 24) and destabilisation of sense of self (4, 5, 6, 8, 9, 10, 12, 16, 21, 23). This destabilisation was associated with feelings of threat, distrust,

isolation and vulnerability (12, 21, 22), and a sense of needing to relinquish a sense of who one is (21). Perceived failure as a trainee was often experienced as failure as a person (23). Training was often seen to lead to disconnection from one's personal self and the development of a false self (2, 5, 16, 22, 23).

This early developmental process of professional identity formation was reported as different for minority and majority groups (14). Both reported a process of integration of personal and professional identities over time. Yet, whilst those with majority identities described an individualised, linear and developmentally focussed narrative of change, those with minority master identities presented narratives in which their experiences of difference and discrimination shaped professional identity formation in a cyclical manner.

Clinical psychologists reported there was an inadequate focus on professional identity during training (2, 5, 20, 21) and that navigating professional identity occurred through informal or opportunistic means (5, 10). This arose alongside recognition that trainee professional identity formation is moderated by the *interaction* between trainees and training environments, highlighting the critical role of training contexts in professional identity development (12). Recommendations for training courses to focus more explicitly on personal aspects of the self and master identities were common (2, 4, 5, 10, 12, 15, 20, 21, 22, 23). Trainees often felt supported to integrate personal and professional identities in the context of supervision, mentoring or reflective practice (2, 3, 5, 6, 10, 15, 16, 17, 20, 22, 23), although the potential for supervision to impinge on this process was also described (15, 23).

The process of professional identity formation was reported as continuing to unfold amongst well-established and practicing clinical psychologists (1, 7, 13, 14, 20, 22). Again, a non-linear and cyclical process was reported amongst clinical psychologists navigating this within the context of wider social identities (4, 7, 9, 11, 15, 16, 18), accompanied by self-doubt about the plausibility of integrating personal and professional identities (15, 16, 18).

Regardless of developmental stage, professional identity formation and changes over time were described as deeply personal and emotionally taxing (2, 7, 9, 10, 12, 13, 15, 16, 17, 21, 22, 23), although the emotional toll was more apparent amongst trainees. Professional identity formation was reported to involve becoming progressively more self-aware and self-accepting (10, 12, 13). Despite being challenging, this process of self-reflection often resulted in greater self-awareness, redefining the 'ideal' clinical psychologist, increased resilience, and increasing precedence given to one's authentic self (2, 5, 9, 10, 12, 14, 16, 17, 22).

In summary, clinical psychologist's professional identities were found to be continuously evolving across the professional lifespan in a non-linear and emotionally taxing process. Training and early career were identified as periods of growth and destabilisation. Education settings and supervision were identified as formative in shaping professional identities although initiatives to support fruitful professional identity development were seen to be lacking. A more explicit focus on professional identity formation in training contexts was requested. The ongoing process of changes to professional identity was described as unique to each person with particular nuances emerging for those with minority identities.

Consultation with Clinical Psychologists (RQ4)

We now consider our fourth research question **"**to what extent do the findings of this review align with the experiences of clinical psychologists?". Responses from clinical psychologists and psychologists who participated in the consultation largely echoed the review findings. With respect to Theme 1, their responses clearly confirmed the delicate balance of navigating the progressive integration of personal and professional identities and need for separation between these. Almost all participants echoed the value of increased self-awareness and self-acceptance as being instrumental in allowing for greater integration of personal and professional identities. They confirmed this results in increased authenticity,

flexibility, therapeutic effectiveness, and a willingness to tolerate uncertainty and move away from the position of expert.

Those consulted who identified with a minority identity commented on related findings in Theme 2. Their experiences were not uniform, nor did they neatly correspond to the experiences of those reported in the reviewed studies. Rather than membership of a particular minority group being challenging per se, the sense of being *different* was indicative of turmoil associated with professional identity. For some, identifying as non-heterosexual or non-Anglo was not problematic, but fears of being perceived as different led to concealing aspects of oneself within the profession.

Regarding Theme 3, the consultation confirmed that training and early career experiences were emotionally taxing. Less experienced clinicians identified closely with experiences of destabilisation of self, expectation to be 'professional' and pressure to conceal personal experiences such as mental health difficulties. Experienced clinicians described the benefits of supervision and reflective environments in supporting professional identity formation, and how this was associated with growth and authenticity.

Findings from the review that clinical training inadequately considers professional identity and its complexities aligned with the experience of almost all respondents. For some, maturation of one's professional identity and congruence with self had occurred *in spite of* clinical training. Training overseas in programs that had an explicit focus on personal development and personal therapy were described as facilitating a congruent professional identity. The consultation featured consistent recommendations for training contexts to focus on the integration of personal and professional identities. More broadly, suggestions were made that a focus on professional identity in training contexts should expand beyond the individual level to consider broader professional issues and debates (e.g., alignment to

medical or more traditional psychotherapeutic approaches) as trainees must navigate these topical issues whilst forming and renegotiating their developing professional identities.

4.6 Discussion

The present review systematically explored and evaluated empirical studies investigating the professional identity of clinical psychologists. Due to the fundamentally different focus of the literature using quantitative research methods these studies were excluded, resulting in the synthesis of findings from qualitative research studies. The majority of articles (n=21) utilised interview data, with the remaining three drawing on published life narratives and reflective journals. This reflects the state of qualitative professional identities research across other disciplines (Gkiousias, 2021; Tong et al., 2020; Wyatt et al., 2021). For example, a recent review of physician identities research identified that semi-structured interview data prevails (Wyatt et al., 2021). We begin by discussing research quality before considering how our findings fit within the wider literature on healthcare professionals identities and new reforms for person-centred care.

In terms of research quality, due to the absence of a widely cited core literature around professional identities in clinical psychology, many studies failed to build upon one another. Research often lacked theoretical clarity and was embedded across a range of theories. Indeed, this is not uncommon in healthcare professions identity research (Cornett et al., 2022; Sawatsky & Monrouxe; Snell, 2020; Tong et al., 2020). This common lack of theoretical grounding across healthcare professional identities research is concerning as it can lead to the siloing of research, and the failure to build knowledge around a solid foundation.

Our findings around increasing integration between personal and professional identities culminating in a more optimal therapeutic self, and the ongoing nature of changes over time typically characterised by early career anxiety, are all consistent with longitudinal research exploring therapist development (Rønnestad & Skovhold, 2013). Furthermore,

concerns of human imperfection, limitations of knowledge (in the context of perceived expectations to 'fix' or take up the position of expert) and feeling like a fraud, were all identified as causing career anxiety, resonate with the wider literature with medical, nursing and social worker professional identities (Freeman et al., 2022; Gallagher, 2019; Hochman et al., 2022; Houseknecht et al., 2019; Kristiansson et al., 2014; Mangione et al., 2018; Nevalainen et al., 2012; Neve et al., 2017). The presence of these constructs are sure to have implications for healthcare reforms. Personal recovery oriented mental healthcare reforms shift the focus from 'fixing' mental illness and requires clinicians to recognise clients as experts in their own experience (inherently requiring an acknowledgement of the limits of clinician's own expertise) as they are supported to find connectedness, hope, identity, meaning and empowerment in their own lives (Leamy et al., 2011). Working in a recovery-oriented way requires flexibility, humility and a tolerance of uncertainty from clinicians; characteristics which our review found are compromised by disruptions to integrating personal and professional identities.

Similarly, our findings are consistent with research revealing strong associations between a therapist's experience of their personal and professional selves in other literature (Orlinsky, 2020) as well as more widely across healthcare professional identities work (Sarraf-Yazdi et al., 2021; Wyatt et al., 2021). Whilst much of the therapist development research is concerned with describing general trends, our review highlighted the deeply personal and idiosyncratic nature of professional identity and suggests that the experience of perceiving oneself as different may be linked to unease as a clinical psychologist. Indeed, the very notion of identities is the feeling of *fit*: identifying with *others like us* in the same profession due to physical, values-based or attitudinal attributes. This finding shares parallels with the literature exploring therapist development (Rønnestad & Skovholt, 2013) and the emphasis on *belonging* to a professional group across the broader healthcare professions

literature on professional identity (Cornett et al., 2022). Indeed, it is easy to imagine how perceptions of how one *should be* as a professional - which conform to and align with established ways of working - can perpetuate the status quo, for better or for worse. If existing ways of *being* and *doing* in mental healthcare service settings do not align with reform priorities, pressure to conform is a threat to reform realisation.

Notably, existing professional identity research considering issues of diversity is sparce across healthcare professions, resulting in criticisms the literature has inadequately considered issues of power relations, inequality and diversity (Cornett et al., 2022; Volpe et al., 2019; Wyatt et al., 2021). We therefore expand on this work in our study. Indeed, the separation between how people experienced themselves *as being* and how they perceived they *should be* was amplified in the case of many clinical psychologists who identified with minority groups. This nuance in how people's experiences of wider master and minority identities intersected with professional identity (Cole, 2009) was subsequently reflected in the divergent consultation responses. Within the studies, and verified by the consultation, identifying as a member of a minority group in and of itself was not described as troubling. In fact, this increased awareness and commitment to issues of power, inequality and discrimination within the profession; issues known to disproportionately impact clients of mental healthcare services and important for clinicians to be aware of from recovery-oriented perspective (Leamy et al., 2011). Rather, it was the sense of being *different* from peers or colleagues, or perceptions of how one should be as a clinical psychologist, that was distressing. Interestingly, similar to other studies (Volpe et al., 2019; Wyatt et al., 2021), we found that many studies exploring minority identities in Western settings were authored by researchers disclosing the same minority or master identities. This finding suggests the researchers may perceive such issues to have been inadequately considered in mainstream

research. Indeed, author position statements were comparatively lacking in studies that did not consider minority identities and diversity issues.

The variation in responses within the studies and consultation attest to the unique ways in which clinical psychologists understand themselves. The understanding of one's own professional identity was identified as being so fluid and personalised that by its very nature it resists oversimplification. This richness is consistent with increasing self-authored personal accounts of the experience of becoming a clinical psychologist (Avivi et al., 2015). If clinical psychology were to adopt the shift occurring in medicine (Monrouxe & Sweeney, 2013) to more explicitly recognising that its trainees and members are *people* – individuals with their own personal, emotional and cultural stories – the profession would be better equipped to support clinical psychologists in their sense-making around their roles and day-to-day activities.

We suggest that these findings exist within the unique social, cultural, political and economic contexts of the primary literature, and that our findings are inherently intertwined with broader debates and developments within the profession of clinical psychology itself. Critiques the profession lacks diversity in its professional membership (Turpin & Coleman, 2010) and theoretical orientations (Levy & Anderson, 2013), as well as the shift towards a medicalised understanding of distress (Johnstone, 2010), undoubtedly shape the professional identities of clinical psychologists, resonate with findings of our review. Although we recognise that broader contexts have influenced the findings of the primary literature and our review, we suggest that further generalisations spanning different time periods and jurisdictions would be speculative and beyond the scope of the present review.

Strengths, Challenges and Limitations

As with all studies there are challenges and limitations in our review. Firstly, quantitative studies were excluded to maintain the theoretical integrity of the review. This

literature overall was considered to represent the profiling of the profession rather than being an exploration of professional identity as a *sense of self*. Although the inclusion of a quality assessment process increased the rigour of our review (Pham et al., 2014), this highlighted that findings from papers with varying levels of reported quality have been synthesised together and should be kept in mind. The inclusion of dissertations protected against publication bias, however the discernible differences in length rendered comparisons problematic as dissertations included noticeably more detail.

Despite these limitations our review has multiple strengths. It is the first systematic review of this topic; a research area of importance amongst healthcare professionals more widely as well as clinical psychologists specifically with implications for the quality provision of healthcare services. The use of rigorous and transparent methods (Arskey & O'Malley, 2005), quality assessment (Blaxter, 2013), extensive collaboration across all authors, and the consultation with practicing and trainee clinical psychologists, increase the trustworthiness of this review alongside novel findings.

Recommendations for Research, Training and Clinical Practice

We begin by providing recommendations for strengthening research across all healthcare professional groups to enable more robust future recommendations. Suggested recommendations for training and clinical practice are then provided, being mindful of data on which they are predicated, that could support the professional identity development of healthcare professions more broadly (with particular relevance for providers of mental health services).

First, professional identity research would benefit from integrating considerations relating to personal identity, intersectionality and changes over time. Second, researchers should clearly define terminology relating to identities, clarify the terms used for participants (e.g. level of study, training etc) and provide descriptions of participants' professional

training and work contexts to contextualise research findings. Third, sophisticated research questions and methods informed by identity theories would ensure coherency between theory and methods to enhance research credibility (Crotty, 1998). Specifically, more sophisticated and inter-disciplinary conceptualisations of identity from a social constructionist perspective would be beneficial in designing research that illuminates how professional identities are constructed and transformed in interactional spaces, and the characteristics of professional identities constructed in these spaces (Benwell & Stokoe, 2006; Tracy & Robles, 2013). Fourth, authors should clearly articulate how they operationalised qualitative methods and not over privilege researcher interpretations at the risk of undermining the credibility of findings (Sandelowski & Barroso, 2003). Researchers considering their own identities and articulating author positions, possible impact on findings, and strategies used to mitigate this influence, is essential. Finally, consideration of intersectionality and diversity matters by *all* researchers, rather than just those who identify as minority groups, would be beneficial (Cole, 2009).

Implications for training and practice are also indicated, although this also requires further investigation. Our findings highlighted that many clinical psychologists experience themselves as different to how they perceive they *should* be, which we suggest may be indicative of problematic perceptions of expected ways of being and doing as a clinical psychologist. This has significance for the realisation of mental health reforms: if clinical psychologists feel compelled to acquire particular professional identities reflecting sanctioned ways of *being* and *doing*, realisation of mental health reform priorities will not be achieved to the extent that these perceived expected professional identities conflict with reform priorities. In other words, realising reforms will require all mental health professionals – not only clinical psychologists – to feel supported in acquiring identities that embrace and sanction ways of being and doing that are required to provide person-centred and recovery oriented clinical care.

At an individual level, perceptions that one differs from how one should be has been associated with burnout, retention difficulties, and compromised wellbeing in clinicians across other healthcare professions (Monrouxe et al., 2017). Collectively, this finding highlights the importance at both system level and individual clinician level of supporting professionals working in mental health contexts (such as psychiatrists, mental health nurses and so on) to acquire optimal and coherent professional identities during training and across the professional lifespan that move services towards reforms. Indeed, the American Association of Community Psychiatrists has noted that reconceptualising professional identities across multidisciplinary healthcare teams will require a shift towards understanding oneself as facilitative rather than directive, hope inspiring rather than pessimistic, and enhancing patient autonomy instead of embracing paternalistic models of care (Sowers, 2005). In particular, attitudes and expectations of oneself when working with patients assessed as 'high risk' have been identified as variables impacting the capacity to work in reform oriented ways (Crowe & Deane, 2018).

The finding that training and entry into the profession inadequately supports professional identity development, including the integration and maintaining separation between personal and professional identities, indicates training institutions can do more to support early career clinicians in developing their professional identities. This is not dissimilar to review findings in medical education where the development of professional identities was one of the top two recommendations addressed (O'Brien & Irby, 2013). Research suggests that a deliberate pedagogical approach that values role models, provides guided reflective practice, and includes longitudinal, inclusive and tailored mentorship in supported learning environments that encourage alignment between values and actions, could be beneficial (Sarraf-Yazdi et al., 2021). Furthermore, training programs could utilise other insights from medicine and support supervisors and educators to understand constructionist-

informed pedagogical methods to facilitate explicit conversations about identity construction. Here, students share their experiences and clarify their goals, values and objectives in becoming clinical psychologists that align with system reforms (Frost & Regehr, 2013). Our findings also suggest such efforts would benefit from being responsive to the developmental stage and individual circumstances of the supervisee (Rønnestad & Skovholt, 2013).

Conclusion

We have reviewed the scope, quality and findings of the literature investigating the professional identity of clinical psychologists and psychologists in clinical settings. The present review indicated that professional identity is an area of emerging research interest, relevant to a range of professional issues, and uniformly recognised as a topic worthy of increased attention within clinical psychology. Further, our results highlighted parallels with the professional identity literature across healthcare professions more broadly and indicate that clinical psychology would benefit from applying this learning, and that these professions may likewise benefit from the recommendations provided. Despite these broad similarities however, we still do not know the distinct ways that clinical psychologists understand themselves: we do not know what it means to be and become a clinical psychologist. Being a clinical psychologist extends further than technical skill and knowledge to a way of *being* and *doing*, and we require a deeper understanding of the processes and outcomes of professional identity formation. These insights are required to nurture and support clinicians from training through to clinical practice in ways that align with and support the realisation of mental healthcare reform priorities. Theoretically sophisticated research efforts to build up a credible literature base to better understand how clinical psychologists develop their professional identities, the unique features or characteristics of these identities, and how this process can be supported, are now needed.

Chapter 5: Interrogations in Clinical Supervision (Study 3)

5.1 Preamble

The findings from the scoping review (Chapter 4) indicate the impossibility of separating clinical psychologists' personal and professional identities, that the process of professional identity formation is particularly nuanced for people with minority identities, and that professional identity formation is a continuously unfolding process across the professional lifespan (albeit with training identified as a particularly critical time of both growth and destabilisation of sense of self). The consultation with clinical psychologists confirmed that despite training being a critical time of professional identity development, clinical psychologists believe professional identity is inadequately considered within education contexts. Moreover, it was suggested that training had actually *hindered* the process of professional identity development for some. Evidently, training is a critical time of identity development for novices entering the profession yet thought to be unsatisfactorily addressed in education settings.

A finding seen in both the Open Dialogue study (Chapter 3) and scoping review (Chapter 4) pertains to this issue of clinical psychologists feeling compelled to conceal vulnerability and take the position of 'expert' (or at least not admit to 'not knowing'), and how perceptions of how one *should be* as a clinical psychologist can be problematic in the process of acquiring professional identities. Given that training is formative in shaping professional identity as described above, the following question arises: how and in what ways do novices acquire these ways of understanding themselves in education settings? Presumably these perceptions of *who clinical psychologists are* and *what clinical psychologists do* have been acquired throughout the process of entering into the profession.

This is where the concept of professional socialisation (see definition on page 69) to explore the in-situ construction of professional identities in interactions within educational

settings offers promise. It is for this reason that Studies 3 and 4 (Chapters 5 and 6 respectively) focussed on answering the third research question of this thesis (see 'Statement of Problem' section for thesis research questions in Chapter 1, page 18): how and in what ways are clinical psychologists socialised into acquiring professional identities in educational contexts? These two studies focussed on utilising theoretically robust and sophisticated research methodologies (as recommended by the scoping review) to explore the professional identity construction of clinical psychology trainees in clinical supervision interactions. Clinical supervision is a key socialisation activity, and therefore a key interactional site in which identities are negotiated and renegotiated. When the ways in which supervision interactions shape and constrain clinical psychologists' professional identities are made visible, educators are better positioned to approach such interactions intentionally with a view support the process of professional identity formation.

The forthcoming study in this chapter (Study 3) focusses on understanding what happens during supervision interactions that may have implications for the professional identity development of clinical psychology trainees, and how this relates to the broader institutional context in which these interactions take place. The data analysed comprised of interrogations initiated by supervisors within supervision interactions because of the rich ways in which identities were seen to be negotiated and renegotiated within these specific interactional sequences. We found that how supervisors approached interrogations influenced the identities that clinical psychology trainees were able to construct and acquire for themselves. Ultimately, the findings demonstrate how supervision interactions are formative in shaping and constraining the professional identity construction of clinical psychology trainees.

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Study Materials: Confirmation of approval from the University of Sydney Human Research Ethics Committee for this study and all study materials are provided in Appendix C.

5.2 Abstract

Background: Professional socialisation is a complex process through which learners *become* healthcare professionals. This process occurs in relational spaces: learners are exposed to norms and expectations of them in interactions during formal and informal learning activities. Research exploring socialisation into the healthcare professions is extensive yet inadequately captures details of actual *processes* of socialisation and *forming* of professional identity. Our study offers a moment-by-moment examination of clinical psychology trainee supervision to provide a deeper exploration of novice healthcare professionals' identity development within formal educational interactions.

Aims: We sought to explore how, and in what ways, supervision interactions impact clinical psychology trainees' professional identity development.

Method: Our data comprises 12 audio recordings of supervisor-trainee interactions in a clinical psychology training clinic. Initial data engagement identified 20 instances of interrogation instigated by supervisors (i.e., repetitive questioning, enquiry) as being key events in which identities are contested and re-negotiated. These sections were transcribed verbatim. Drawing on positioning, framing and impression management theories, we explored identity construction in interrogations using discourse analysis.

Results: Supervisors approached interrogations of trainees from either a quality control or a reflective frame focussing on the client or trainee respectively. These frames influenced the positions being made available to trainees. Reflective frame interrogations often defaulted back to quality control. Trainees employed impression management tactics to manage perceived face-threat.

Discussion: Findings highlight challenges with maintaining a reflective space in supervision during interrogations. Supervisors had authority to initiate interrogations that could be taken up, negotiated or resisted by trainees, ultimately maintaining certain professional knowledge

and truths. We illuminate the ways in which socialisation processes at the interactional level during formal learning activities ultimately make available (and restrict) certain ways for trainees to think, feel and be.

Interrogation in Clinical Supervision Sessions: Exploring the construction of clinical psychology trainees' professional identities

5.3 Introduction

Professional socialisation is the complex and ongoing process through which individuals are exposed to and internalise the norms and values of a given profession and acquire professional identities (du Toit, 1995; Shahr et al., 2019). It influences the development of professional identities as neophytes acquire ways of making sense of themselves and of others, shaping how they think, feel and behave in professional contexts (Monrouxe, 2010). Professional socialisation provides an informative perspective for understanding how healthcare students *become* healthcare professionals during formal and informal learning activities. Although the professional socialisation literature in healthcare education has a long history, research has progressively adopted a *functionalist* perspective with an over-emphasis on society's influence in shaping and moulding individuals into professionals (Brown & Finn, 2021; Shahr et al., 2019). Yet, socialisation occurs in and through relationships; learners develop an understanding of who they are and who they are becoming through interaction. This *interactional* perspective conceptualises socialisation as a reciprocal, ongoing process: learners are influenced by, *and* have agency to accept or resist, the influence of society and others as they become professionals (Shahr et al., 2019). An interactional perspective can therefore offer more detailed explorations of actual *processes* of socialisation (Brown & Finn, 2021). This study extends the interactional exploration of professional socialisation processes by observing and exploring the moment-by-moment construction of trainee clinical psychology students' professional identities in clinical supervision sessions: a central formative activity of professional learning. This facilitates a deeper appreciation of how, and in what ways, novice healthcare professionals' professional identities are actively shaped in formal educational contexts.

Educational Interactions and Professional Identity Development

Within medical and nursing education, there is a longstanding interest in examining socialisation and professional identity development in learning contexts. In their seminal study, Becker et al. (1961) explored the socialisation of US medical trainees in the 1950's, setting the tone for future interactionist research using qualitative research methods to examine how interactions with educators shape identity development (Traynor & Buus, 2016). A notable finding was that socialisation into professions involves a slow and halting process of identity transition (generating anxiety and vulnerability), with learners acquiring professional identities that reflect and perpetuate sanctioned ways of knowing, maintaining a profession's social position (Becker et al., 1961). The contribution of this early work was the focus on *interactions* in healthcare profession education settings and shedding light on how these shape professional identity development.

Since this early work, numerous studies have explored socialisation and professional identity formation in healthcare profession education contexts (e.g., Ajjawi et al., 2015; Brown et al., 2020; C Elsey et al., 2017; MacLeod, 2011; Monrouxe, 2009; Traynor & Buus, 2016), particularly in medicine and nursing (Cornett et al., 2022). The research draws upon different theoretical understandings to shed light onto how socialisation impacts the process of becoming a healthcare professional and the ways in which healthcare professionals conceptualise themselves in relation to their work. Much of this literature exploring socialisation in the healthcare professions has shifted away from the early interactional perspective adopted by Becker et al. (1961) towards a functionalist approach (Brown & Finn, 2021; Shahr et al., 2019). Functionalist perspectives emphasise how the social world shapes the person; through socialisation processes, individuals 'internalise the values and norms' of the profession, reproducing the status quo of the social order (Brown & Finn, 2021). Alongside this there has been a methodological trend towards relying on self-report measures

with studies moving away from an interactional perspective (Olson et al., 2016), relying on interviews (e.g., Olson et al., 2016) and focus groups (e.g., Shaw et al., 2018; Traynor & Buus, 2016) to investigate *claimed* identities (what people *tell* about who they are).

More recently, and within medical education in particular, there is a reinvigorated interest in examining socialisation processes and the development of professional identities from an interactional perspective (Rees et al., 2020). Much of this literature investigates the *enactment* of identities using observational methods in interactional settings to uncover how people reveal and recreate a sense of who they are in-situ (e.g., Ajjawi et al., 2015; Brown et al., 2020; Elsey et al., 2017). Several studies focus specifically on supervision and feedback encounters as a key site of socialisation (e.g., Ajjawi et al., 2015; Brown et al., 2020; Cantillon et al., 2022; Elsey et al., 2017; Lingard et al., 2003; Rizan et al., 2014), which indicate an appreciated need to better understand how formal learning activities, like clinical supervision, impact professional identity development. Findings from this research have illuminated the reciprocity in identities claimed by and made available to supervisors and supervisees in supervision encounters in the context of unequal power relations (Brown et al., 2020); the interactional effectiveness of correction strategies used by educators (Rizan et al., 2014); ways in which patients' personhood is rendered visible or invisible through the acts of bedside teaching (Elsey et al., 2017); the reproduction of professionally and culturally sanctioned ways of knowing in education interactions (Cantillon et al., 2022); and how learners approach uncertainty (due to limitations in knowledge) as a condition to be avoided or disguised at all costs (Lingard et al., 2003). The contribution of this research lies in making visible precisely *how* it is that interactions between learners and educators influence professional identity development, culminating in useful guidance for educators to more effectively navigate interactions with learners in ways that support this process (e.g., Rizan et al., 2014 describe effective linguistic correction strategies educators can use to optimise

learning). What is consistent in these approaches is the systematic analysis of real-world moment-by-moment interactions (and use of language and actions within them) to illuminate *how* socialisation impacts professional identity development.

In this research we draw on an interactional perspective (Benwell & Stokoe, 2006) to examine processes of identification to explore how learners are continually developing and re-shaping self-understanding in interactions within educational contexts. This perspective assumes there are multiple identities available to learners: through socialisation processes and exposure to a range of interactions, learners continuously transform and redefine who they are, and are becoming, as healthcare professionals (Burr, 2015). From this perspective, professional identities refer to how we position ourselves in relation to others by differentiating, affiliating, being, doing and challenging or accepting knowledge within our professional world (Achugar, 2009).

Institutions and Clinical Supervision

Professional identities develop through formal and informal socialisation processes within institutions. Institutions comprise socially legitimised expertise alongside people authorised to implement this expertise (Benwell & Stokoe, 2006). Universities, therefore, are training institutions specifically mandated to ensure learners acquire accepted and sanctioned ways of knowing and behaving within a given profession. Educators represent institutions and are required to realise the institution's mandate through interactions with learners. Thus, institutions are inherently hierarchical (Benwell & Stokoe, 2006). Students are moulded to think, behave, and understand themselves as clinicians, in ways consistent with institutional structures and cultures through their interactions with institutional representatives. In the education of clinical psychologists, much of this happens in university-based training clinics where trainees provide therapy to clients experiencing mental health difficulties under close supervision by supervisors employed by the university. As representatives of institutions,

supervisors are in positions to transform, influence and mould supervisee behaviour to align with sanctioned ways of *how to be* a clinical psychologist. As such, naturally occurring supervision interactions become key sites for closely examining the in-situ construction of identities. This research extends beyond much of the conceptual clinical supervision literature (e.g., Falender et al., 2004) that focusses on guidance and methods (e.g., Milne & Reiser, 2016) or measures perceptions of supervision satisfaction (e.g., Britt & Gleaves, 2011), and shifts the site of analysis to every-day supervision interactions.

Interpersonal supervisory processes occur within this broader formative institutional context in which sanctioned ways of knowing and doing are explicitly and implicitly communicated (Benwell & Stokoe, 2006). Clinical supervision is a distinct professional activity in which novices are socialised into the profession through a collaborative interpersonal process with the overarching aim of providing safe and appropriate clinical care (Falender & Shafranske, 2004). This socialisation process is complex and involves the internalisation of skills, knowledge, and behaviours, as well as the values, attitudes, and goals of a profession (e.g., Bifarin & Stonehouse, 2017; Traynor & Buus, 2016). Furthermore, there are multiple and potentially conflicting roles and objectives for the supervisor and supervisee. For instance, supervisors are tasked with *assessing* competence whereas trainees are tasked with *demonstrating* competence. Despite multiple models of clinical supervision, three core functions repeatedly appear throughout the literature (Simpson-Southward et al., 2017): i) normative/managerial (overseeing effective and efficient service delivery), ii) formative/educational (enhancing knowledge and skills), and iii) restorative/supportive (providing support, removing psychological/emotional barriers to clinical work). These core functions appear in the widely recognised models of supervision by Kadushin (1976) and Proctor (1986).

Framing, Positioning and Impression Management: Constructing professional identities

Little is known about how professional identity develops or which theoretical frameworks are most useful for understanding it (Gordon, 2015), yet framing (Goffman, 1974), positioning (Bamberg & Georgakopoulou, 2008) and impression management (Goffman, 1959) are all useful theoretical frameworks for investigating how language is used in everyday educational activities to construct identities (Gordon, 2015; Monrouxe et al., 2009). Frames are the 'definitions of situations' that speakers interactionally establish (Goffman, 1974). A frame is the stance or perspective through which a person approaches interaction and is shaped by prior interactions and ways of doing things (known as intertextuality; see Gordon, 2015).

Positioning theory (Bamberg & Georgakopoulou, 2008) considers how people display themselves and are seen by others – or the *positions* they adopt for themselves and make available to others – and the interaction between these. It is in the *act* of claiming these positions in day-to-day situations that people continuously practice, examine and re-construct their identities (Bamberg & Georgakopoulou, 2008). Importantly, positioning theory emphasises that positions employed by speakers to display contextualised identities are both created (we actively construct who we are by adopting certain positions) and constrained (the broader context restricts the positions available to us). Frames and positions are interconnected; people create frames by taking up and making certain positions available. Conversely, people make certain positions available based on the frames they create (Gordon, 2015). Examining positions from this perspective illuminates an intimate connection between identities and broader institutional power relations (Benwell & Stokoe, 2006).

Goffman (1959) asserts people are performers on the stage of life, using impression management techniques to present desirable images of themselves to others. Goffman (1959) distinguishes between frontstage and backstage: frontstage we perform (using impression management techniques) to portray and position ourselves, whereas backstage we drop the

performance. People relax backstage knowing that contradictions to how they are trying to present themselves are unobservable to others. In our study, we anticipate that trainees might utilise a range of impression management strategies to portray themselves (frontstage) as competent in order to be perceived and assessed as competent by the supervisor. Inevitably, the construction of professional identities requires trainees to reveal or transform aspects of themselves in ways that may be perceived to be at odds with their pre-established identities or a desired impression of themselves. From an interactional perspective, Goffman (1959) explains that social encounters have the potential to disrupt the impressions people portray of themselves, with such disruptions being highly threatening. People are motivated to protect the position or identity they claim for themselves frontstage (saving face), with any interaction jeopardising this being considered *face threatening* (Goffman, 1959). Thus, during supervision, interactions in which wedges are revealed between the projection and reality of identities being claimed by trainees would be expected to generate discomfort and a range of manoeuvres to manage face threat and restore their desired impression.

Aim: We sought to explore how and in what ways supervision impacts the professional identity development of clinical psychology trainees.

Research Questions: 1) What occurs during supervision interactions that may have implications for the construction of trainees' professional identities? 2) What is the relationship between these interactions and the wider institutional context?

5.4 Method

Design

Naturally occurring supervision sessions were audio recorded, transcribed and analysed using discourse analysis (Benwell & Stokoe, 2006). Benwell and Stokoe (2006) note the academic variety present in approaches to analysing discourse, ranging from conversation analysts interested in the micro-analysis of instances of talk (micro approaches)

to critical theorists with an interest in power and social practices (macro approaches). As recommended by Burr (2015), our approach integrated both a micro-oriented approach focusing on instances of talk-in-use (Potter & Wetherell, 1987) and a macro-oriented critical discourse approach to consider the relationship between interactions and power relations (Fairclough, 2013). This allowed for interactional micro-analysis with a broader macro-level appreciation of interactions as a social practice in which power is enacted and negotiated.

Study Context

This study took place in Sydney, Australia. In Australia, clinical psychology trainees complete placements with individual supervision as part of their two-year postgraduate training. The supervision sessions occurred in a university training clinic in which trainees provide clinical care to community members presenting with mental health difficulties. Trainees receive one hour of weekly individual supervision. Supervisors must assess trainees as competent for placement completion. Participating trainees had completed at least six months of supervised clinical practice. Supervisees are encouraged to discuss their cases or any other concerns in supervision. Ethics for this study was obtained by The University of Sydney Ethics Committee (project number 2020/788). All participants provided informed consent to have their supervision sessions audio recorded.

Participants

Four supervisors (female) and twelve trainees (eight female, four male) participated in the study. All supervisors and trainees working in the university training clinic at the time of this research were invited to participate and we included all who accepted the invitation. Trainees were aged 20-40 years old with all supervisors being over 40 years of age. Twelve participants self-identified as Caucasian, two as Asian and one as Hispanic/Latino. One trainee self-identified as having a disability. Supervisors differentially self-identified their

theoretical orientation as: interpersonal/relational, attachment based, cognitive behavioural and eclectic/integrative. See Appendix C.11 for detailed demographic information.

Data Collection

Individual supervision sessions were audio recorded by participating supervisors. Twelve sessions were recorded (635 minutes total). All recordings were deidentified and transcribed verbatim (Hepburn & Bolden, 2017; see Appendix C.12 for transcription conventions). Transcriptions were checked against the original recordings for accuracy.

Analysis

The analysis involved two broad phases: data organisation and discourse analysis. To organise the data, complete transcripts were coded to identify interactional sequences and categorise the structure of supervision sub-activities (Levinson, 1979). An initial coding framework was developed whilst listening to and re-reviewing half of the transcripts. This coding framework was reviewed by all authors, tested against the initial recordings and transcripts, and applied to the remaining data. Initial engagement with the data identified recurring interactions where supervisors initiated an interactional sequence with direct questions where trainees' response prompted further supervisor questioning, redirection, or correction. We named these sequential activities 'interrogations' and decided to explore them in detail because of the unique ways in which interactional power was enacted by the supervisors and accepted or resisted by trainees. In total, 40 minutes and 21 seconds of audio from 20 interrogation instances across six separate transcripts were extracted. Interrogations lasted between 50 seconds and 264 seconds (mean 121 seconds).

We then conducted a micro-level line-by-line analysis of transcripts, analysing linguistic features of talk and their function (Potter & Wetherell, 1987), as well as a macro-level critical analysis of the relationship between language use and broader social and power structures (Fairclough, 2013). This approach was considered most appropriate because it is

consistent with an interactionist perspective (Burr, 2015): the agency of the speaker is accounted for whilst also acknowledging the influence of wider social processes that restrict agency. The emphasis was on a *dual* relationship of influence operating in both directions: individuals construct the world through interactions and language, and in turn this becomes a reality constraining their agency (Benwell & Stokoe, 2006; Burr, 2015). Half of the transcripts were analysed in detail by all authors, with all subsequent transcripts analysed by author SS and checked by the research team. As previously discussed, being consistent with social constructionism and encompassing social and psychological aspects of interactions, the theoretical frameworks of framing (Goffman, 1974), positioning (Bamberg & Georgakopoulou, 2008) and impression management (Goffman, 1959) were used to guide our analysis. Together, these theoretical frameworks enabled a sophisticated and layered analysis of identity construction in social interactions (Gordon, 2015).

Researcher Position and Approach

The research team comprised an Australian Doctor of Philosophy student working in a public emergency mental health setting (SS), an Australian-Danish nurse with expertise in qualitative research (NB), an English psychologist with a background in cognitive linguistics and expertise in researching professional identity in healthcare education (LVM), and an Australian clinical psychologist with senior roles overseeing the accreditation and education of clinical psychologists in Australia (CH). All authors familiarised themselves with the data and were actively involved in the analysis. The diversity and experience of the research team, alongside a collaborative approach, strengthened the analysis by generating new ideas and challenging individual authors' assumptions and interpretations.

5.5 Results

Our analysis led to two distinct yet interrelated perspectives of understanding the data, including: i) the frame through which supervisors approach interrogations, and ii) the

emphasis (or focus) on either trainees or clients in the interrogation. In presenting our results, we first focus on the frames and positions made available in supervision, and the influence of the broader institutional context on this. We show how each frame creates and constrains supervisors' and trainees' positions. We subsequently explore and contrast interrogations where the focus is on the trainee or the client, and the frames and positions identified in each. We present in-depth analyses of two excerpts to illustrate our findings, demonstrating the multiplicity of ways that naturally occurring supervision interactions build, sustain and challenge trainee clinical psychologists' professional identities. This allows for an exploration of what occurs in supervision interactions that might have implications for professional identity (Research Question 1). The relationship between these interactions and the wider institutional context (Research Question 2) is explored in the discussion.

Framing and Positioning: Constructing identities within institutional contexts

Our analysis highlighted supervisors' authority to conduct conversational manoeuvres made available to them by virtue of their institutional position. Supervisors were found to initiate interrogations from one of two frames: a reflective or quality control frame. Each frame invited trainees to take up distinct positions.

Reflective Frame: Supervision interrogations as a site of learning

Supervisors' interrogations sometimes invited trainees to consider certain ideas or experiences of themselves or their clients to achieve a deeper meaning or understanding (e.g., "So so what were you feeling?" - Excerpt 1). Supervisors adopt positions of masters or mentors, and by extension, encourage trainees to adopt student or novice positions from a place of curiosity and inquiry (whether this was taken up by trainees varied). In approaching the sessions from this frame, supervisors appeared to be enacting the expected institutional requirement to support the development of self-insight and mastery in trainees.

Quality Control Frame: Supervision interrogations as a site of oversight

On other occasions, supervisor's interrogations requested trainees to respond to the supervisor by recounting information (e.g.,"Is she depressed?"–Excerpt 2). This frame functioned to ensure the supervisor was equipped with relevant information or administration details. In doing so, supervisors positioned trainees in a manner that resulted in their minimal engagement and brief responses. An administrative focus appeared to ensure supervisors upheld institutional requirements to safeguard client care.

Classifying the frame of each interrogation enabled us to identify *how* supervisors were approaching interrogations, and by extension, the positions they adopted and encouraged trainees to adopt. This, in turn, shaped the opportunities for how both supervisors and trainees approach the interactions in a continually unfolding and reciprocal process. Mostly, interactions were complementary with trainees accepting positions supervisors made available to them. Occasionally trainees resisted such positions. Further, we identified that interrogations varied according to the extent that the trainee or client was the focus.

Topicalising the Trainee vs. the Client

Each interrogation was found to topicalise either the trainee (e.g., Excerpt 1, Table 5.1) or the client (e.g., Excerpt 2, Table 5.2). Moreover, as the focus varied, there were distinct patterns in identified frames and positions as well as trainees' impression management tactics.

Trainee-focussed: Foregrounding the therapist

The thoughts, feelings or behaviours of trainees were the focal point of 8/20 interactions (*trainee-focussed*). Excerpt 1 is an example of a trainee-focussed interaction between a supervisor (female, over 46 years old) and trainee (male, 20-25 years old).

Trainee-focussed interrogations were approached by supervisors from reflective (n=7) and quality control frames (n=1), with variations in whether the frame was maintained. When supervisors approached interrogations from a reflective frame, almost half defaulted

back to a quality control frame (n=3). This was seen when interrogations initiated by an invitation from supervisors for trainees to reflect on their thinking or experiences (indicating a reflective frame) transitioned into a supervisor-led series of direct questioning and interruptions (indicating a quality control frame) within the same sequence. Each frame was found to position trainees in unique ways. Across reflective frames, we identified conversational markers indicating trainee discomfort (e.g., hesitations) in interactions as supervisors used continuous questioning to explore or expose trainees' inner experiences (e.g., Excerpt 1, lines 1-21) and thus disrupt the positions trainees were claiming for themselves. Simultaneously, trainees utilised various impression management tactics to diffuse or evade interrogations (e.g., claiming not knowing), which functioned to uphold the desired impression of themselves (e.g., Excerpt 1, lines 15 and 22-41). A back-and-forth pattern was identified in which supervisors attempted to bring forward aspects of trainees for reflective discussion, whilst the trainees resisted and projected a different image of themselves that conceals these private, backstage experiences. In contrast, when supervisors defaulted to a quality control frame, trainees typically reduced their engagement in the interaction (e.g., responses reduced to 'mm' or 'yeah').

Below we present our analysis (Excerpt 1) in which the supervisor maintains a clear focus on a reflective frame despite increasing trainee discomfort.

Table 5.1

Excerpt 1. Trainee-focused interaction (05:38-07:27).

Prior to this interaction, the supervisor highlights how the trainee missed validating the client's distress due to his own discomfort. He attempts to defend his behaviour but the supervisor interrupts:		
1	S	= So so what were <u>you</u> feeling?
2	T	= Oh ¯um: (2.0) I was actually feeling quite (1.0) good that he was opening up. =
3	S	Mm:
4	T	[I was] =

5	S	[But] why did you feel the need to diffu::se it?
6	T	(1.0) Yeah I'm not I'm not sure. I think it was probably just a (0.5) an instinctual
7		response (.) like I don't think I pau:sed.
8	S	- But that's an intellectual response- >That's what you're thinking< So what were
9		you f- fee::ling? >Like< .hh see there's some sort of urge going on there that
10		(.)'he's getting overwhelmed (.)I better diffuse this or lighten it up'.
11	T	(2.0) .hh Mm:::: (6.5) I don't know maybe awkward = ?
12	S	Mm.
13	T	Maybe awkward. But =
14	S	[Mm]
15	T	(2.0) I >I don't know< at the moment.
16	S	[Mm] (3.0) Do you think: (.) that perhaps if you were noticing feeling aw:kward
17		in the session: (.) that sort of using a bit of humour is a way to =
18	T	= Probably yeah =
19	S	is that >is that< kind of one of your strategies like that you would use humour to =
20	T	[Yeah: it probably would be]
21	S	[diffuse?]
22	T	I wasn't >I wasn't< thinking of it explicitly in the moment =
23	S	[Mm]
24	T	- >Like I wasn't thinking< 'I feel awkward. Let's try and (.) come up with a way to
25		diffuse tension' =
26	S	[Mm]
27	T	- or anything or make him feel a little bit more at ease.
28	S	Mm.
29	T	(1.5) .h I think maybe cause it (.) it was (.) if he was feeling overwhelmed (2.0)
30		there's a (.) there's a thought that >you know< 'if it gets too overwhelming he'll just
31		shut up shop =
32	S	[Mm]
33	T	= and stop going further'. So it's kind of like 'alright we've gone a step (.) let's just.
34		diffuse a little of the tension then we can go back into (.) the hard stuff again'.
35	S	Mm.
36	T	>I don't know< That's probably what I was thinking at the time. Or just kind of
37		doing it instinctively.

38	S	Mm. Mm. .hh. Okay. We =
39	T	= (just trying not to push) too deep too soon.
40	S	Mm. Mm.
41	T	>I'm not sure<

The supervisor ends the interrogation by redirecting the conversation, reminding the trainee of the benefit of self-reflection, and demonstrating a more skilful approach.

In Excerpt 1, the supervisor initiates the interrogation by interrupting, shifting topic, and employing directive questioning (Searle, 1975) to elicit the trainee's own feelings (Line 1). Her question appears to invite self-reflection, positioning the trainee to self-disclose his internal experiences: bringing frontstage that which is usually kept backstage (Goffman, 1959). The trainee resists (Line 2), thereby creating a tension between the position being made available to him by the supervisor and the position he is self-authoring. This concealment suggests a perceived face-threat (Goffman, 1959); threatening the position the trainee is attempting to claim (which appears to be one of competence). The supervisor interjects again, questioning the trainee (Line 5) and challenging his (assumed) need to diffuse tension. Another pause from the trainee indicates contemplation of how to respond, before admitting he is unsure and then hedging ("I think it was probably…") to distance himself from his suggestion that it was an "instinctual response" (Lines 6-7). His rationale for not pausing (Line 7) absolves him of accountability, suggesting *it just happened*. The supervisor discredits this explanation (Line 8). Offering her own interpretation, she tells the trainee what she thinks he might have been thinking (Line 10). So far, the supervisor has used a directive questioning sequence, pursuing the trainee to reflect on his experience, despite his evasions.

Prolonged pauses suggest that the trainee has realised he is left with little choice but adopt a reflective position (Line 11). His rationale of feeling "awkward" is delivered as a question which suggests it functioned to appease his supervisor rather than being an honest

reflection. At this point, that which has been kept backstage (i.e., feeling awkward) is offered frontstage. The supervisor incorporates this disclosure into a proposition about the trainee's tendency *more generally* of using humour to diffuse tension (Lines 16, 17, 19, 21): in doing so explicitly disrupting the competence image the trainee is trying to portray (Goffman, 1959). The trainee initially concedes to the supervisor's assertions (Lines 18 and 20) before shifting to defend his response (Line 22).

Subsequently, there is a shift as the trainee corrects the supervisor, attempting to re-claim his competent position (Lines 24, 25 and 27). This reduces the supervisor's input for the remainder of the interaction as he continues to explain himself. He directly references his own thinking, challenging the accuracy of the supervisor's suggestion (Lines 24 and 25), and proposes an alternative thought process (Lines 30, 31, 33, 34) that repositions him as intentional, considered and attuned to the client's distress. Nevertheless, we see markers that indicate the trainee feels uncertain (e.g., increased intonation and prolonged pauses). Interactionally, the supervisor retreats (engaging minimally with brief 'mm' responses in a tone that indicates an increasing lack of persuasion) as the trainee continues with excessive justification (Lines 22 onwards) before admitting to his own uncertainty (Line 36 onwards). This signals an interactional dynamic in which the supervisor appears to be unconvinced about the trainee's competence (who, in response, attempts to portray a more desirable impression of himself).

Initially in this interaction, there is a clear sense of the position that the supervisor is claiming (question asker) and the position she is inviting the trainee to occupy (reflective responder). The supervisor has institutional authority to enlist (or attempt to enlist) the trainee into a particular way of being. Thus, immediately there is an asymmetry formed between each person's roles and speaking rights (Benwell & Stokoe, 2006). Yet the trainee attempts to save face and in doing so contests supervisor authority. More broadly in trainee-focussed

interactions, there were ways in which supervisors could draw upon institutional norms, roles and speaking rights to forefront the experience of the trainees within supervision, and the multiple ways in which trainees can adopt or resist the positions and identities being made available to them.

Client-focussed**: **Shifting the therapist to the periphery

Thoughts, feelings or behaviours of clients were the focal point of 12/20 interrogations (*client-focussed*). Here, the trainee's own experiences are peripherally topicalised for the primary purpose of understanding clients. Excerpt 2 is an example of a client-focussed interaction between a supervisor (female, over 46 years old) and trainee (male, 26-30 years old).

Client-focussed interrogations were exclusively approached by supervisors from a quality control frame. There was no encouragement for trainees to self-reflect. The initial question from supervisors that initiated interrogations was marked by a focus on treatment, assessment or diagnostic issues, or case formulation/conceptualisation (e.g., "Is she depressed?" - Excerpt 2, line 1). Supervisors occupied positions of knowing or expertise, and by proxy positioned trainees as not knowing. Trainees were positioned as being accountable to supervisors as observed in three distinct responses patterns: trainees agreeing with the supervisor, minimising or discounting their own clinical judgements, and proposing answers acceptable to the supervisor (e.g., Excerpt 2, lines 2 and 7). These responses functioned as impression management tactics as they were seen to not threaten the supervisor's expertise, enabling trainees to position themselves as cooperative and compliant. Although there were displays of trainees portraying themselves as competent (identified by lengthier responses characterised by technical language and clinical justifications), client-focussed interrogations were typified by a pattern of trainees' reduced responding (with Excerpt 2 reflecting a variation of this). Collectively, this indicated that trainees use language to manage two

distinct impressions of themselves: the competent and the obliging trainee. Below we present our analysis of Excerpt 2 in which the supervisor maintains a quality control frame during a client-focussed interrogation.

Table 5.2

Excerpt 2. Client-focused interaction (47:41-49:26)

With the session almost over, the supervisor explicitly requests a brief update on a new client not yet discussed before beginning the interrogation:		
1	S	((Ruffling paper)) Is she depressed = ?
2	T	((Ruffling paper)). Um: Moderate. According to the BDI.
3	S	(2.5) But according to yo:ur clinical interview = ?
4	T	hhh She's so high functioning. That's the only thing- that kind of gets me. Because
5		she's she gets distinction in everything-. In all her subjects.
6	S	= 'You can get distinctions and still be depressed.'
7	T	= hh I(h) kn(h)ow.
8	S	Um: (1.5). So what we're >kind of< looking at with depression is where she says to
9		you 'I don't get pleasure out of things:: .h I – it takes - yes I do get high distinctions
10		but have to put a lot of effort into it' =
11	T	[Mm]
12	S	= um I >or actually< she might say 'that's the one area when I'm by myself and
13		studying that I feel (.) reasonably okay =
14	T	[Mm]
15	S	- um but otherwise: I don't get pleasure in things: My mood is flat:' There's m =
16		maybe there's been some neurobiological changes >you know< appetite, sleep =
17	T	Oh.
18	S	= um that kind of thing (.) Energy.
19	T	Yeah.
20	S	Um are you picking that up = ?
21	T	She goes to the gym and she enjoys it =
22	S	[Mm hm]
23	T	= and a couple times a week (.) um and >but then< sleep is in the area of concern as
24		well (.) uh and I think there are external factors at play (.) because she grew up in

25		different >very different< climate (.) New Zealand .h Like a colder region,
26		windier: and so being here in a hot humid (.) summer (.) uh sleep has been a big
27		problem throughout the summer months =
28	S	.h So I suppose the on- the thing is (1.0) this is a new person, isn't it?
29	T	Yeah.
30	S	.h So: (.) the thing to think is (.) 'what (.) is (.) the (.) focus (.) of (.) clinical (.)
31		attention (.) here'?
32	T	Mm. .hh hh

The interrogation ends as the trainee begins to speculate about a diagnosis of depression and the supervisor shifts to correcting the trainee's understanding about diagnosis.

The supervisor uses discursive strategies including interruption, topic shift and directive questioning (Searle, 1975) to initiate the interrogation (Line 1). She is gathering information to assist her in overseeing the trainee's work. Her question is ambiguous: it could elicit an open response based on clinical judgement or a closed (yes/no) response based on quantifiable measurement. The uncertain trainee ("um") interprets the question as the latter (Line 2) and is informed he is incorrect (Line 3). It becomes evident *after* this correction that the supervisor is expecting the trainee to adopt the position of the critically thinking clinician (Line 1). The trainee, missing this invitation, responds with a quantifiable metric (Line 2). He is then redirected to rely on his own clinical judgement (Line 3). The trainee, noting the supervisor's disapproval, shifts to a position that privileges clinical judgement and perceptiveness (Lines 4-5) before being abruptly corrected (Line 6). Thus, we see two instances of face-threat (Goffman, 1959) occurring within similar question-answer sequences: the supervisor questions the trainee and the trainee responds before subsequently being exposed as incorrect. This sequence demonstrates how the position the trainee is attempting to claim for himself is being interrupted. The positions established – in this case by the supervisor – are the *supervisor as expert* and *trainee as non-expert*. Laughter and hedging

(Line 7) are used by the trainee to distance himself from his error and manage face-threat (Goffman, 1959).

At Line 8, we see the supervisor shift positions, although she remains within the quality control frame. She instructs the trainee on how to identify depression (Lines 8-18); speaking *at* rather than *with* the trainee. Interactionally, we see the trainee's input decline (reduced to 'mm' 'oh' or 'yeah; Lines 11,14,17,19) and an absence of his own thoughts or judgement.

At Line 20, the supervisor further questions the trainee to elicit whether he has observed the features of depressed mood. Engaging in corrective facework (Goffman, 1959), the trainee attempts to reclaim a position of being competent, insightful, and capable of his own clinical judgement by elaborating on the points raised by the supervisor (Lines 21-17). He scatters in technical language (e.g., "area of concern") to accentuate this impression. Indicators of uncertainty (increased pitch, "um" and "I think") distance him from his responses, possibly to protect himself should they be deemed incorrect.

We then see another abrupt shift from the supervisor (Line 28) without acknowledging the trainee's response to her last question (Line 20). She interrupts, hesitates, and indicates her own uncertainty about the client's details (Line 28). The trainee retreats, returning to minimal, closed responding (Line 29). The supervisor then proposes yet another line of questioning (Lines 30-31). Here, she reclaims for herself a position firmly constructed within a quality control frame overseeing the "focus of clinical attention".

Throughout this interaction it is possible to observe the moment-by-moment ways that a quality control frame creates and reinforces the position of expert for the supervisor (with sanctioned knowledge of how to think and be as a clinical psychologist) and novice for the trainee (lacking such knowledge). The asymmetry in knowledge is apparent, establishing an interactional pattern whereby the trainee uses conversational tactics to manage a desirable

impression of himself to the supervisor. This restricts opportunities for the trainee to contribute his own thinking, knowledge, and ways of making sense of the client's experience. From a broader perspective, client-focussed interactions demonstrate how institutionalised knowledge and sense-making about clients can constrain possibilities for trainees to develop independent ways of understanding their clinical work; a phenomenon which perpetuates established ways of knowing.

5.6 Discussion

Explorations of professional socialisation activities (e.g., supervision) from an interactional perspective offer insights into the moment-by-moment *processes* through which the professional identities of healthcare professionals are constructed in education settings. We analysed interrogations within supervision sessions using micro- and macro-oriented approaches to discourse analysis, drawing on the theories of framing (Goffman, 1974), positioning (Bamberg & Georgakopoulou, 2008) and impression management (Goffman, 1959) to guide the analysis. Our analysis identified that supervisors approached interrogations from either reflective or quality control frames, and that this was associated with different positions being made available to trainees. We found trainees were either central or peripheral as the topic of interrogative conversation. This was associated with differences in the frames through which supervisors approached interrogations, the positions made available to and taken up by trainees, and trainees' impression management tactics. These findings demonstrate how a detailed interactionist approach to examining in-situ clinical supervision sessions can illuminate how professional identities are developed and constrained in key socialisation activities, such as supervision.

Framing sets the scene for meaning making in any given interaction and is shaped by our prior knowledge and experience of particular situations (Gordon, 2015). Within institutions (universities), institutional representatives (supervisors) are bound by institutional

agendas whilst also being granted speaking rights to realise these agendas (Benwell & Stokoe, 2006). We suggest that the reflective and quality control frames through which supervisors approached interrogations reveal how these institutional goals and speaking rights surface in supervision encounters (Mayr, 2015). Shifting from viewing supervisors as simply having designated roles, duties and behaviours (Simpson-Southward et al., 2017), the emphasis from a social constructionist perspective is on how supervision encounters are both shaped by *and* re-create institutional norms. Recognising this reciprocity encourages supervisors to be aware of how wider institutional agendas both constrain and are re-created in supervision interactions. Although reflective practice is considered a cornerstone of clinical practice and education (Bennett-Levy, 2019), it is one thing to declare the importance of reflective practice and another thing entirely to consider the intricacies of *how* reflective practice is accomplished effectively (Mann et al., 2009). The finding that only interrogations focussed on the trainee were approached from a reflective frame, and that this often defaulted back to a quality control frame, suggests a transient quality to reflective frames in supervision in these forms of interaction. Further, across reflective frame interrogations, typical escalations in supervisor question-asking and apparent trainee discomfort indicates that reflective spaces may be experienced as threatening by trainees. One way of conceptualising this is to consider the tension for learners between seeking credibility (ascertained by an assessment of competence) and expressing vulnerability (such as uncertainty) in formal learning interactions, with a tendency to promote credibility and hide vulnerability (Molloy & Bearman, 2019). This is thought to limit learning and the quality of clinical practice and be particularly prevalent in healthcare professions where incompetence can have dire consequences (Molloy & Bearman, 2019). Indeed, learners have admitted to fabricating narratives in reflective practice exercises to achieve assessment objectives and promote credibility (Maloney et al., 2013), indicating an endemic need to prove credibility and

conceal vulnerability amongst learners (Molloy & Bearman, 2019). Reflective practice demands vulnerability, requiring learners to take risks in making judgements about their own performance (Molloy & Bearman, 2019).

It is also possible to consider this finding using the widely recognised models of supervision (e.g., Kadushin, 1976; Proctor, 1986) that propose a separation between the formative or educational functions of supervision (akin to our reflective frame because of the focus on eliciting trainees' reflections about their own responses and reactions in order to increase knowledge and skill) and the normative or managerial functions of supervision (akin to our quality control frame because of the focus of supervisors on monitoring and overseeing clinical work) (Simpson-Southward et al., 2017). Our results suggest that formative or educational functions can easily be subsumed by normative or managerial functions in interrogative interactions. Supervisors require intentional and explicit interactional strategies that are formative or educational (Rizan et al., 2014; Molloy & Bearman, 2019). A promising avenue is the concept of 'intellectual candour' by Molloy and Bearman (2019), which explains that supervisors modelling vulnerability builds trust, invites reciprocal vulnerability, and models balancing the vulnerability-credibility tension as a foundation for professional learning and practice. Interestingly, displays of vulnerability by supervisors were not found within our data.

Our findings highlight how the frames that supervisors construct for interrogations function to position trainees in specific ways, and by extension, make available (and limit) ways to think, feel and be. This reciprocal nature of trainee and supervisor identities in which each makes available and takes up identities in relation to the other is consistent with other interactional studies of supervision (e.g., Brown et al., 2020). Our finding that the positions made available by supervisors for trainees can be taken up, negotiated or resisted, challenge simplistic binary notions of institutional power and reflects power as a *process* or action

achieved in interactional spaces (Mayr, 2015). The results of this study demonstrate how trainees enact their agency to take up, negotiate and resist institutional agendas; making visible at the interactional level findings from studies of medical students and nurses resisting wider institutional agendas using self-report (interview) measures (e.g., Shaw et al., 2018; Traynor et al., 2010b). Furthermore, we identified instances of incongruence between positions being made available to trainees by supervisors and positions being claimed by trainees. This is consistent with findings demonstrating how emerging professional identities encouraged by institutions can conflict, collide or otherwise enter into a struggle with existing identities (e.g., Traynor & Buus, 2016), with this study enhancing these findings further by demonstrating *how* this unfolds at the interactional level. Finally, we identified that a quality control frame and focus on clients was associated with trainees adopting competent or compliant positions (identities). The tendency for learners in healthcare education contexts to position themselves in this way is widely documented (e.g. Becker et al., 1961; MacLeod, 2011), and relates to the vulnerability-credibility tension described above. We acknowledge that all functions of supervision are necessary, yet we think it important that supervisors are aware of the constraints of each, and the risks associated with certain functions taking precedence over others. At an interactional level, our results demonstrate how a quality control frame leaves minimal room for authentic, creative and independent clinical judgement and learning opportunities in interrogations.

The proclivity for trainees to present themselves as competent in evaluative supervisory contexts is unsurprising when we consider that trainees have been required to excel academically to progress. Furthermore, academic programs themselves are subject to the financial and academic pressures from the institutions within which they reside. If who we are is created in interactions, and in interactions we feel compelled to position ourselves as competent or compliant in the face of institutional pressures, what potentially emerges is a

new generation of clinical psychologists who privilege competence and compliance, concealing aspects of their identities that conflict with these desired impressions. The way we act becomes who we are. No doubt this will impede learning: learning necessarily requires being open to the possibility of being and doing things differently (Molloy & Bearman, 2019).

From a broader perspective, our findings speak to the ways in which *ways of knowing and being* as a clinical psychologist are maintained and perpetuated. In supervision, trainee clinical psychologists encounter sanctioned understandings of what it means to *be* a clinical psychologist through *what* supervisors say and *how* they say it (Mayr, 2015). Although sanctioned truths or ways of knowing are specific to healthcare professions like clinical psychology, our findings expand upon those from across healthcare professions highlighting the importance of educational interactions as socialisation sites in which trainees are exposed to – and positioned to internalise – ways of knowing and being (Ajjawi et al., 2015; Elsey et al., 2017; Monrouxe et al., 2009). The finding that interrogations can explicitly contest and challenge trainees' self-authoring of their identities, as well as silence the spaces in which trainees offer their own perspectives, demonstrates how dominant ideas and established ways of doing things can be preserved, internalised and carried forward within supervision, yet also challenged and contested (Benwell & Stokoe, 2006; Mayr, 2015).

Various limitations and strengths of this research should be taken into consideration when interpreting the findings. The in-situ data collected was extensive and heterogeneous, and required categorisation which allowed us to methodically focus on interrogation activities. We identified several other activities in the supervision sessions, which had different interactional characteristics (e.g., supportive and restorative functions) and introduced different frames. Therefore, the data analysed is not representative of all clinical supervision activities and interactions, and we are mindful not to judge the quality of

supervision interactions for this reason. Although our findings may be transferable to other healthcare supervision settings, our sample was restricted to trainees from a particular institution and profession. It is noteworthy that the supervision sessions analysed concerned a profession focussed on the therapeutic potential of interpersonal encounters (i.e., therapy), which may have implications for the results. Future studies could explore whether comparable findings are identified in trainees from other professions, developmental stages, and institutions. Finally, the theories of framing, positioning and impression management allowed us to explore the nuanced in-situ ways that identity are created, but do not allow us to make claims about speaker's intentions nor do they lend themselves to quantifiable measurement or truth claims. Notwithstanding these challenges, the inter-disciplinary research team and application of micro- and macro-oriented discourse analytic techniques ensured a theoretically informed approach and rigorous analysis.

Conclusion

Our findings offer a sophisticated lens through which to explore the intricacies of a common professional activity and complex interpersonal process, therefore offering insights for educators responsible for training and supervising clinical psychologists. Analysing in-situ talk between trainees and supervisors with a critical lens, considering the institutional context and power relations, allowed for a richer understanding of *how* trainees become clinical psychologists. By making explicit that which is easily overlooked, our findings invite education institutions, supervisors, and trainees to pay close attention to language and power, and how taken for granted ways of being as clinical psychologists are perpetuated and maintained in interactional spaces during professional learning activities. Intentional efforts through a critical lens are required within clinical psychology education settings to navigate interpersonal supervisory spaces in ways that optimally support professional identity

development. Hoping clinical psychology trainees just ‘get it right’ when it comes to professional identity development will not suffice.

Chapter 6: Fragilising Clients in Clinical Supervision (Study 4)

6.1 Preamble

Similar to the previous study (Study 3), the final study in this thesis focusses on exploring the professional identity construction of clinical psychology trainees in supervision interactions and is therefore focussed on answering the third research question of this thesis (see 'Statement of Problem' section in Chapter 1, page 18): how and in what ways are clinical psychologists socialised into acquiring professional identities in educational contexts? The findings of Study 3 spoke to the reciprocity of identity construction in interactional settings, how power is enacted in institutional interactions, and how professionally sanctioned ways of knowing and being can be preserved (and contested) in interactional sites. These interwoven threads are picked up in the study that follows in this chapter (Study 4). Study 4 explores how the professional identities of clinical psychology trainees (the self) as well as the identities of the clients they see (the other) are constructed in supervision interactions. There is no denying that any understanding of the *self* is inherently interconnected with an understanding of the *other* (Bernasconi, 2012); our identities are reciprocally constructed. We cannot understand the professional identities of clinical psychologists without understanding the ways in which they construct identities for their clients.

As described in Chapter 1, reforms in mental healthcare services require clinicians to shift towards a person-centered model of clinical care (see 'Enabling System Reforms' section in Chapter 1, page 32). It was clear in Study 1 (Chapter 3), however, that clinical psychologists' professional identities can act as a barrier to the implementation of reform-oriented ways of working. The ways in which clinical psychologists saw themselves and their roles interfered with their capacity to embrace new ways of working. Taking together the reciprocity of clinical psychologists' and client identities, and the ways in which clinician's

professional identities impact the implementation of new ways of working, questions arise: how are clinical psychologists' understanding themselves and their roles interrelated with how they understand their clients? Are clinical psychologists understanding their clients in ways which then position them to see themselves and their roles in ways that do (or do not) align with mental healthcare reform priorities?

The current study explored interactional sequences in which clients were positioned as fragile (unable to manage distress) and how this pertained to the identities clinical psychologists claimed for themselves, as well as the wider relevance of this to the professional identities of clinical psychologists. We found that the positioning of clients as fragile, in turn, positions clinical psychologists to take up identities that perpetuate paternalistic models of care that do not align with reform priorities. Through our analysis, we also demonstrate how this is achieved and how it is that such professional identities are preserved and re-created in interactional sites within education settings. This study therefore brings this thesis full circle: clinical psychologists' professional identities are implicated in their willingness and capacity to work in reform-oriented ways (Study 1, Chapter 3), and yet their professional identities are inherently bound up in their understanding of their clients (Study 4, this chapter). Clinical psychologists must critically consider how they construct identities for the clients they see and the implications for this for their own professional identities and mental healthcare clinical service delivery.

Publication: This study is being revised and resubmitted following peer review for publication in Medical Education in 2023. The following chapter is a reproduction of material submitted for publication. No formatting or reference changes have been made.

Study Materials: Confirmation of approval from the University of Sydney Human Research Ethics Committee for this study and all study materials are the same as those for the previous study (Chapter 5). These are provided in Appendix C.

6.2 Abstract

Context: Western mental healthcare system reforms prioritise person-centered care and require clinicians to adjust their professional positions. Realising these reforms will necessitate clinicians – including clinical psychologists – acquiring professional identities that align with reforms. Learners develop professional identities through socialisation activities: within *interactional* spaces such as supervision learners come to understand the self (clinician) and, by extension, the other (client). A clinician's understanding of *who I am* is intertwined with an understanding of *who they are*. Interactions with educators therefore need to support learners to acquire professional identities that position themselves and clients in ways that align with reforms. Our study offers a moment-by-moment examination of supervision interactions of clinical psychology trainees to illuminate *processes* through which the identities of therapists and clients are constructed.

Aim: We examined how clinical psychology trainees and supervisors construct identities for themselves and clients in supervision.

Methods: We used positioning analysis to explore identity construction during interactions between supervisors (n=4) and trainees (n=12) in a clinical psychology training clinic. Twelve supervision sessions were audio recorded and transcribed. We found that clients were frequently positioned as fragile and subsequently analysed these sequences (n=12).

Results: Clients' identities were constructed as fragile, which co-occurred with clinical psychologists' claiming positions as responsible for managing their distress. Supervisors played an active role in positioning clients and trainees in this way. Trainees rarely contested the identities made available to them by supervisors.

Discussion and conclusion: We suggest that positioning clients as fragile perpetuates paternalistic clinical discourses that do not align with mental healthcare reform priorities. We make visible how this is achieved interactionally and influenced by organisational power

relations. Intentional efforts are required to support the professional identity construction of clinical psychologists in ways that do not perpetuate paternalism. We offer recommendations for education and clinical practice to support these efforts.

Clinical Psychology Trainees' Construction of Professional Identities in Clinical Supervision Interactions: A positioning analysis

6.3 Introduction

Current Western mental healthcare system reforms prioritise person-centered approaches and *personal* recovery for clients, which require clinicians to reconceptualise their professional approaches in the provision of care (e.g., Commonwealth Department of Health, 2013). Yet mental healthcare systems continue to be critiqued for privileging *biomedical* views of recovery and not aligning with reform priorities (Hardy et al., 2022; Jackson-Blott et al., 2019). These person-centered reforms prioritise a range of interconnected processes and outcomes including autonomy, self-determination, empowerment, shared decision making, and so on (Leamy et al., 2011; Tambuyzer et al., 2014). Clinical supervision is a key professional activity in which mental healthcare professionals are socialised into the profession (Toh et al., 2022); trainees *become* clinicians and come to understand themselves and clients in particular ways through repeated supervision interactions in education settings. Supervision is a space in which contentious understandings of the self (clinician) and other (client) can be perpetuated and carried into clinical work within healthcare services, potentially undermining healthcare system reform aspirations. Further, socialisation processes are context-specific (Cantillon et al., 2022); specific healthcare disciplines (e.g., clinical psychology) have unique discourses and cultures that shape this process and therefore need to be understood independently. Although research exploring professional identities is expanding within medical education and health services (Brown et al., 2020; Schrewe et al., 2017; Skoura-Kirk, 2022); there is an absence of equivalent research within mental health and clinical psychology (Schubert et al., 2023). It remains unclear *what* professional identities clinical psychology trainees can claim for themselves that align or depart from reform priorities, and *how* supervision interactions

influence this process. As central providers of mental healthcare clinical services (Jackson et al., 2021), we require high quality research providing insight into the impact of supervision on clinical psychologists' emerging professional identities so educators can support future generations of clinical psychologists to develop professional identities that align with reform directions in mental healthcare settings (Schubert et al., 2023).

Therapists and Professional Identities

Clinical psychologists are highly specialised mental healthcare clinicians within healthcare settings (Jackson et al., 2021), and provide therapy as their primary professional activity (Norcross & Karpiak, 2012), Therapists can only understand themselves and their roles in relation to their clients (Schrewe et al., 2017; Skoura-Kirk, 2022), the provision of therapy is primarily focussed on making sense of the *other*: assessing, formulating, diagnosing, and treating. Therapists – including clinical psychologists – have consequently been critiqued for inadequately examining their own professional identities (Orlinsky et al., 2020; Rønnestad & Skovholt, 2013), which suggests an under appreciation that any conceptualisation of 'the other' (the client) is inherently intertwined with an understanding of the self (the therapist). By continuing to lack insight into the complexities of clinical psychologists' professional identities and how this relates to their sense-making about clients, their readiness to implement health service reforms suffers (Schubert et al., 2021; Skoura-Kirk, 2022). A nuanced understanding of reciprocal professional-client identities is critical so that clinical psychologists better understand themselves and their clients in ways that support the provision of person-centered care.

Supervision and Socialisation

In related fields to clinical psychology and mental health, healthcare professions like medicine have grasped the importance of researching professional identities. The role of education in socialising novices into healthcare professions and contributing to the

construction of professional identity is widely recognised (Christopher Elsey et al., 2017; Elsey et al., 2014; Jarvis-Selinger et al., 2012; Monrouxe, 2010; Monrouxe et al., 2009; Rees et al., 2013; Rees & Monrouxe, 2008, 2018). Professional socialisation is the means through which lay people are exposed to and acquire the relevant language, actions, and ways of thinking, believing and valuing, of the profession they are joining (Gee, 2004). This has culminated in calls for educators to explicitly prioritise professional identity development in curricula (Irby et al., 2010), and efforts to identify educational strategies to support this process (Binyamin, 2018). More recently, research is examining *how* trainees across healthcare professions discursively construct identities for the patients they see and the implications this has for professional identity formation (Schrewe et al., 2017; Skoura-Kirk, 2022). Such research makes visible the consequential interactions between educators and trainees: trainees are exposed to, take up and reproduce taken for granted ways of understanding patients or clients in a profession through repeated interactions with educators. Indeed, the cultural worlds of specific healthcare professions anchor and constrain the identities of educators and trainees in specialty-specific ways of knowing and being (Bennett et al., 2017; Cantillon et al., 2022), highlighting the merits of specialty-specific research into how this process unfolds. Within clinical psychology, however, research focusses less on socialisation and in-situ professional identity construction, and more on the *effects* of supervision on professional development as described by trainees (Wilson et al., 2016). We therefore do not currently know how or in what ways supervision in clinical psychology education settings impacts the process of professional identity construction.

Therapists and the Process of Constructing Identities

Therapists' stance towards themselves and their clients matter, and supervision is a key educational activity in which professional identities are constructed (Toh et al., 2022). Researchers are therefore increasingly using discourse analytic methods to investigate

professional identity construction in education settings (Brown et al., 2020; Cantillon et al., 2022; Gordon & Luke, 2016). This allows for an exploration of the *process* of socialisation and identity construction *as it happens* and allows investigators to explore *what* identities trainees construct for themselves and *how* these identities are negotiated interactionally within the constraints of broader professional discourses. Evidence also suggests this process is highly contextualised within specific healthcare disciplines that each have their own cultural norms and discourses (Bennett et al., 2017; Cantillon et al., 2022). We therefore sought to understand the ways in which trainees and clients position themselves and are positioned during supervision interactions, how this process unfolds interactionally, and the broader implications for the professional identity development of clinical psychologists.

Theoretical Frameworks

We adopt a social constructionist perspective (Burr, 2015). Professional identities are understood as both a product of, and produced in, interaction with others. Our identities are continually being re-negotiated in the social world, being formed in the context of relating to others within specific cultural frameworks that sustain power (Benwell & Stokoe, 2006; Tracy & Robles, 2013). We contend that trainees' professional identities are often constructed in their interactions with supervisors and that the identities that can be claimed are dependent upon the identities made available to them (de Fina et al., 2006). We draw upon narrative inquiry frameworks increasingly used in healthcare education research to explore trainees' professional identity construction from this theoretical perspective (Clandinin et al., 2017). Narrative approaches have shifted away from viewing narratives as sequential events that make up a story, to focussing on how identities come into being through the act of storytelling itself (Clandinin et al., 2017; de Fina et al., 2006). Every-day interactions are considered the sites of identity work; the places in which we continuously practice, test-out and create a sense of who we are. This reflects the theoretical shift that

regards narratives and storytelling as interconnected with identities and their construction (Tannen et al., 2015).

Aims and Research Questions

The aim of this study was to explore how clinical psychology trainees and supervisors construct identities for themselves as therapists and for clients of mental health services in every-day supervision encounters.

The following research questions guided our analysis:

RQ 1: How are trainee clinical psychologists and clients positioned, and how do trainees position themselves, in clinical supervision interactions in training settings?

RQ 2: What is accomplished by constructing the identities of clinical psychologists and clients in these ways?

RQ 3: What does this reveal about the professional identities that clinical psychologists are socialised into acquiring and what is the wider impact of this?

6.4 Method

Design

Naturally occurring clinical supervision sessions were audio recorded and transcribed. Data were analysed using Positioning Analysis (Bamberg, 2020).

Study Context

This study took place in New South Wales, Australia. In Australia, clinical psychology trainees undertake clinical placements during post-graduate training. The supervision sessions recorded as part of this study took place in a university training clinic in which post-graduate clinical psychology trainees provide therapy to adults from the community experiencing mental health difficulties. Trainees must complete one hour of individual supervision each week. All trainees had completed at least six months of supervised clinical practice. Supervisors are all registered clinical psychologists and approved

to provide supervision by a national registration board. Ethics for this study was obtained by the University of Sydney Ethics Committee (project number 2020/788). All participants provided informed consent to have sessions audio recorded and were informed about their right to withdraw consent at any time. Supervisors recorded the sessions so participants had no direct interaction with researchers during data collection.

Participants

Twelve trainees (eight female, four male) and four supervisors (four female) took part in this study. All supervisors and trainees working within the training clinic at the time of the study were invited to participate. Trainees were aged between 20-40 years old and all supervisors were over the age of 41. All participants identified as Caucasian except for two who identified as Asian and one who identified as Hispanic/Latino. One participant identified as having a disability. Half of the supervisors had 0-5 years or 11-20 years of supervision experience respectively. Supervisors identified a range of theoretical perspectives spanning interpersonal/relational, attachment based, cognitive behavioural or eclectic/integrative orientations. See Table 6.1 for further demographic details.

Table 6.1

Demographic Information about Participants

Participant Information	Trainee	Supervisors
Participant numbers	12	4
Gender		
Female	8	4
Male	4	-
Other	-	-
Age Range		
20-25 years	4	-
26-30 years	5	-
31-35 years	1	-
36-40 years	2	-

41-45 years	-	1
46+ years	-	3
Race/Ethnicity		
Caucasian	9	3
Asian	1	1
Hispanic/Latino	2	-
Disability		
Disability	1	-
Prefer not to say	1	-
Sexuality		
Heterosexual	10	4
LGBTIQ+	1	-
Prefer not to say	1	-
Education		
Bachelors	5	-
Masters	5	2
Doctorate/PhD	2	2
Theoretical approach (supervisors)		
Interpersonal/relational	-	1
Attachment	-	1
Cognitive behavioural	-	1
Eclectic/integrative	-	1
Supervision experience (supervisors)		
0-5 years	-	2
5-10 years	-	-
11-20 years	-	2

Data Collection

Individual supervision sessions were audio recorded by the participating supervisors. Researchers were not present at the time recordings were made. 635 minutes of recordings was collected across twelve supervision sessions. All recordings were anonymised and

transcribed verbatim (see Table 6.2 for transcription conventions). All transcriptions were checked by the first author against the original recordings for accuracy.

Table 6.2

Transcription Conventions(Hepburn & Bolden, 2017)

Symbol	Description
(.)	Pause < 1 second.
(x.0)	Pause of x seconds.
=	Latching between utterances.
-	Dash indicates a cut off.
[ ]	Square brackets indicate the start and end of overlapping speech.
↑↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech.
:::	Colons show degrees of elongation of prior sound (more colons indicate longer elongation).
@	Laughter.
.h	Audible inhalation.
hh	Audible exhalation.
Underlining	Emphasis (extent of underlining indicates location of emphasis)
><	Indicates phrases spoken at faster speed.
(( ))	Additional comments from the transcriber.

Data Analysis

The analysis involved two broad phases: organising the data and conducting a positioning analysis (Bamberg, 2020). To organise the data, complete transcripts were coded by author SS to identify interactional sequences and categorise the structure of sub-activities (e.g., formulation, treatment planning) occurring within supervision interactions (Levinson, 1979). This identified discrete sections of interaction that we used to explore the identity construction of clients. Substantial variation in the construction of client identities across and within these sub-activities meant that the research team agreed analysing a specific sub-activity would provide an incomplete and misleading representation of how clients identities

were constructed. Author SS returned to the original transcripts and recoded all interactions that were 30 seconds or longer in duration (to assure sequences were sufficient in length to analyse positioning) and focussed on a specific client. These interactions were coded using an iterative process to identify the primary ways in which clients were being positioned by SS and reviewed by the research team. We found that clients were frequently positioned as fragile (defined as clients being undermined in their capacity to cope or tolerate distress or discomfort effectively) and subsequently focussed specifically on these sequences. We identified 12 interactional sequences (total of 28 minutes and 55 seconds) in which clients were positioned as fragile (see Table 6.3).

Table 6.3

Interactional Sequences Positioning Clients as Fragile.

	Session	Supervisor	Trainee	Time	Description of interaction
1	1	F, 46+ years	F, 20-25 years	3:07	Client positioned as easily triggered. Therapist positioned as unable to contain distress.
2	1	F, 46+ years	F, 20-25 years	2:16	Client positioned as easily triggered by decisions. Therapist positioned as needing to reduce client decision making.
3	1	F, 46+ years	F, 20-25 years	4:02	Client positioned as having personality vulnerabilities. Therapist positioned as needing to moderate validation.
4	3	F, 46+ years	F, 26-30 years	1:34	Client positioned as having insecure attachment and engaging in problematic behaviours. Therapist positioned as needing to reduce avoidance behaviours.

5	6	F, 46+ years	M, 26-30 years	0:58	Client positioned as extremely anxious. Limited discussion of therapist identity or role.
6	6	F, 46+ years	M, 26-30 years	0:58	Client positioned as having no self-esteem. Limited discussion of therapist identity or role.
7	6	F, 46+ years	M, 26-30 years	1:50	Client positioned as vulnerable. Therapist positioned as wanting to rescue client then positioned as feeling helpless.
8	6	F, 46+ years	M, 26-30 years	1:32	Client positioned as having sense of shame and failure. Therapist positioned as needing to be aware of motivational comments.
9	8	F, 41-45 years	F, 31-35 years	3:41	Client positioned as uncomfortable with close relationships. Therapist positioned as needing to be aware of therapeutic relationship.
10	8	F, 41-45 years	F, 31-35 years	1:33	Client positioned as chaotic and unpredictable. Therapist positioned as over-functioning in therapy sessions.
11	11	F, 46+ years	F, 20-25 years	1:38	Client positioned as engaging in triggering behaviours. Therapist positioned as needing to stabilise.
12	11	F, 46+ years	F, 20-25 years	0:46	Client positioned as raising material then becoming distressed. Therapist positioned as needing to contain distress when topics raised.

Note: Sequences 1 and 7 comprise Excerpt 1 (see Table 6.4) and Excerpt 2 (see Table 5.6) in the results section respectively.

We then conducted a positioning analysis (Bamberg, 2020) on these twelve sequences. Positioning analysis is a form of narrative inquiry practice that analyses talk-in-interaction across three analytical levels to examine identity construction (Bamberg, 2020). In the first analytic step (level 1), researchers analyse what the interaction is about, what is being said and about who. This level also analyses identity construction across three continua: differentiating whether identities are marked as similar or different to others (sameness-difference), whether identities are constructed with a sense of agency (influence over the world) or passivity (influenced by the world) (agency-passivity), and the extent to which identities are constructed as constant or undergoing change (continuity-change). At the second analytic step (level 2), the analysis focusses on the objectives of the speakers and what are they trying to accomplish in the interaction itself. The third and final step (level 3) expands to consider whether and how narrators are making claims about who they are above and beyond the local conversational situation. This level analyses how speakers construct themselves as a particular type of person and in doing so construct broader discourses about identities within the social world. Whilst these findings are derived from specific interactions, researchers can assume that these patterns of sense-making ultimately produce an enduring sense of how to understand oneself across other situations (Bamberg, 2020). Each level of analysis corresponds to the research questions respectively.

All excerpts were analysed line by line by author SS according to these three levels and reviewed collectively by the research team for accuracy. All researchers reviewed the initial positioning analyses on the twelve sequences. Patterns across the twelve sequences were then identified, discussed and agreed in the research team. Divergent cases were also reviewed and discussed, and we identified these as meaningful given the variation they displayed.

Team Reflexivity and Author Positions

Social constructionist research regards objectivity as an impossibility and asserts that researchers cannot step outside of their own world view. Researchers must acknowledge their own involvement in the research process and consider how this influences research findings (Burr, 2015). The authors were an Australian, female PhD student and clinical psychology registrar working in a public mental health suicide service; a Danish, male academic and nurse with expertise in qualitative and clinical supervision research; an English, female academic psychologist with expertise in cognitive linguistics and professional identity in healthcare settings research; and an Australian, female academic and clinical psychologist with experience in the regulation, accreditation, and education of clinical psychologists. We acknowledge that our own identities and experiences will have inevitably influenced the findings of this research. All authors were actively involved in the design and analysis of this study but otherwise work in separate research and professional domains. This diversity of the research team ensured researcher assumptions and interpretations were challenged as all authors worked closely and collaboratively across the duration of the study.

6.5 Results

Positioning clients as fragile was found to be accompanied by both supervisors and trainees claiming responsibility for managing this fragility by actively *doing* something to or for clients to contain their distress. We present a detailed text analysis (analytical levels one and two) of a single sequence, which exhibits numerous patterns identified across sequences. This detailed text analysis is augmented by a text box summarising these patterns at different analytical levels (see Box 1). Quotes from other sequences are included to demonstrate the breadth of findings. Following this, we present a second detailed text analysis (analytical levels one and two) of a sequence that represented a divergent result. We found two exceptions in which the fragilization of clients generated a supervisor-guided series of questions that positioned trainees to re-characterise their own identities, which they saw as

needing to 'rescue' clients or manage clients' distress. All findings relevant to the third analytical level are included within the discussion as they represent an interpretation of the broader meaning of the results.

Key Finding: Fragilisation of clients creating therapist identities oriented around managing distress.

The first sequence (Excerpt 1, Table 6.4) analysed involves an interaction (3 minutes and 15 seconds) between a supervisor (S: female, over 46 years old) and a trainee (T: female, 20-25 years old).

Table 6.4

Excerpt 1. Fragilisation of clients creating therapist identity oriented around managing distress

After the supervisor asks for an update about a client discussed previously in supervision. The trainee responds with her formulation and diagnosis. The supervisor then offers her perspective on the dynamics in sessions during which she begins remarking on the client's distress.		
1	S	.h But it became clearer to me in the third session .h that: (.) um (.) she can be (.)
2		triggered quite easily
3	T	°Yeah°
4	S	And almost unbeknownst to you↓.
5	T	°Mm°
6	S	Um (.) so y- you will just say something like >you know< "what I am going to do is
7		I'm going to go away:: try and – get a sense of what's going: on: (.) and then I'm .h
8		come back and share my thoughts with you: (.) and (.) um (1.0) if there is a body of
9		work that we can do (.) definitely let's talk that through. However (.) if it seems like
10		we do not – we do think about who – we need to think about who to link you with -"
11		(1.0) That's all it took for her to comple:tely unravel (.)
12	T	°Mm°
13	S	In a way that was not a refle:ctive (.) unravelling.
14	T	Yeah.
15	S	Right. (.) She just fell apart in front of you.

16	T	Mm.
17	S	A- and that falling apart in front of you was part (1.5) anxious distress (.) but she was
18		also angry.
19	T	Yeah.
20	S	And it didn't take much (.) and she didn't actually really recover.
21	T	°Mm°
22	S	She almost (.) just (.) gave up.
23	T	°Mm°
24	S	.h Um no matter how hard you tried (.) to: (.) explain and re-explain and (.) help her
25		(.) and try and contain her. It didn't really work↓.
26	T	Yeah:
27	S	.hhh Um hhh so that that's something of who she is. And now that we know (.) that
28		about her (.) I think what we're: (.) both aware of (.) is:: (.) "Okay so how I (.) >I've
29		got to be< >as you said< I've got to be thinking about boundaries. I've probably got
30		to be thinking about – >even if she's agreeable to us doing a body of work< -
31		probably got to really be thinking about how I say things to her::"
32	T	°Mm°
33	S	.hh So what we now have is a picture of someone who (1.5) >even if she's agreeable
34		to do a body of work< (.) we're actually ↑always just going to be (1.0) doing that
35		dance↑ (1.0) How much do I go: (1.0) forward? How much do I pull back:? It's uh
36		about >you know< "how am I going to manage ((client name)) to make sure she's
37		okay? ↓"
38	T	Yeah:
39	S	So it's not to say that we're not going to offer her something because there may
40		very well be something that we can offer her. (.) .h um and w- we'll talk a little bit
41		about (.) how you're gonna (.) man- >you know< how to (.) how to (.) sort of um:
42		(1.0) discuss it with her. .h Um: but I think she's complex (.) i- in that way. And
43		understandably. She has a history that (.) makes (1.0) us understand why there is that
44		level of complexity.
45		Mm.
46		Um. So >you know< I'm not um (2.0) it it's no: (.) it it's not (.) um (1.0) judging her.
47		Yeah no.
48		There's not even any expectation that she should be doing anything differently.

49	T	Mm.
50	S	But what it says to us as <u>therapists</u> is "okay, <u>I've</u> got to be thinking about (.) how
51		I manage".
52	T	°Yeah°

Following this sequence, the supervisor remarks on how difficult it is to predict the level of distress the client will present with and explains the complexities of collaborating with highly distressed clients.

Analytical level one:

This sequence displays how clients were the focus of discussion and were positioned as fragile and unable to cope with distress. The client is positioned by the supervisor as easily triggered (line 2) as demonstrated by her complete unravelling (lines 11 and 13) from which she didn't recover (line 20). The repetitive positioning of the client in this way by the supervisor (lines 1-25) and the juxtaposition between how little it took to "completely unravel" the client (line 11) accentuates the client's fragility. Across sequences, the positioning of clients as fragile was either explicit or indirectly revealed through assumptions about the client's capacity to cope (see Box 1). The attribution of the client's fragility to their "history" (line 43) and "complexity" (line 44) demonstrates a pattern that was identified across sequences in which client fragility was explained according to a range of factors (see Table 3).

The trainee, in contrast, is positioned by the supervisor in a contradictory way: as responsible for managing distress in the client (lines 28-31, 34-37 and 50-51), and yet understandably unaware and powerless to contain intense distress (lines 4 and 24-25). In most sequences, the positioning of clients as fragile co-occurred with participants being positioned as responsible for managing client distress (see Box 1). More specifically in this sequence, the client is positioned as easily uncontained (lines 1-2) with the trainee then positioned as being responsible for providing containment. This reflects a broader pattern in which clients being positioned as *lacking* a particular quality (e.g., containment, hope, boundaries, stability)

was accompanied by trainees being positioned as responsible for *providing* that quality (see Box 1).

The onus on trainees to claim responsibility for managing clients' distress applied only up to a point. When clients were positioned as particularly fragile (e.g., extremely dysregulated or traumatised), trainees were then positioned as *not* being able to (nor being responsible for) containing distress. In these instances, the fragility of clients was portrayed as an enduring aspect of who they are beyond the influence of trainees (see Box 1). Analysing the sequence from the three continua across which identities are navigated (sameness-difference, agency-passivity and continuity-change), a sense of *sameness* is constructed between the supervisor and trainee through the use of collective pronouns such as "we" (e.g., line 28) and "us" (e.g., line 50). This highlights the sense of shared identity (as therapists) between the supervisor and trainee (discussed further in analytical level two); there is a sense of the two as a *therapist team*. The client then becomes *othered* from the therapists: the client is complex and fragile (as opposed to the therapist team who is tasked with managing distress) and on the *receiving* end of the service offered (lines 39-40). This established sense of a shared identity between supervisors and trainees who are then othered from clients was a pattern identified across sequences (see Box 1). Initially positioned passively as not having any influence over the client's distress (line 24-25), the trainee is then positioned alongside the supervisor (as therapists) as agentive in being responsible for managing boundaries and interactions when the client is positioned as not being able to do so (e.g., lines 34-37). This was indicative of a broader pattern in which the fragilisation of clients was associated with positioning them *passively* (i.e., under-stating their influence over themselves and the world around them) with participants being positioned as *agentive* (i.e., over-stating their influence over clients and responsibility for managing their distress) (see Box 1). Finally, the use of truisms by the supervisor when constructing the identity of the

client (e.g., line 27) creates a sense of *continuity* in the client as fixed or static in their fragility, culminating in an explicit discounting of an alternate way of being for the client (line 48). There is a sense that this is *who the client is* and *how they will stay*, which appeared to preclude *change* or progress across sequences (see Box 1).

Box 1.

Key Findings (Positioning Analysis: Level One).

- **Clients as fragile and unable to manage distress** (either explicitly labelled or implicitly suggested):
  - Explicit construction:. *"Not being able to handle that kind of mishap is very, very fragile*" (supervisor, sequence 8)
  - Implicit construction:. "*We've got to titrate how much burden we put on her for making decisions because she will find it too burdensome*" (supervisor, sequence 2)
    - **Explanations for fragility**:
      - Trauma: *"Her trauma history is the worst kind of all. Which is in the family trauma*" (supervisor in sequence 2)
      - Lack of self-esteem: *"I would say no self-esteem*" (supervisor, sequence 8)
      - Personality disorder: *"It's probably more along the borderline range….we'd need more information"* (supervisor, sequence 3)
      - Attachment style: *"Think back to that attachment which is probably more preoccupied, right? She's got that style"* (supervisor, sequence 6)
- **Supervisor and trainee role in managing distress:**
  - Responsible: "*So it's just her reaction that we are going to have to manage…I think the focus being on 'how do we stabilise?'"* (supervisor, sequence 3)
    - Client lacks X therapist provides X: *"…just trying to empower him a little bit. Because he obviously feels quite helpless"* (trainee, sequence 9)
  - Not-responsible (extreme distress): *"No matter how hard you tried to explain and re-explain and help her and try and contain her. It didn't really work…so that's just something of who she is"* (supervisor, sequence 1).
- **Supervisor and trainee (therapist team) vs client (othered):** *"So the way **we** collaborate with **her**, we've got to really think about that"* (supervisor, sequence 2).
- **Agentive therapists vs passive clients**: "*We've got to titrate how much burden we put on her for making decisions because she will find it too burdensome*" (supervisor, sequence 2)
- **Enduring fragility (continuity):** *"There's not even any expectation that she should be doing things differently"* (supervisor, sequence 1).

No single sequence exhibited all findings and there are therefore some findings not described in the above detailed text analysis. Most notably at the first analytical level, clients were positioned as agentive (with a recognition of their capacity for influence over their own experiences) with the capacity for change in some sequences despite the predominant positioning of the client as being passive. For instance, acknowledging the clients' actions as maintaining or exacerbating distress (sequences 4, 6 and 11) and recognising client progress and resilience (sequences 4 and 7) both functioned to position the clients in a way that acknowledged their agency and capacity for change.

Analytical Level Two

In the sessions, trainee participants occupied two identity positions: novice therapist (accessing supervision to guide clinical work) and student (being assessed by supervisors). Likewise, supervisors occupied two identity spaces: the experienced therapist (guiding and developing clinical skill) as well as assessor (determining whether trainees meet requirements of the placement). Intuitively, these identity spaces carry with them unique objectives and influence the ways in which each speaker approaches the interaction.

Amid this broader context, the sequence in Excerpt 1 occurred after the supervisor declared she would offer her perspective on the client in focus. The supervisor claims for herself a position as knowledgeable and sufficiently informed to offer insights regarding the client (lines 1-2). Across sequences, supervisors positioned themselves as wiser and knowledgeable about *how to be* and *how to do things* as a therapist and were found to be the primary narrators (i.e., speak more than trainees) across sequences (see Box 2). As the primary narrators positioning themselves as more knowledgeable, supervisors typically - by extension - assigned trainees into positions as less knowledgeable (see Box 2). This is evident in Excerpt 1 through the supervisor's delivery – or *how* she speaks to the trainee - which is characterised by a prolonged monologue delivered *at* the trainee (assigning the trainee to a

passive, listening position). In contrast, the trainee's minimal contribution with single word responses indicates agreement (e.g., "yeah" or "mm") without resisting the position being made available to them by the supervisor; a finding that occurred across sequences (see Box 2).

Yet, a closer examination of *what* the supervisor says to the trainee reveals a contradictory positioning of the trainee. The supervisor positions the trainee on a more equal level through a constructed shared identity as therapists (line 50) through the frequent use of pronouns "we" and "us" (see Box 2). This use of pronouns was generally ambiguous and it was unclear whether it referred to *the therapist* as being both the supervisor and trainee (inclusive) or the supervisor or trainee only (exclusive). Our analysis suggested that these pronouns were used in the inclusive sense, and that this functioned to demonstrate a sameness between supervisors and trainees. There was a sense of shared identity - *we as therapists* - which communicated (and invited the trainee to adopt) a particular therapist identity shared with the supervisor in a way that masks power differentials between the supervisor and trainee.

As the primary narrator, it is the supervisor in Excerpt 1 who is accountable for instigating and maintaining the positioning of the client as fragile and therapists as responsible for managing client distress. This pattern was identified across sequences (see Box 2). That is, trainees themselves rarely instigated the positioning of clients as fragile (and where this did occur it occurred in sequences where supervisors likewise positioned the clients as fragile). On no occasion did trainees contest supervisors' positioning of clients as fragile.

Box 2.

Key Findings (Positioning Analysis: Level Two).

- **Supervisors as primary narrators:**
  - **Positioning themselves as knowledgeable:** *"Maybe just give me a sense of what you've taken from what I've said? What your thoughts are?"* (supervisor, sequence 3) and use of monologue, repetitive questioning, redirection or correcting trainees.
  - **Positioning trainees as less knowledgeable:** *"And almost unbeknownst to you"* (supervisor, sequence 1).
    - **Trainees agreeing with supervisors:** Use of minimal responses *"Yeah" "Mm" "Yep"* by trainees signalling agreement with supervisors across sequences.
  - **Positioning clients as fragile:** See Excerpt 1 as an example.
- **Shared identity between supervisors and trainees (using pronouns):** *"So the way we collaborate with her, we've got to really think about that"* (supervisor, sequence 2)

Deviant Interaction: Fragilisation of clients generating a re-characterisation of therapist identity

Below we analyse another sequence (Excerpt 2) as an example of a discrepant case using Bamberg's (2020) first two levels of positioning analysis. We purposefully searched for a sequence that deviated from our main finding to display the variation in data collected and to increase the transparency and credibility of our results.

The following interaction (Excerpt 2, Table 6.5) occurs between a supervisor (S: female, over 46 years old) and a trainee (T: male, 20-25 years old).

Table 6.5

Excerpt 2. Deviation from main finding

This sequence occurs after the trainee asks the supervisor whether she watched the recording of his session with a client and the supervisor says she has not. The trainee then states how "directive" he was in the session whilst nervously laughing (after having been critiqued by the supervisor for avoiding the client's distress), before disclosing his "need" come in and "rescue" the client.

1	T	But I I just >I don't know< I felt this need to: (.) >I mean maybe it's just because he's
2		vulnerable and you want to come in and help him and resc -
3	S	[Mm::]
4	T	- But .h just like (0.5) this need to:: (1.0) that l- like this cycle of <u>failure</u>↓ (1.0) that he
5		feels that it defines him (.) >and that it's constant< .h I just kind of wanted to make a
6		point that 'it- it doesn't (.) it doesn't <u>have</u> to define you↑' –
7	S	Mm.
8	T	- like 'the cycle can be broken'.
9	S	Mm.
10	T	Like 'it doesn't (.) doesn't have to be set in stone' and that (.) >you know< 'there are
11		things you can do↑'. (1.0)
12	S	And how do you think he received that?
13	T	Uh (1.0) well (.) he got <u>very</u> emotional.
14	S	Mm:
15	T	He got very (.) he got a lot (.) quite teary. Sort [of like] –
16	S	[Right::]
17	T	- probably the <u>most</u> teary, actually.
18	S	What did you [say] -
19	T	[Um]
20	S	- °in response to that°?
21	T	I said:: (3.5) I think I- I- I noted it. (1.0) And I said 'you know what what what >you
22		know< what's what's going on for you?' And he said (1.5) >°I can't remember° I
23		think he said< I think he said 'I'm just absorbing the wisdom from ((trainee first
24		name and last name)) or something' -
25	S	Right::
26	T	It was a bit (.) bit odd.
27	S	Yeah. So –
28	T	- [I I -]
29	S	- [in some] ways you would be the <u>antithesis</u> of what he experiences in himself (2.0).
30	T	M::aybe:: (1.5) Mm. (.) I- I just I caught myself doing it. (1.0) I don't I don't think it'll
31		end <u>badly</u>. (0.5) And I think he'll probably go away and reflect on it.
32	S	Mm mm.
33	T	So I think it had the desired effect↓ (.) I just don't know if it's appropriate↓. (1.0)

34	S	°Mm°
35	T	Cause you kinda - you kind of do need to say it. (.) Like (.) I guess he we can come to
36		it (.) but you kind of need to (.) to put that spark ((trainee clicks fingers)) in there↑.
37		This (.) just this little idea for him to chew on over the next week -
38	S	Mm
39	T	- that 'it doesn't have to be this way' (.) like 'you can change it↑'.
40	S	Mm.
41	T	Just trying to empower him a little bit (1.0) because if he obviously feels (.) quite
42		helpless.
43	S	Mm. Well it sounds like you feel are feeling quite helpless too. You needed to (.) -
44	T	Mm
45	S	- give him some instruction.
46	T	Mm. I think so (.) yeah.

Following this sequence, the trainee nervously redirects the conversation by more broadly reflecting on his uncertainty about how to conclude sessions with clients.

Analytical Level One

The client and the trainee – and their reactions to each other – both feature as the focus of discussion. In this sequence, it is the trainee positioning the client as fragile: the client is positioned as vulnerable (lines 1-2), stuck in a cycle of failure (line 4), teary (lines 15 and 17), and helpless (lines 41-42). This occurs alongside the trainee positioning himself as wanting to 'help' and 'rescue' the client (lines 1-2). It is less clear how the supervisor positions the client; she consistently engages minimally (lines 3, 7, 9 and 14) in response to the trainee's positioning of the client as fragile. Instead, she uses questioning (lines 12 and 18) to elicit the trainee's perception of and response to the client before ultimately positioning the trainee as helpless (line 43). She is focussed on the trainee specifically and re-constructs the narrative: rather than the client being helpless (as positioned by the trainee), it is in fact the trainee who is feeling helpless. At no point does the supervisor reinforce the trainee's position of wanting to 'help' or 'rescue' the client.

This sequence reveals variations from our main finding in how identities are constructed along the continua of sameness-difference, agency-passivity and continuity-change. There is no sense of *sameness* or shared identity as therapists between the supervisor and trainee; there is no 'we' or 'us'. Rather, sameness exists between the trainee and client: both feel helpless (lines 41-43). This contrasts with the trainee's initial attempts to position himself as some sort of hopeful cheerleader (and therefore *different* from) the helpless client. There is a constructed difference between the trainee and the client: the client is positioned as perceiving the trainee as the "antithesis" of himself (line 29) and the trainee distances himself from the client by ridiculing his "odd" behaviour (line 26). Initially, the trainee positions the client *passively* (stuck in this cycle of failure: lines 4-5) and claims for himself an active or *agentive* position: 'helping' and 'rescuing' (line 2) presupposes the trainee has influence over the client's experience. However, the supervisor exposes this as untrue: by constructing the trainee as feeling helpless she re-positions him *passively*. Furthermore, he goes on to accept this position (line 46). We therefore see the agentive position being claimed by the trainee (responsible for 'helping' and 'rescuing') in response to the passive positioning of the client (stuck in their own fragility) being re-constructed by the supervisor as a defence against the trainee himself feeling helpless. This suggests an inconsistency: although the trainee outwardly positions the client as capable of *change* (lines 4-6), it exposes a concealed fear that the client will *continuously* remain in this cycle of despair. In *what* the trainee says, he appears hopeful that this is not who the client is and that things can change. Yet his need to intervene is being constructed by the supervisor as indicative of the opposite: of the trainee's sense of hopelessness that things cannot change.

Analytical Level Two

Excerpt 2 occurred 31 minutes into the supervision session following an earlier sequence in which the trainee was questioned about his discomfort tolerating the client's

distress. As in Excerpt 1, the supervisor claims for herself a position of knowing although *how* she executes this differs. Initially, she establishes an interactional dynamic in which she takes authority to ask questions (lines 12 and 18-20) and explore the trainee's understanding of himself. This moves the trainee into an active role; minimal engagement is not perceived as an option and he must respond. Further on, she shifts to the use of truisms (lines 29 and 43-45) and re-categorises the identities of both the client (as the antithesis of the trainee) and trainee (as feeling helpless). She positions herself as a knowledgeable outside observer and conveys to the trainee *who he is* and *who the client is*. There is limited invitation for the trainee to respond and restricts scope for the trainee to accept or contest these constructed identities.

What is notable is that the trainee accepts this construction of himself as helpless (line 46), which stands in contrast to his earlier positioning of himself. The trainee's positioning of himself fluctuates across the sequence: initially he positions himself as wanting to help and rescue the client (lines 1-2), being hopeful and cheerleading the client (lines 4-11), confident and yet also unsure about his actions (lines 30-33), and then ultimately as feeling hopeless (line 46). That is, he takes up the identity position being made available to him by the supervisor.

6.6 Discussion

To explore the construction of professional identities of clinical psychologists in supervision interactions, we audio recorded supervision sessions and analysed sequences in which clients were positioned as fragile using positioning analysis (Bamberg, 2020). Assembling the above findings demonstrates how the identities therapists make available for clients and claim for themselves are interrelated and actively constructed and re-constructed within educational supervision settings. An outline of what transpires through this process reveals that the fragilisation of clients by trainees and supervisors co-occurs with them

claiming identities for themselves characterised by assuming responsibility for managing client distress. This invites a broader conversation regarding *what* professional identities clinical psychologists claim for themselves as therapists and *how* socialisation into the profession through supervision impacts this; that is, the precise questions explored in the third analytical level of Bamberg's positioning analysis (Bamberg, 2020). Below we interpret the results through this analytical lens alongside a review of broader theories and literature.

Perpetuating Paternalistic Discourses: What identities therapists make available to clients and claim for themselves

The fragilisation of clients co-occurring with trainees and supervisors claiming identities responsible for managing distress was interpreted as perpetuating paternalistic clinical discourses that legitimises a professional identity for therapists. Paternalistic care is characterised by a well-meaning attitude of knowing better ("we know, you don't") and over-protection by the care provider (Fernández-Ballesteros et al., 2019; Gallagher, 1998; Szerletics, 2015). What is problematic is not the benevolent intent but the consequences of over-protection that can infringe on autonomy and self-determination (Fernández-Ballesteros et al., 2019; Szerletics, 2015). In this way, paternalism jeopardises person-centered recovery oriented care that is client-centered, built on equal partnership, and facilitates self-determination and empowerment (Leamy et al., 2011; Slade et al., 2014). We also contend that the fragilisation of clients in which they are presumed to need over-protection (due to being unable to manage their own distress) functions in a way that legitimises a role for therapists in managing distress. That is, assumptions about the other (client) and the self (therapist) enable therapists to create and makes valuable a role for themselves both in specific interactions but also collectively as a profession (de Fina et al., 2006). Simply put, therapists can only exist in so far as there are clients requiring the services of therapists. Therapists exist because clients do (Schrewe et al., 2017).

Although 'strong' paternalistic care (acting *against* the wishes of a person) is now widely considered obsolete (Breeze, 1998; Charles et al., 1999; Thomasma, 1983), 'weak' paternalism (acting in the *presumed* best interest of a person) endures across a range of healthcare settings (Coulter, 1999; Driever et al., 2022; Elger et al., 2015; Hayashi et al., 2000; Juliá-Sanchis et al., 2019; Upton et al., 2011). Driever et al. (2022) found that paternalistic attitudes in medical trainees were associated with beliefs about being *responsible* for determining the *correct* diagnosis to provide the *best* evidence-based treatment. This reflects the privileging of scientific evidence, reinforces the idea that there is one (correct) approach, and steers trainees towards paternalistic care by undervaluing the patient's own expertise (Driever et al., 2022). Further, this is consistent with evidence indicating medical trainees hold assumptions about (and are motivated to acquire) the uniform 'good doctor' identity (Bennett et al., 2017; Whitehead, 2011). In our study of interactions away from the client, supervisors occupying positions of *knowing* implies expertise; it foregrounds technical expertise, models a hierarchy of knowledge, and potentially communicates what is expected of a 'good therapist'. The propensity for healthcare trainees to convey competence and what they consider to be desirable professional identities is widely documented (Gordon & Luke, 2012; Lingard et al., 2003; MacLeod, 2011). We suggest that as learners, trainees witness the ways of knowing that supervisors prioritise, potentially uptake these ways of knowing either to demonstrate competence or through curiosity to learn and become 'good therapists', and in doing so come to privilege institutional 'truths'. This risks undervaluing other ways of knowing and forms of expertise (including client's own expertise about their experiences; a critical priority for person-centered care that gives credence to knowledge derived from lived experience of distress (Leamy et al., 2011; Slade et al., 2014) and functions to maintain and perpetuate the status quo.

Paternalistic discourses and constructing clients as fragile undermined the agency and self-determination of clients in our study. Clients were positioned as being stuck or without potential for change. This co-occurred with therapists assuming agency and occupying positions of needing to *do* something to clients to contain distress (provided the distress was manageable). This reflected an action orientation or readiness to intervene. Elsewhere this has been associated with therapist discomfort and an intolerance of uncertainty (Binyamin, 2021; Schubert et al., 2021). This is not to suggest that an action orientation is inherently problematic; there are times when 'doing something' is clinically indicated. We do suggest, however, that compulsions to intervene arising from therapist's *own* discomfort pertaining to their sense of professional identity was problematic as it was geared at alleviating *their* discomfort rather than arising from clinical need. In terms of reforms, assumptions about needing to intervene to *treat* symptoms, as well as the absence of hope and optimism for a person's capacity for personal recovery, are most certainly at odds with reform priorities (Leamy et al., 2011). Supervisors can therefore play an active role in challenging this action orientation in trainees as seen in our second excerpt; although this gives rise to additional complexities associated with a lack of congruence between the supervisor's positioning of the trainee and the trainee's authoring of themselves (Brown et al., 2020).

Maintaining the Status Quo: *How* therapist identities are re-created and preserved

Our analysis demonstrated *how* client focussed supervision interactions influenced and constrained the identities trainees can claim for themselves as therapists. This process was neither immediate nor independent of the relational space (Schrewe et al., 2017). Trainees learn *from* the talk of supervisors as well as learning *to* talk as therapists (Lave & Wenger, 1991). It is through this socialisation process that professional norms about *who therapists are* are reproduced and renegotiated. Indeed, this has been observed across a broad range of healthcare education settings (Binyamin, 2018; Brown et al., 2020; Schrewe et al.,

2017). As trainees progressively establish ways of making sense of clients as fragile through recurrent interactions in supervision, the contours and foundations of how they make sense of themselves (i.e., their own professional identities) came in to focus (Schrewe et al., 2017) Over time these were ultimately reproduced in discursive constructions of clients as fragile. And the cycle continued.

Our close inspection of language illuminated the nuances of how this was achieved. The construction of a sense of shared identity *as therapists* between supervisors and trainees through the use of pronouns was one way in which professional identities were negotiated. Elsewhere, the use of "we" by health educators to socialise novices into caring professions has been documented (Gordon & Luke, 2016; Newman et al., 2016; Rees & Monrouxe, 2008). Gordon and Luke (2016) noted that counselling supervisors use "we" to mean "you (the trainee) and I, as members of the profession" to invite counselling trainees into a community of practice. This is comparable to our finding of how supervisors use "we" to establish a sense of a therapeutic team (level 2). Supervisors employ "we" multifunctionally: to construct a sense of professional sameness, and orient and invite trainees into the professional field and the identity of being a clinical psychologist. In addition, we found that supervisors position clients as fragile (level 1), position trainees as responsible for managing distress (level 1) and position themselves as more knowledgeable about professional norms and about how to be as a therapist (level 2). Taken together, this revealed how assumptions about clients as fragile and identities for therapists characterised by claiming responsibility for containing distress were transmitted to future generations of clinical psychologists. It demonstrated how relational interactions in educational institutions play a critical role in perpetuating paternalistic clinical discourses.

Critically, this was a co-construction in which trainees were active participants. Professional identity construction was not something that only happens *to* people as a result

of wider social forces shaping and colonising them. Nevertheless, our findings indicated that trainees rarely contested the positions being made available to themselves and clients by supervisors, and that supervisors predominantly initiated the construction of clients as fragile. *Co*-construction does not equate to an *equal*-construction (de Fina et al., 2006). Supervision interactions occur within educational institutions and are therefore inherently bound up in complexities deriving from institutional power (Benwell & Stokoe, 2006). Supervisors – as representatives of educational institutions – occupy positions of power and are able to dictate terms of knowledge regarding what it means to act and be as a therapist, as well as how clients are to be understood and made sense of (Benwell & Stokoe, 2006). Although power can be contested and resisted (Rees et al., 2013; Rees & Monrouxe, 2010; Shaw et al., 2018), we found that trainees typically accepted ways of knowing put forward by supervisors. In Excerpt 2, we demonstrated how a trainee's sense of himself (i.e., his professional identity) was re-negotiated in response to the supervisor's challenging of his understanding of himself. That was, in enacting her power the supervisor challenged and transformed the trainee's understanding of himself, and (although he could) he did not challenge this but instead self-authored his professional identity in a way that was congruent with how he was being positioned by the supervisor. It was in and through these institutional interactions that power was exercised, ways of knowledge were reproduced, and trainees acquire (through adopting or resisting) ways of understanding themselves and their own professional identities.

Limitations and Strengths

Our study had several limitations and strengths. We acknowledge that our data and findings had been drawn from one university training clinic which cautions against assuming generalisability or transferability. Social constructionist research makes no truth claims, yet we do argue that supervision in this context is likely to have similarities with other clinical contexts particularly related to the provision of mental healthcare services. Further, the

interactions analysed were select excerpts from broader supervision interactions and were therefore not indicative of supervision as a whole. Finally, it was not our intention to suggest that paternalistic clinical discourses were the *only* discourses shaping and being shaped within supervision. We consider our interpretative direction of the data as one of many potential directions. We also acknowledge that our discussion of paternalism was restricted to clinical care but that the benevolent intentions of supervisors to impart wisdom onto trainees could also be interpreted through this lens. This warrants further investigation. Methodologically, our focus on integrating close-text analysis *and* broader social discourses overcomes criticism of social construction research that focusses on either exclusively (Benwell & Stokoe, 2006; Burr, 2015). The interdisciplinary nature of the research team allowed us to integrate theoretical perspectives (e.g., social constructionism, socialisation and professional identities) into the profession of clinical psychology – a specialist professional group in the provision of mental healthcare services – that otherwise tends to focus research on clinical interventions. The diverse nature of the research team meant researcher assumptions were contested and challenged to increase the robustness of our results. Our research also extends emerging literature highlighting how healthcare workers professional identities are contingent upon how they construct their identities of their clients and patients (Schrewe et al., 2017).

Implications for Education and Clinical Practice

We have demonstrated how interactions between supervisors and trainees entail more than the exchange of information; trainees *become* therapists in supervision. Clinical supervision was an interactional site in which identity work happened; trainees' professional identities were created and re-created through talk with supervisors (Elsey et al., 2017; Elsey et al., 2014; Goldie, 2012; Monrouxe et al., 2009; Rees et al., 2013; Rees & Monrouxe, 2010; Tracy & Robles, 2013). Supervisors and educators need to acknowledge the *productive*

potential of their interactions (Foucault, 1972; Giddens, 1981): professional "truths" and norms that they communicate and enact serves to shape trainees' emerging professional identities. More precisely, clinical psychology supervisors must be aware of the *specialty-specific* norms and discourses within the profession that frame clinical education (Cantillon et al., 2022). Rather than trying to 'improve' education and 'teach' professional identity, critical engagement with profession-specific discursive practices is required to observe, understand and shift unwanted norms in education settings (Cantillon et al., 2022; Skoura-Kirk, 2022). In particular, positioning distressed clients as fragile – despite benevolent intentions – is at risk of inadvertently re-producing paternalistic approaches as trainee's internalise ways of understanding clients and themselves.

As professional representatives, supervisors need to appreciate the position of power they occupy (Benwell & Stokoe, 2006). Supervisors enact power each time they persuade and elicit cooperation from trainees into profession-specific sanctioned ways of knowing and behaving (Foucault, 1972). Although this is not something to be *overcome* per se, supervisors need to recognise the positions of power they occupy and learn how this might be relinquished or transferred over to trainees depending on trainee readiness (Brown et al., 2020). All of this suggests that explicit and intentional efforts are required by educators to facilitate identity transformations that align with policy reforms. It cannot be left to chance and requires more than "teaching" professional identity (Cruess et al., 2014; Jarvis-Selinger et al., 2012; Rees & Monrouxe, 2018). A critical stance and attention to discursive practices is required by educators alongside efforts to enquire and explore sense-making with trainees about oneself and clients in ways that align with reform priorities. Collaborative reflection to support self-inquiry (Binyamin, 2018), use of the conversation analytic role play method (CARM) to reflect on conversations and identity construction (Stokoe, 2014), and video

reflexive ethnography (Iedema et al., 2015), represent examples of strategies educators may utilise in training settings to this end.

How insidiously paternalistic clinical discourses are perpetuated across generations of therapists invites a critical reconsideration of the ways therapists understand clients and themselves (de Fina et al., 2006). Undoubtedly, clients present to therapists distressed and yet, as clinicians, it is worthwhile considering *other* ways of making sense of and responding in such situations. Shifting away from paternalistic care towards a person-centered recovery approach necessitates therapists to prioritise clients' active participation in decision making, empowerment, agency, autonomy and valuing of lived experience expertise (Tambuyzer et al., 2014); that is, all things that are *not* consistent with positioning clients as fragile. Assuming clients are unable to tolerate distress risks overshadowing aspects of client identity that align with recovery-oriented reform priorities: focussing on strengths and expertise and the inherent capacity of a person to recover (irrespective of their distress), and assuming capacity for (and promoting) full participation in all aspects of recovery as well as choice and self-determination (Farkas et al., 2005). If therapists recognise these attributes in clients, it partly dismantles a professional identity for therapists bound up in needing to be responsible for *doing* something in the perceived best interests of distressed clients because of perceptions of what a 'good therapist' should do. The identities of clients become foregrounded with assumptions about their agency, capacity of change and expertise regarding their recovery. Indeed, the dilemma of balancing clinical care responsibilities without adopting paternalism is not new in the field of healthcare ethics (Fernández-Ballesteros et al., 2019; Thomasma, 1983), and yet clinical psychologists – and clinicians in mental healthcare settings more broadly – require thoughtful reconsideration of the identities they construct for themselves and their clients when they present in distress. We suggest that these findings are applicable across a range of healthcare professions working in mental

healthcare settings, particularly those involved in the delivery of therapeutic interventions (e.g., psychiatrists, social workers etc.).

Conclusion

Education in its broadest sense is about the transformation of the self into new ways of relating and thinking (Goldie, 2012). We have shown how the process of sensemaking about oneself as a therapist is interrelated with how trainees are socialised into constructing the identities of their clients in supervision encounters, and how benevolent intentions and existing professional norms can unwittingly perpetuate paternalistic models of care that deviate from directions in mental healthcare reforms. We already know that the professional identity of clinicians has important implications for clinical practice and that these identities are formatively shaped in interactions within educational institutions (Monrouxe, 2010). It is now time for an intentional and critical engagement with the ways in which discursive practices in education and supervision settings create and perpetuate professional identities, and the extent to which this aligns with directions in mental healthcare services. Reform literature almost exclusively focusses on *what* is required from clinicians in these settings. Yet a focus on education and socialisation into mental healthcare professions - like clinical psychology - offer an avenue for understanding *how* future generations of healthcare professionals can be supported to acquire professional identities that align with mental healthcare reforms.

Chapter 7: General Discussion

To introduce this final chapter, I revisit why exploring the professional identities of clinical psychologists matter and the aims of this research. I then present an overview of the approach to the research and research findings before discussing implications for the profession, research, and educators in clinical psychology. Finally, I discuss the limitations and strengths of this research, and offer some final thoughts. Rather than offering a final word on the matter, my hope is that this section will initiate a critical reflection and invite fruitful conversations about the professional identities of clinical psychologists. For ease of reading, I refer to the individual studies included within this thesis in the order in which they are presented.

7.1 Why Should We Care About Clinical Psychologists' Professional Identities?

The professional identities of clinical psychologists refers to their *sense of self* as a professional and enables them to make sense of who they are and want to be in a professional context (Monrouxe, 2010). The professional identity literature across healthcare professions tells us that our professional identities matter across personal, interpersonal and professional levels (Cornett et al., 2022). More specifically, the importance of health care professionals' professional identities spans issues such as performance and clinical conduct, wellbeing and burnout, difficulties working in interprofessional contexts and so on (see 'Literature on Professional Identity within Healthcare Professions' section in Chapter 2, page 67). The recognised importance of professional identities is reflected in the rapid growth in research exploring this topic across health care professions culminating in a recent proliferation of reviews on the topic (e.g., Cornett et al., 2022; Rasmussen et al., 2018; Snell, 2020; Volpe et al., 2019; Wyatt et al., 2021). This literature tells us that – for better or worse – professional identities do matter (Rees & Monrouxe, 2018). What is notable in this literature, however, is

the comparatively underdeveloped research in clinical psychology and mental health specifically.

My scoping review (Study 2) identified that the literature base exploring professional identities in clinical psychology is underdeveloped, poorly theorised and characterised by quality issues. A lack of robust exploration of clinical psychologists' own professional identities is unsurprising given the longstanding critique that therapists – including clinical psychologists – privilege an examination of the *other* rather than of themselves (Orlinsky, 2020). Indeed, the very essence of clinical psychologists' work revolves around intimately knowing the *other* (clients) and building therapeutic relationships in which their identities become more and more visible. Arguably, therapists – including clinical psychologists – have done themselves a disservice. What they have overlooked is that any understanding of the *other* (clients) necessitates and arises out of an understanding of the *self* (as clinical psychologists; Schrewe et al., 2017). Quite literally, clinical psychologists only exist in so far as their clients do.

7.2 Research Aims and Approach

The aims of this research evolved over time and reflect the empirical and theoretical journey taken over the years I completed this PhD alongside my training, registration and endorsement as a clinical psychologist. My initial aim was to explore clinicians' professional identities in a public youth mental healthcare setting, and how their professional identities were transformed by the implementation of Open Dialogue as a model of care (Study 1). When the findings of this study indicated aspects of clinicians' professional identities were discipline specific and influenced their ability and readiness to implement ways of working that align with mental healthcare reform priorities, the primary aim of the PhD became the exploration of the professional identities of clinical psychologists. I then reviewed the empirical literature available investigating the professional identities of clinical psychologists

and assessed the quality of this literature (Study 2). With this review indicating that the literature in clinical psychology is under-theorised and characterised by quality issues, and with education settings identified as formative in influencing professional identity construction, the focus of this PhD shifted towards exploring professional identity construction in in-situ supervision encounters in training settings (Studies 3 and 4). The purpose was to gain insight into how and in what ways notable interactions (e.g., interrogations) influence professional identity construction (Study 3), and the nexus between clinical psychology trainees' professional identity construction and the positioning of clients (Study 4).

This research explored identities from a social constructionist epistemological framework and drew on the theoretical tenets of symbolic interactionism (see 'Epistemology and Theory' section in Chapter 1, page 34). I understood identities as being negotiated within the social world through the use of language, with assumptions that people have the capacity to construct identities for themselves and others, *and* that power and societal discourses construct people (Burr, 2015). This approach overcomes the problematic dualisms between strictly *micro* versus *macro* social constructionist approaches (see discussion of this distinction in Chapter 1, page 36). This discursive lens through which to view identities meant the focus of the research was both on the *what* – the particular characteristics of clinical psychologists' professional identities – as well as the *how* – the ways in which clinical psychologists acquire and renegotiate their professional identities. Moreover, identities were considered as being inherently intertwined with the ongoing and dynamic process of *identification* – a process both constrained by wider social discourses *and* something we agentively do – as we continuously create and recreate our understanding of who we are. This understanding reflects a divergence from how identity is conceptualised within psychological and social theories (see 'Theorising about Identities' section in Chapter

2, page 54), and opened up a rich theoretical space from which to explore clinical psychologists' professional identities.

Within this framework and as the interdisciplinary makeup of the supervisory team expanded, my assumptions and ideas were continually challenged and constantly evolving. A critical approach was adopted which drew on ways of knowing from across different professions, research areas and theoretical perspectives, which ultimately contributed towards progressing a research topic that is under explored within clinical psychology compared to other healthcare professions (Cornett et all., 2022). This required approaching different perspectives (including my own) as just that: a *perspective* rather than a *truth*. The findings reviewed below are best considered in this light.

7.3 Summary of Findings

Presented below is brief summary of the findings from the studies included within this thesis. The findings are then discussed in relation to the existing literature in the next section of this chapter.

Study 1 involved an exploration of the transformation of professional identities of clinical psychologists, psychologists and psychiatrists implementing Open Dialogue in a public youth mental healthcare setting. The results indicated that clinicians' professional identities were multiple and contrasting, and integrated with their personal identities. Clinical psychologists and psychologists focussed on the technical aspects of therapies they were able to deliver, although this occurred alongside a co-existing uncertainty about the expectations of their role and their limitations on helping. Clinicians saw Open Dialogue as a way to work differently in a predominantly medicalised mental healthcare system, although there was also a sense that Open Dialogue compromised their professional identity by threatening expertise and requiring vulnerability that was perceived to be professionally discouraged. With Study 1 demonstrating the impact that professional identities can have on clinical psychologists'

willingness to implement mental healthcare reforms, this research shifted to exploring the professional identities of clinical psychologists more broadly.

Study 2 involved a scoping review of qualitative literature exploring clinical psychologist's professional identities. Findings were organised thematically around three themes: 'integration of personal and professional identities', 'intersectionality' and 'changes in professional identities over time'. The results suggested clinical psychologists' personal and professional identities are interconnected, intersect with other identities (with notable implications for those outside of the hegemony), and change over time, but that the research base is underdeveloped and characterised by research quality issues. The scoping review revealed that educational settings are formative in shaping professional identity construction, but that professional identity is thought to be inadequately considered within education settings and the profession itself. Studies 3 and 4 subsequently shifted to focus on clinical psychologists' professional identity construction during supervision encounters in university training clinics.

Study 3 drew on theories of positioning, framing and impression management to explore identity construction during supervisor-initiated interrogations. The results identified that supervisors approached interrogations from either a quality control or reflective frame, but often defaulted back to quality control. The frame through which supervisors approached supervision influenced what identities trainees constructed for themselves; that is, how supervisors approached interactions with trainees actively constrained the professional identities trainees acquired. When trainees were the focus of interrogations supervisors were able to draw on their position of power to forefront the private experiences of trainees, with trainees displaying a range of ways in which they adopt or resist the identities being made available to them by supervisors. Client focussed interactions often reinforced positions of supervisors as more knowledgeable, which ultimately then constrained opportunities for

trainees to acquire independent ways of understanding clinical work. Collectively, the findings displayed how supervision constrains the identities trainees can take up for themselves; ultimately creating and constraining professional identity construction.

Study 4 focussed on supervision encounters in which clients were positioned as fragile. This co-occurred with clinical psychologist's claiming identities comprised of being responsible for containing distress by actively *doing* something to or for clients. Supervisors played an active role in positioning clients as fragile in a way that rendered them passive with a sense of ongoing or enduring fragility, and yet trainees rarely contested the positioning of clients in this way. The findings reveal how positioning clients as fragile perpetuates paternalistic clinical discourses that do not align with clinical reform priorities and how these institutionalised ways of knowing are reproduced and passed down through supervision.

Evidently, the professional identities of clinical psychologists matter for them as clinicians, as well as for their clients and the provision of mental healthcare clinical services. It seems timely that clinical psychologists open themselves up to consider from a critical perspective who they are and want to be, and how tomorrow's clinical psychologists might be supported to acquire professional identities that align with mental healthcare policy reforms and directions. Being intentional and aware with regard to supporting tomorrow's clinical psychologists to acquire professional identities that support and enable the implementation of mental healthcare reform priorities is important. Reflections and considerations for research, education and clinical practice arise and are presented below.

7.4 Moving Forward: Reflections and considerations

These findings invite a wide range of reactions for the profession at large, and for researchers and educators. These reflections and considerations are offered with three disclaimers. First, I make no claims that what comes next is *truth*. This is but one perspective (out of many potential perspectives). Second, if there is no one *true* way, then there cannot be

a *right* way. And if there is not a right way then there cannot be a *wrong* way. Critically shining the spotlight on issues within the profession in these reflections is not commensurate with accusing the profession of being or doing something wrong. Rather, the hope is that this offers a new perspective; a different lens through which clinical psychologists might consider themselves, their profession, and the direction in which they wish to head. Third, the temptation towards *solutionism* – the tendency to dive headfirst into simple solutions before understanding problems that often do not have benign solutions – needs to be resisted (Ajjawi & Eva, 2021). Much of what follows is focussed on raising further questions that are going to be effective in the long run, rather than providing simple and superficial solutions that – in the end – are going to be of little use. This section outlines some considerations for the profession of clinical psychology, researchers exploring professional identities, and educators involved in supporting the professional identity construction of tomorrow's clinical psychologists.

7.4.1 For Clinical Psychology: What now for the profession?

Conceptualising a *profession* as an occupation with a sanctioned body of knowledge that provides an intellectual base for practice and through which the profession claims power over ways of knowing (Lancaster & Smith, 2002; Weissman, 1984) reminds us that clinical psychology as a profession is *not* neutral: it is inherently political and tied up in notions of power (Benwell & Stokoe, 2006). Such an approach moves us away from a simplistic focus on professional *traits* towards professional *power* (Macdonald, 1995), and encourages us to shift the lense away from the *other* and onto *ourselves*. Indeed, this has been a repeat criticism of therapists including clinical psychologists: the focus is most often on clients without adequately considering who therapists themselves are and the implications for this on therapeutic change (Orlinsky, 2020). What follows is an invitation for the profession to consider a different perspective; to be willing and curious so that clinical psychologists might

increase their awareness of their own identities and why this might matter. It is time to ask some difficult questions: how and in what ways does clinical psychology privilege expertise and certain ways of knowing? Does clinical psychology inadequately consider intersectionality and overlook the diverse identities and experiences within the profession? Have clinical psychologists become detached from the broader mental healthcare system of which they are a part? And, of course, for all these questions: why does this matter?

7.4.1.1 Privileging Expertise and Competence

A perceived sense of oneself as a clinical psychologist as someone who should display competence and expertise arose in the findings of all studies, albeit in different ways. This is consistent with the literature across other healthcare professions identifying dominant discourses surrounding *competence* in supervision and training settings (e.g., Gordon & Luke, 2012; Lingard, 2009; Lingard et al., 2003; MacLeod, 2011). Competence discourses are understood as referring to the technical aspects (knowledge and skill) of being healthcare professional (MacLeod, 2011). At first glance, clinical psychologists positioned themselves as competent by fore-fronting technical expertise and knowledge about therapies to *deliver* (Studies 1, 2 and 3). There was also a sense of competency involving the *doing* of something to clients to effectively contain client distress (Study 4). Yet, there appeared to be evidence of a discomfort around not always being to uphold such an ideal: anxiety about needing to *know what to do* and discomfort with not being able to admit to *not knowing* was identified (Studies 1 and 2). An impossible situation thus arises: admitting to not knowing is vulnerable (threatening expertise) *and* perceived expectation to assume a knowing stance (claiming expertise) is an impossibly high standard that invokes anxiety (Studies 1 and 2). In a similar way, competence discourses in medicine that privilege evidence based practice as gold-standard require that humanness and imperfection be made less visible (Goldenberg, 2006). What my research demonstrates is that this cannot be understood outside of clinical

psychology training contexts (Studies 3 and 4; discussed further on in this chapter). Trainee clinical psychologists position themselves as competent and conceal aspects of themselves that disrupt this impression of themselves (Study 3), and when working with distressed clients claim positions which necessitate a level of expertise in containing client distress (Study 4). This latter point about education and socialisation processes is discussed further on in this chapter.

It makes sense that clinical psychologist's privilege certain ways of knowing. The legitimacy of any profession rests on its distinctiveness and ownership over ways of knowing (Weissman, 1984), with clinical psychologists required to enrol in specialised postgraduate courses to acquire distinct knowledge made only available to them. Displaying competence allows clinical psychology to claim distinct technical expertise, differentiate itself from other professions, and provides clinical psychologists a way to define themselves (Weissman, 1984). Clinical psychology's emphasis on the science practitioner model is noteworthy here: the sanctioned knowledge base in clinical psychology is evidence-based and empirically verified *truths* (see section on 'Ways of Knowing' in Chapter 1, page 21). It is perhaps no wonder clinical psychologists experience difficulties admitting to a *not knowing* position (Anderson & Goolishian, 1992; see Study 1, page 116). Admitting to not knowing in a professional world in which empirically verified truths are privileged assumes a truth that *can* be known (but is not). Admitting one does not know then risks undermining a person's position as a member of a profession (since standing in the profession is defined by occupying certain knowledge). The limitation becomes one of the *clinician's capabilities* rather than the profession: it assumes there *is* a way of understanding and responding rather than considering that the issue at hand may be more complex, nuanced and without definite solution (Atkinson, 1984). If there is a way to know (and therefore a way to be) as a clinical

psychologist – verified through scientific research and expected to influence clinical practice – there is an implied way of *not* knowing (and being).

Such a tension is not unique to clinical psychology. As discussed, other healthcare professions have historically privileged technical expertise and competence to their detriment. In medicine, this accounts for the growing interest in *becoming* a doctor and rapid expansion of the professional identity literature (Jarvis-Selinger, Pratt & Regehr, 2012). The focus on objective, evidence-based science *reinforces* discourses of competence that medical trainees are socialised into and then attempt to demonstrate themselves (Macleod, 2011). They become primed to acquire identities that display confidence, capability and – by extension – suitability for the profession (Macleod, 2011). Indeed, becoming a competent doctor is often connected to notions of science and evidence (Goldenberg, 2006; Lingard, 2003; Macleod, 2011; Philips & Dalgarno, 2017). Naturally, uncertainty or not knowing then leads to vulnerability and is therefore actively avoided or disguised (Langard, 2003), and clinicians risk becoming detached from the emotional nuance of clinical work (Philips & Delgarno, 2017). This is not dissimilar to clinical psychologists feeling compelled to conceal not knowing and vulnerability (Studies 1 and 2), with trainees positioning themselves as competent during interrogations with supervisors (Study 3). Of note, much of this literature is done with medical trainees and yet it mirrors observations that therapists in training experience anxiety with a propensity for easily mastered, discrete interventions, and a propensity for presenting a sort of false, professional persona (Ronnestad & Skovholt, 2003). This is not without consequence: clients of mental healthcare services often have rich and complex lives with mental healthcare reform agendas prioritising a recognition of lived experience expertise (Commonwealth of Australia, 2017; NSW Mental Health Commission, 2014). How do clinical psychologists reconcile their expertise with other expertise and ways of knowing? If they are socialised into the profession in ways that privilege certain

(scientific) ways of knowing, it is hardly surprising that admitting to not knowing and valuing other ways of knowing are going to be challenging. Study 1 demonstrates why this needs addressing: if clinical psychologists cannot find a way to tolerate the limitations of their expertise and value other ways of knowing, they are going to hinder the implementation of mental healthcare reforms.

7.4.1.2 Personal and Professional Identities: Intersectionality

A notable finding of this research (Studies 1 and 2) is that the personal and professional identities of clinical psychologists are intertwined and progressively integrated across the professional lifespan. Although not explored through the same theoretical lense, this is consistent with the therapist development literature (e.g., Rønnestad & Skovholt, 2013) and the person-professional development literature (e.g., Goodbody & Burns, 2011) discussed in Chapter 1 (see 'Related Research: Professional development', page 87). What extends beyond this therapist development literature, however, and resonates with critiques of the professional identity literature (e.g, Volpe et al., 2019; Wyatt et al., 2021), is the finding that the process of integrating personal and professional identities is more complex and nuanced for those who identify as a minority with respect to their gender, race, ethnicity, culture, age, sexuality and disability status (Study 2). I used the concept of intersectionality in Study 2 to consider the meaning and consequences of these aspects of people's identities in relation to their professional identities. Clinical psychologists who identified as being a member of a minority group often feel *othered*: an isolating and painful sense of being different from the white, homogenous culture of mainstream clinical psychology. This is consistent with the experiences of trainees from healthcare professionals more broadly from traditionally under-represented groups experiencing a sense of *not fitting in* to the typical identity of the dominant healthcare professions culture (Volpe et al., 2019). The difficult task of integrating these aspects of one's identity was found to be necessary to promote self-

respect and cohesion in sense of self, with the benefit of fostering empathy, cultural awareness, and an awareness of power dynamics in clinical psychologists (Study 2).

It is curious that 10 of 24 studies included in the scoping review (Study 2) focussed on the experiences of clinical psychologists with diverse social and minority identities, despite criticisms of professional identity research suggesting researchers have generally failed to critically engage with issues surrounding intersectionality and associated power relations (e.g., Sarraf-Yazdi et al., 2021; Volpe et al., 2019; Wyat et al., 2020; Wyatt et al., 2021). One difference is that many of the original studies reviewed in Study 2 were *unpublished* dissertations, whereas the published reviews and syntheses of the literature included *published* articles. As discussed in Chapter 1 (see section on 'Becoming a Clinical Psychologist: Personal accounts', page 24), clinical psychologists who identify with particular social identities - particularly minority identities not well represented professionally - are increasingly publishing personal accounts (rather than empirical studies) describing the complexities of navigating integration of these identities into their professional identities (e.g., Blake, 2015; Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009; Hurd, 2016; McGowen & Hart, 1990; Pearlstein & Soyster, 2019; Prajapati, 2019). The determinantal impact on professional identity when the profession disregards other cultural and indigenous knowledges in favour of white, Eurocentric perspectives has been documented (Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009; Prajapati, 2019). Trainees describe feeling conflicted about their professional identities in the context of diverse racial identities (Davidson & Patel, 2009; Prajapati, 2019), with more experienced clinicians describing the transformative albeit challenging experience of progressively integrating racial identities into their professional identity (Comas-Diaz & Weiner, 2011; Davidson & Patel, 2009).

It is possible that the primary literature – collated in other reviews of the professional identity literature - represents the perspective of the hegemony. It's concerning to think that in *addition* to being marginalised within the profession, these accounts of the impact of marginalisation on professional identity might be being further marginalised from academic publishing spheres. Criticisms about failing to consider intersectionality and power relations often cite the perpetuation of dominant ideologies and the status quo of historically white healthcare professional cultures as particularly problematic (Volpe et al., 2019; Wyatt et al., 2020; Wyatt et al., 2021), and this seems like a worthwhile consideration in this instance.

Importantly, this is not to say that *all* research has inadequately considered these issues. Increasingly, researchers are turning their attention to the experience of healthcare professionals who identify with minority groups and their experiences of professional identity to highlight the complex ways in which these trainees navigate their professional identity construction in the context of challenging sociohistorical contexts (e.g., Frost & Regehr, 2013; Volpe et al., 2019; Wyatt et al., 2021). This is a promising turn. Nevertheless, without critical reflection of the representativeness and applicability of the currently available research findings to diverse groups, we inappropriately treat people as neutral when they are not. This will only serve to further disadvantage certain groups within healthcare professions (Volpe et al., 2019).

If intersectionality involves the meaning and consequences of aspects of a person's other identities in relation to their professional identities, then arguably this can be extended to experiences of distress and hardship that have shaped people's sense of self. Less discussed in other healthcare professions is the issue of how personal experiences of distress impact professional identity formation. Yet in clinical psychology, self-authored published accounts of navigating professional identity as a clinical psychologist in the context of suicide, divorce or mental health difficulties are emerging (Blake, 2015; Murray-Swank,

2019; Nash & Chapman, 2019). Questions around self-disclosure, difficulties admitting to and locating support, and identification with needing (rather than providing) support emerge (e.g., Murray-Swank, 2019; Nash & Chapman, 2019). It has been suggested that as psychologists, such experiences are particularly challenging because of the use of the self in clinical work, and the inescapable reminders of one's own pain when encountering the pain of others (Nash & Chapman, 2019). This has led to calls for the profession to more openly acknowledge vulnerability and admit to and face its shared humanness with clients (Nash & Shapman, 2019); a perspective similarly reflected in the findings of Study 2. It may be that given the nature of the work – encounters with others experiencing distress (in which clinical psychologists position themselves as being responsible to contain and manage distress; Study 4) – that clinical psychologists risk claiming identities for themselves that are impossible to maintain; identities comprised of responsibility for managing distress of others without room to acknowledge their own vulnerabilities and imperfections. Moreover, competence discourses which privilege science and conceal the vulnerability and imperfection of being human may perpetuate this (MacLeod, 2011).

7.4.1.3 Repositioning Clinical Psychologists

Clinical psychologists – like the rest of us - position themselves in relation to the *other*; they adopt, resist and negotiate the positions made available to them and in relation to the world and other people. In doing so, clinical psychologists claim certain positions for themselves and continually construct and re-construct their professional identities. This then shapes the repertoire of acts and behaviours they have access to (Harré et al., 2003). The findings of this research draw attention to two meaningful ways in which clinical psychologists position themselves in relation to the other: how they position themselves in relation to the broader mental healthcare system (person – world) and in relation to the clients with whom they work (person – person). This is a reminder to clinical psychologists to shift

their gaze outwards: their professional identities are transformed as they interact with the broader social world and those within it.

7.4.1.3.1 Part of Mental Health Systems (Person-World)

"Identity in everyday interactions is both reflective and constructive of social reality" – De Fina, Schiffrin and Bamburg (2006)

Studies 1, 3 and 4 of this thesis serve as a reminder that professional identities and the broader mental healthcare system are not mutually exclusive. Professional identities influence and constrain the readiness clinical psychologists (and other mental healthcare clinicians) to implement models of care that align with system reform priorities (Study 1) *and* they acquire aspects of their professional identities that position them to work in certain ways (that may not align with reforms) through exposure to educational institutions (Study 4). Clinical psychologists' professional identities and the systems around them are interconnected: their identities are both *shaped b*y broader systems (educational institutions; Studies 3 and 4) and *shape* systems (mental healthcare services and the implementation of models of care; Study 1). This is aligned with symbolic interactionism; for all of us, our identities are both shaped by and shape the world around us (see section on 'Symbolic Interactionism' in Chapter 1, page 38). Clinical psychologists are trained specialists in the assessment, diagnosis and treatment of people experiencing mental health difficulties (Jackson et al., 2021); they are trained specifically to work with a diverse range of people experiencing distress in health settings. Yet, they are increasingly working in private practice settings from a primarily cognitive-theoretical orientation (Norcross & Karpiak, 2012). It is concerning to think that clinical psychologists are becoming more siloed and increasingly disconnected from the broader mental healthcare system in which they could play a critical role.

When clinical psychologists re-position themselves (and conceptualise their professional identities) as being interconnected with the mental healthcare system more broadly, the following questions need asking: to what extent do clinical psychologists' professional identities align (or not align) with reform priorities in mental health? What are the barriers to, and facilitators of, this alignment at the individual and societal level? The current global and national shift towards recovery-oriented practice encompasses a move away from focussing exclusively on clinical recovery (emphasising symptom reduction) to an emphasis on personal recovery (emphasising participation and empowerment) (Slade, 2009). There is some variation in the literature with how this is discussed, yet the concepts of empowerment, autonomy, person-centred care, and personal recovery all reflect trends in Western healthcare settings away from paternalistic and medicalised models of mental healthcare (Tambuyzer et al., 2011). Indeed, Australia's *Fifth National Mental Health Plan and Suicide Prevention Strategy* (Commonwealth of Australia, 2017) and NSW's *Living Well: A Strategic Plan for Mental Health in 2014-2024* (NSW Mental Health Commission, 2014) both commit to recovery-oriented approaches and require clinical psychologists to revisit and reflect on themselves and their roles in alleviating distress (see section on 'Enabling System Reforms' in Chapter 1, page 32). From this perspective, a client's involvement in their clinical care involves participation in decision making, agency, recognition of client/personal expertise, and collaboration with professionals (Tambuyzer et al., 2011). This stands at odds with the ways in which supervision in training contexts can facilitate the positioning of clients as fragile and in turn position clinical psychologists to claim agency, responsibility and control over clients (Study 4). Privileging expertise and sanctioned ways of knowing (see earlier section in this chapter, page 235) with clients experiencing mental distress runs a very real risk of perpetuating paternalistic clinical care ("we know, you don't"'; Study 4) (Fernandez-Ballestros et al., 2019). Positioning clients as

fragile and unable to cope also strips clients of their agency and capacity for change; both of which misalign with directions for services outlined by Tambuyzer et al. (2011). It is a tricky yet necessary balance: supporting distressed clients who feel disempowered *and* doing so in such a way that promotes agency.

This is not where it ends, however. We also need to consider the broader consequences of clinical psychologists' professional identities: to what extent do their professional identities *impact* on the mental healthcare system itself (by influencing their capacity to implement reform priorities in mental healthcare settings)? Much of the literature relevant to implementing reform agendas provides guidance on clinical practice (e.g., Le Boutillier et al., 2011) or explores clinician perspectives of reform priorities (e.g., Le Boutillier et al., 2015), yet consideration must also be given to clinician's experiences and capabilities to implement reforms. Study 1 demonstrated how the implementation of a model of care (Open Dialogue) that introduces elements of reform priorities into high-risk public mental healthcare services is invariably influenced by (and in turn, influences) the professional identities of clinicians. This tells us that realisation of reforms – at least partially – hinges on issues pertaining to the professional identities of clinicians. Intuitively, this makes sense. It is the clinicians – the actual people whose actions and behaviours make up the delivery of any mental healthcare service – who are tasked with the real-world changes required to shift mental healthcare service delivery. Although not researched or reported through a professional identity theoretical lens, comparable findings have emerged with clinical psychologists experiencing discomfort and challenges in working in recovery-oriented ways (e.g., Cooke et al., 2019; Tickle et al., 2014). Perceptions of risk and a sense of one's responsibility in relation to risk (Ticklet et al., 2014) and perceptions of a sense of fit with medicalised models of distress (Cooke et al., 2019) pose dilemmas for the delivery of recovery-oriented mental healthcare services. Of note, negotiating the tension between *expert*

and *not knowing* positions has been described as important for working in recovery-oriented ways in medically oriented mental healthcare systems (Cooke et al., 2019). On the other hand, research exploring the professional identities of medical students has demonstrated how acts of resistance can promote subtle transformations to dominant medical structures (Shaw et al., 2019).

7.4.1.3.2 In Relation to Clients (Person-Person)

"Only when there is an Other can you know who you are" – Hall (1989)

The way in which clinical psychologists position and discursively construct identities for their clients in every-day interactions (e.g., supervision, therapy) reflects and originates out of the positions clinical psychologists claim for themselves (Schrewe et al., 2017). The two are inherently bound up in one another. For instance, positioning a client as lacking insight is, simultaneously, claiming a position for oneself as having insight (otherwise how could one be aware of the client's lack of insight?). Study 4 directly draws attention to language use in supervision interactions to highlight how constructions of client identities (e.g., as fragile) have direct implications for the identities clinical psychologists claim for themselves (e.g., as responsible for managing client distress). This phenomenon of reciprocal and mutually unfolding construction of identities – that is, the underlying process in which positioning of the *other* and the *self* are intimately connected and born out of one another – applies irrespective of the *what* or characteristic (e.g., fragility) being attributed to the other. Any time clinical psychologists position their clients in a particular way, they are invariably positioning themselves. Seen this way, the divide between clinical psychologist (the professional) and client (the service user) dissipates. Both are, in fact, cut from the same cloth; clinical psychologists understanding of their clients reflects their understanding of themselves (Schrewe et al., 2017).

Professional identity researchers are beginning to shift their attention to the co-occurring construction of clinician and client identities, shedding light onto implications for stigmatising attitudes towards healthcare service users and alignment with reform (e.g., Schrewe et al., 2017; Skoura-Kirk, 2022). For instance, Skoura-Kirk (2022) demonstrated precisely why this matters: the construction of client identities by social workers in ways that *individualise* broader social issues (e.g., constructing clients as weak or strong – characteristics of the *individual* – rather than situating difficulties within a broader context) has problematic repercussions. Similar to the findings of Study 4, well-intentioned constructions of client identities as *vulnerable* were linked to negative stereotyping, perpetuating power inequalities, reproducing positions of *otherness* and passivity, and ultimately perpetuating oppressive clinical practices (Skoura-Kirk, 2022). Furthermore, positioning clients as vulnerable co-occurred with social worker students' claiming professional identities characterised by the provision of expert (albeit sensitive) professional and de-politicised interventions (Skoura-Kirk, 2022). Even in medicine, students' positioning of patients primarily as *diseased* (i.e., foregrounding and constructing patient identities through a medical lens) prevents a more comprehensive conceptualisation of *who patients are* that considers their physicality as one (albeit important) thread interwoven into a broader tapestry of identity (Schrewe et al., 2017). If healthcare professionals are to move towards person-centred care in which patients are authentically and truly the *centre* of clinical care, then it becomes critical to think about *who patients actually are* rather than *who clinicians make them out to be* (MacLeod & Frank, 2010).

Yet, any sustainable centring of patients and clients in this way will necessarily involve a reconfiguration of power in healthcare services, and this pursuit could easily be undermined if healthcare professionals – including clinical psychologists - are not attentive to how they are constructing the identities of clients and patients in the first place (Schrewe et

al., 2017). If clinical psychologists can recognise that when they construct client identities through medical (or other professionally sanctioned) lenses this may have untoward implications, then they will be better equipped to reconsider the ways in which they engage with broader discourses when understanding and making sense of who are clients are (Schrewe et al., 2017). Why this matters is because the way clinical psychologists position their clients has direct implications for the quality of clinical relationships and outcomes (Skoura-Kirk, 2022). As an applied example, it is useful to consider this phenomenon in the context of existing research looking at clinical attitudes towards clients diagnosed with Borderline Personality Disorder (BPD) with whom clinical psychologists might work. BPD is a particularly divisive and stigmatised diagnosis in mental health in which clients typically present with high levels of distress and suicidality (McKenzie et al., 2022). Evidence suggests that clinicians aware of a diagnosis of BPD (i.e., where a client has been positioned as having a particular diagnosis sanctioned by the mental healthcare industry) have different attitudes and respond differently – often unhelpfully and in stigmatised ways - towards these clients (Knaak et al., 2015). There is no denying that clinician's professional identities are defined in relation to the other (Samuriwo et al., 2021); the ways clinicians position clients are inseparable from the identities they claim for themselves (including the attitudes and behaviours they take up in professional roles). This is where education becomes critical: if education in its broadest sense is about the transformation of self into new ways of thinking and relating with the other (Goldie, 2012), it is imperative that educators play an active role in fostering professional identities that support clinical psychologists to understand clients in humane and de-stigmatising ways.

7.4.2 For Educators: How can tomorrow's clinical psychologists be supported?

Clinical psychology educators are tasked with supporting the professional identity construction of tomorrow's clinical psychologists. The critical role of educators in supporting

professional identity construction has seen a rapidly increasing plethora of research and guidance across healthcare professions focussing on how to support this process (e.g., Cruess et al., 2019; Goldie, 2012; Hatem & Halpin, 2019; Maree Johnson et al., 2012; Marañón & Pera, 2015), and culminating in a range of reviews on the topic (e.g., Mount et al., 2022; Raso et al., 2019). This surge in research reflects the well-documented temptation in healthcare profession education to want *solutions* to complex professional issues: tangible, practical guidance ready for educators to implement (Ajjawi & Eva, 2021). Indeed, a recent critical review of the literature exploring professional identity construction efforts in medical education by Mount et al. (2022) found there is guidance on interventions available. However, most of this guidance derives from an *individualist* perspective that de-emphasises essential *social-cultural* factors that influence identity formation (Mount et al., 2022). For instance, the dominant interventions in the literature to support professional identity formation involve reflective writing and the use of narrative reflections which both emphasise the interiority - and de-emphasise the social and relational aspects - of professional identity formation (Mount et al., 2022). This is consistent with research emerging from psychology researchers about supporting professional development (see 'Related Research: Professional development' section in Chapter 2, page 89). From a social constructionist perspective, the construction of trainee clinical psychologists' identities cannot and should not be separated from the social, relational and interactional education spaces in which they are negotiated (Burr, 2015). If it is, learners are left responsible for managing identity formation as individuals, even though we know they get socialised into professions with an expectation to *fit* with professional norms, lest they face undesirable personal, professional and social consequences (Frost & Regehr, 2013). Focussing only on the individual de-politicises the process of identity construction in ways that only serve to maintain the status quo (Schrewe et al., 2017; Volpe et al., 2019). Instead, research from other healthcare professions tell us it is

critical to attend to socialisation processes (e.g., interactions with supervisors and mentors) through which novices are exposed to hidden curricula to better understand and influence the identity construction of tomorrow's clinical psychologists.

The scoping review (Study 2) found that training and early career periods are critical times for professional identity construction. This is consistent with finding across the healthcare professional identity literature (Monrouxe, 2010) and therapist development literature (Rønnestad & Skovholt, 2013). For clinical psychologists, this involved a destabilisation in sense of self (including acquisition of a false of professional persona) and was accompanied by feelings of threat, distrust, isolation and vulnerability. The consensus that professional identity was inadequately considered in education and training contexts culminated in requests for the profession to more explicitly address professional identity (Study 2). Shifting to closely examine in-situ supervision interactions, however, Studies 3 and 4 clearly demonstrated that ways in which professional identities are *always* being acquired and negotiated; education institutions and their representatives (e.g., supervisors, teachers, mentors) are influencing learners' professional identities irrespective of whether or not this is the explicit focus of the interaction (Goldie, 2012). This insight has led authors to question whether targeted professional identity initiatives are required (Mount et al., 2022), and whether we may be better served by critically examining the ways in which professional identity is influenced through hidden curricula and interpersonal interactions (e.g., supervision) in education contexts.

7.4.2.1 Hidden Curricula

Requests for educators to explicitly address professional identity in training settings (Study 2) invites questions for educators: can we *teach* professional identity in education and training settings? If so, how? From the medicine literature (and, increasingly, nursing literature) we know that professional identities are developed through both formal and hidden

curricula (Goldie, 2012; Hafferty & Hafler, 2011; Pourbairamian et al., 2022; Rees & Monrouxe, 2018; see Chapter 1). Hidden curricula are a critical component of professional identity formation (Hafferty & Hafler. 2011; Wyatt et al., 2021). The *formal* curriculum refers to formal and planned educational outcomes, whereas the *hidden* curriculum refers to the cultural norms of a profession that are transmitted - but not openly acknowledged - through formal and informal education practices (Hafferty & Hafler, 2011). Hidden curricula are unstated but nevertheless vital; it is through hidden curricula that learners learn *how things work* (Raso et al., 2019). Hidden curricula are particularly important because of what they convey about important ethical cultures, norms, and rules appropriate emotions and behaviours - all of which have implications for clinical and professional practice (Pourbairamian et al., 2022). Moreover, widely documented misalignment between formal and hidden curricula have long been identified as problematic for the socialisation and professional identity construction of healthcare professionals (e.g., Allan et al., 2011; Cook, 1991; Hunter & Cook, 2018; Shaw et al., 2018).

The scoping review (Study 2) hinted at hidden curricula present in clinical psychology. Concealing aspects of oneself (perceived unfavourable personal characteristics, vulnerability and limitations in knowing) suggest that clinical psychologists learnt during their training that these characteristics are *not how one should be* as a clinical psychologist. This fits with observations that attitudes around not knowing are passed down through education contexts (Lingard et al., 2003). Across all four studies in this thesis, clinical psychology trainees appeared to have tacitly acquired messages about the need to be competent, helpful and able to manage distress (see earlier in this chapter). Moreover, issues pertaining to intersectionality in Study 2 hinted at the hegemony: experiences of feeling *othered* when one belongs to a minority group indicate tacit messages about the expected identities of clinical psychologists' as being aligned with the majority. These findings suggest

that tacit messages in the hidden curricula communicated in education settings often pertain to *personal* characteristics or ways of being; a finding consistent with Pourbairamian et al. (2022) who - after reviewing the hidden curriculum literature in medicine - found that educational issues (*how* messages are communicated) and personal characteristics (*what* messages are communicated) were the two most important factors relevant to hidden curricula. Studies 3 and 4 demonstrated how educational influences (i.e., supervision interactions) tacitly communicate to clinical psychology trainee's messages about *how to be*. Extending this further, Study 4 demonstrated how a supervisor's positioning of clients tacitly (and likely unintentionally) communicated and facilitated paternalistic attitudes. Again, this is not dissimilar from findings that institutional and educational practices can negatively impact nursing practice through hidden curricula (Raso et al., 2019). No doubt educators and supervisors do not set out to perpetuate problematic discourses that hinder clinical care. And yet, Study 4 demonstrates just how easily every-day interactions can influence the professional identity construction of clinical psychology trainees in such ways. In fact, one of the key aspects of hidden curricula is that the lessons communicated are *unintended* (Gupta et al., 2020; Raso et al., 2019)

Clinical psychology is silent on issues pertaining to hidden curricula. In clinical psychology, the focus is on explicit curricula and the attainment of core competencies (Australian Psychology Accreditation Council, 2019). Yet it should now be clear that hidden curricula and the construction of clinical psychologists' professional identities are intertwined and interconnected: as novices are socialised into clinical psychology they are exposed to tacit messages through educational activities including supervision (Hatem & Halpin, 2019; Kelly, 2020). Clinical psychology educators are therefore well-placed to learn from other professions by first acknowledging the nature and impact of the hidden curriculum. Although guidance from medicine on how to integrate professional identity explicitly into curricula is

available (e.g., Cruess et al., 2019), it is likely to be more fruitful to consider broader considerations for addressing hidden curricula in any given context.

As in other healthcare professions, it is important that clinical psychology does not see the hidden curriculum as *negative* (Raso et al., 2019); hidden curricula operate in *all* educational contexts. What becomes important is directly and intentionally addressing hidden curricula with a focus on using them to *reinforce* formal curricula and alignment with the values of the profession (Hafferty & Hafler, 2011; Raso et al., 2019). Educators need to consider: what qualities are important to foster in future generations of clinical psychologists, and in what tacit and implicit ways can this be communicated? Just as hidden curricula can hinder healthcare professionals' identity formation (e.g., hidden curricula devaluing qualities such as *caring* amongst nurses; see Raso et al., 2019), they can, at the same time, be used to foster desirable qualities (Hafferty & Hafler, 2011). Stipulating what these qualities are is beyond scope here, but I would suggest qualities that align with mental healthcare reform priorities are a good starting point. Second, attending to organisational cultures and institutional norms – and what implicit messages these communicate - are essential as a key influence on hidden curricula (Hafferty & Hafler, 2011; Pourbairamian et al., 2022; Raso et al., 2019). For instance, when trainees are assessed for their competence in systematically assessing, diagnosing, treating (usually by *delivering* a specialised treatment), and demonstrating 'success' by a reduction in symptoms, what hidden messages are they receiving about what it means to *be* a clinical psychologist? Does this set them up to acquire an over-simplified, linear and ultimately unhelpful understanding of themselves and their role? A third focus will need to be on intersectionality and how hidden curricula operate in nuanced and complex ways for those outside of the majority (Study 2). Hidden curricula are not neutral and de-politicised; they have potential to perpetuate disadvantage and maintain the status quo (Volpe et al., 2019; Wyatt et al., 2021). Finally, educators would benefit from

considering closely how language and interactions in relational spaces influence hidden curricula (see Raso et al., 2019 who comments on the problematic absence of this in the nursing hidden curriculum literature). One practical implication of this may be to expand the interactional and relational experiences trainees have (e.g., interactions in public settings and with a range of relevant stakeholders including those with lived experience) to broaden trainee's exposure to different ways of knowing that might influence tacit messages about what it means to be a clinical psychologist.

7.4.2.2 Supervision

From a social constructionist perspective, relational spaces (e.g., supervision) are formative in shaping professional identity (Gordon & Luke, 2012); novices are exposed to explicit and hidden curricula as they are socialised into the profession in interactions with others (Hafferty & Hafler, 2011). Indeed, reviews of the literature confirm supervision is critical to professional identity construction (Toh et al., 2022; Woo et al., 2014). Yet, despite recognition that supervision is a discursive and social phenomenon through which norms, values, attitudes and behaviours are acculturated, the majority of research pertains to the *effects* of supervision and supervisees self-reported *experiences* of supervision (e.g., Milne & James, 2002; Soheilian et al., 2014). There is scarce exploration of supervision through a social constructionist perspective to understand the *process* through which supervision influences professional identity construction (Gordon & Luke, 2012). It remains less clear exactly *how* communication in supervision contributes to identity construction (Gordon & Luke, 2012). Studies 3 and 4 demonstrated that whenever we talk, we convey something about who we are in relation to others. When trainees and supervisors talk, they construct identities for one another (Study 3), and they also construct and convey their own identities – and identities for their clients - when they talk about clients (Study 4). Identity work is taking place *all the time* (Warmington, 2019). Trainees change who they are as clinicians, in part, by

talking about themselves and their clinical work within supervision. When educators recognise this – when they consider that learners acquire an understanding of themselves in *all interactions* – they are required to be more mindful of interactions with students. This is essential, as supervision and mentoring experiences – as particularly important sites of identity construction – most often support but can also hinder professional identity construction (Study 2).

It is important to revisit the complexities surrounding supervision; supervisors and trainees occupy dual and potentially conflicting roles (Study 3). Supervisors are tasked with supporting the clinical development of trainees *and* assessing competence (Falender & Shafranske, 2004), whereas trainees are tasked with demonstrating competence (to pass assessment) *and* acquiring the clinical skills (to deliver clinical care). This is consistent with the findings of Study 3: supervisors approached interrogations from quality control (ensuring competent behaviour) and reflective (supporting the development of clinical skills) frames. The contribution of Study 3, however, lies in demonstrating the subsequent impact of this upon trainees' professional identities: supervisors' frames interacted with and influenced the positions made available to and claimed by trainees. This builds upon research – outside of healthcare professions – utilising these two theoretical perspectives to provide sophisticated analyses of identity construction (e.g., Gordon, 2015; Kendall, 2008). As noted by Gordon (2015), framing (Goffman, 1974) and positioning (Bamberg, 1997; Bamberg & Georgakopoulou, 2008) are inherently interconnected and lend nuanced insight into the layers at play in the discursive construction of meanings, situations, relationships and identities. Clinical psychology trainees' professional identities are inherently bound up in the stance or lens through which supervisors approach supervision.

Moreover, supervision occurs within institutions that are inherently hierarchical and in which institutional norms and sanctioned truths are communicated by members of the

institution (e.g., supervisors; Benwell & Stokoe, 2006; Agar, 1985). Through supervision, discourses and ways of doing things are passed down to future generations of clinical psychologists. Research across nursing, medicine and counselling demonstrates how supervisees claim identities that align with sanctioned knowledge and truths; often by positioning themselves as competent (see section on 'Privileging Expertise and Competence' earlier in this chapter, page 235), aligned with dominant ways of knowing, and thus suitable to enter the profession (e.g., Brown et al., 2020; Gordon & Luke, 2012). Moreover, these ways of knowing are specialty-specific to each profession (Cantillon et al., 2021). Taken together, in and through supervision interactions, clinical psychology trainees witness clinical psychology-specific ways of knowing and seek to position themselves as competent by demonstrating alignment with these ways of knowing. Through this process, dominant ways of knowing are perpetuated (as demonstrated in Study 3); trainees learn ideas about *how to be* through what and how supervisors talk (Mayr, 2015). More specifically, Study 4 displayed how specific dominant discourses – including those less desirable (e.g., paternalism) – may be unintentionally communicated and preserved through supervision interactions. When we conceptualise trainees as performers (Goffman, 1975) trying to project a desirable (competent) identity for themselves in an educational context (tasked with conveying sanctioned truths and assessing the competence of learners), it is easy to see how professional identities emerge than maintain the status quo. Although learners self-author their own identities in different ways within the same dominant discourses (Bennett et al., 2017), I agree with Cantillon et al. (2012) that education and supervision has the potential to limit emerging professional identities whilst promoting the reproduction of culturally sanctioned beliefs and practices within specific professions.

We cannot discuss supervision and the reproduction of knowledge without considering power. Studies 3 and 4 demonstrated how supervisors occupy and have authority

to enact power (Brown et al., 2020; Monrouxe et al., 2017). It is critical to consider the knowledge and institutional values supervisors are tasked with reproducing. What knowledge base are universities privileging: academic research (knowledge produced within and preproduced in universities) or ways of knowing based on clinical realities in mental healthcare settings? What explicit and tacit messages does this communicate about what it means to be a clinical psychologist? The knowledge privileged will have different implications. For instance, the profession's ties to the science-practitioner model have seen research dominated by randomised control trials (RCTs) examining effective treatments for particular diagnoses measured by symptom reduction. Knowledge based on real world clinical settings, in contrast, likely emphasises a much richer but more complex understanding of client difficulties and ways of working. The former might lend itself to clinical psychologists conceptualising their role (with implications for professional identity) as delivering discreet, evidence-based interventions to reduce symptoms, whereas the latter might lend itself to a broader – perhaps less straightforward - conceptualisation of one's role. Furthermore, the enactment of power by supervisors in ways that reproduce and perpetuate discourses was made clear in Study 4: paternalistic discourses can be reproduced when supervisors claim positions characterised by expertise and exhibit ways of knowing about clients that position them as fragile. This is not dissimilar to other researchers who have demonstrated how dominant discourses and ideologies are passed down through supervision and educational activities (e.g., Brown et al., 2022; Monrouxe et al., 2017). What is clear is that no identity work occurs outside of wider social and institutional influences (Wyatt et al., 2021), and is therefore inherently bound up in – and reproduces – power and privileged ways of knowing.

Supervisors require guidance to foster professional identity construction yet research has cautioned against solutionism (Ajjawi & Eva, 2021). 'One size fits all' approaches are

unlikely to be of use (Bennett et al., 2017). What is provided, therefore, are considerations to guide supervisors across varied contexts. At the *macro* level, institutions need to recognise the role they play – including the influence of norms, truths and sanctioned behaviours - in hosting effective supervisory interactions (Toh et al., 2022). Supervision is embedded within the cultural milieu of education institutions in which identities are constructed, and therefore professional identity construction cannot be separated from this context (Volpe et al., 2019). Supervisors do not just communicate the explicit curriculum; they expose trainees to the hidden curriculum with implications for professional identity construction (Hafferty & Hafler, 2011). Further, supervisors are representatives of the institution; they enact institutional power afforded to them (Benwell & Stokoe, 2006). Awareness of the power they are able to exercise and positions they are able to claim for themselves (and make available to trainees) matters. At the *micro* level, supervisors need to thoughtfully consider *what is said* and *how it is said* with consideration of the frame through which they are approaching supervision and the subsequent impact on trainees' professional identities. For instance, although reflective practice is now widely used in clinical psychology, Study 3 highlights the importance of carefully considering *how* this is done (Lilien & Basterfeld, 2020). It seems plausible that trainees may experience supervisor invitations for self-reflection as disciplinary or intrusive, and inadvertently generate attempts to avoid self-reflection (Study 3). This will require attention at the interactional level and educating clinical supervisors about *processes* in supervision that influence trainee identity construction (Warmington, 2019). Trainees may benefit from being oriented to the nature and purpose of supervision (e.g., the dual and potentially conflicting purpose and roles, expectations etc.), encouraged to reflect on their own personal and professional identities (including any tensions arising, intersection with other pre-existing identities, changes to identities etc.), and supported to engage in their own

sense-making about who they are and want to become as clinical psychologists (Rees & Monrouxe, 2018).

There are some additional considerations that are relevant to supervisors but also educators more broadly. Educators need to ask themselves: who do we want tomorrow's clinical psychologists to be and how can education settings cultivate such professional identities in relational spaces? It is clear clinical psychology educators would be well placed to take seriously the experiences of those outside of the majority, be attentive to talk and the ways in which socialisation processes communicate hidden curricula about the hegemony, and critically engage on issues of power and how it is enacted (Volpe et al., 2019; Mount et al., 2022). Supervisors are also only one – albeit important – figure that trainees interact with and learn from. Cantillon et al. (2021) highlights the need for customizing curricula for the politics and realities of the places where clinicians go on to work. Overall, educators need to shift their attention beyond the formal curriculum and the content *taught* to focussing on the every-day-interactions that tacitly communicate to learners what it means to be a clinical psychologist. By acknowledging their monopoly over knowledge and their privilege and power in shaping tomorrow's clinical psychologists, educators have the capacity to influence and redefine how things are done by attending to the interactional spaces in which trainees learn to become clinical psychologists (Macdonald, 1995).

7.4.3 For Researchers: What do we need to know and how can we know it?

All research reflects fundamental assumptions about *what* can be known and *how* (see 'Approaching this Research' section in Chapter 1, page 34). As a profession built upon the science-practitioner model, clinical psychology privileges an objectivist epistemological perspective that assumes the existence of an objective, external truth to be known (e.g., truth about our identities) that can be discovered through the use of experimental methods striving for prediction, control and generalisability (Merriam & Tisdell, 2015). This contrasts with

other epistemological perspectives (e.g., social constructionism) that assume ways of knowing (e.g., knowing or understanding our identities) are continuously changing and therefore seek to understand and interpret these phenomenon (Merriam & Tisdell, 2015). Researchers interested in exploring professional identities (or arguably any social phenomenon) require a solid theoretical understanding of the phenomenon they are investigating and to select appropriate methods (see Study 2 recommendations, page 154). There is much to be gained by looking beyond psychological conceptualisations of our identity as a stable, fixed, internal and continuous phenomenon (and accurately accessible via *what* people tell about who they are). Alternate perspectives that account for the complexities of our identities and the processes through which they are changed and transformed will generate richer understandings to move us forward. This will, however, require two shifts: i) a more theoretically informed and sophisticated approach to qualitative research methodologies, and ii) appreciation of different epistemological perspectives (e.g., social constructionism) that offer an alternative to objectivist ways of making sense of (and researching) identities. This section briefly covers both requirements in further detail.

7.4.3.1 Embracing Qualitative Research Methodologies: Looking beyond quantitative methods

Many authors have commented on the hegemony of positivism in psychology in which experimental, quantitative methods are privileged over other epistemologies and methods (Breen & Darlaston-Jones, 2010; Gough & Lyons, 2016). Not only are quantitative methods dominant but historically qualitative methods have been devalued, with Australian psychology academics and students perceiving qualitative research as lacking legitimacy (Povee & Roberts, 2014). This is likely attributable to an overarching positivist perspective (rarely contextualised as one of many ways of knowing), compulsory under-graduate and post-graduate education in quantitative research methodologies (with minimal training in

qualitative research methodologies), and publishing practices (pressure to publish in high impact journals that require adherence to principles and practices of positivist informed psychological science) (Cox, 2012; Elliott et al., 1999; Gough & Lyons, 2016; Levitt et al., 2017). The dominance of positivist criteria in publishing spaces often results in an inappropriate application of assumptions underpinning quantitative research to qualitative research methods resulting in sanitised, realist qualitative research that perpetuates existing psychological theories rather than expanding knowledge (Gough & Lyons, 2016). It is therefore unsurprising that quantitative measures are being used to measure professional identity in clinical psychologists (e.g., Foo & Green, 2022). In Study 2, quantitative research purporting to investigate professional identity was found to be fundamentally measuring a different construct (and often without clarification of what they were measuring) and was therefore not included in the scoping review. It is important to ask: what does it *mean* to measure professional identity on a quantitative scale? What does this tell us and how does it help us? What are educators to make of this and how are they to know what to do with this information? Any answers to this latter question are likely to be speculative at best, although this is not to deny the contributions of this type of research. Quantitative methods enable us to better understand correlations between identity and constructs with important implications for identity (e.g., burnout). Nevertheless, turning towards qualitative research methods that allow us to ask different research questions will offer different and helpful insights.

In recent years, the use of qualitative research methods has begun to increase within psychology (Elliott et al., 1999; Gough & Lyons, 2016), although Elliott et al. (1999) long ago raised concerns that a growth in the use of qualitative research methods in psychology without sufficient theoretical or methodological expertise had already (and would continue to) give rise to problems of quality control. The results of Study 2 (specifically the quality issues identified in the studies reviewed) suggest this is the case. Research adopting

qualitative methodologies is broad and cuts across disciplines, which makes it impossible to impose a single, all-encompassing definition or guidance (Smith & Sparkes, 2016). Instead, what is most fundamental is that researchers ask themselves (and ensure coherence between) these three questions posed by Guba and Lincoln (1994): 1. Ontological question: what is the nature of reality and therefore what can be known about it? 2. Epistemological question: what is the relationship between the knower/researcher and what can be known? 3. Methodological: How can the researcher go about finding out whatever they believe to be real and able to be known? Importantly, the answer to the final question is constrained by the answer to the former two; not just any methodology is appropriate (Smith & Sparkes, 2016). For instance, relying on self-report techniques to collect data (methodology) assumes that identities are real (ontology) and that people are able to know, accurately report and are willing to report this (epistemology). From a social constructionist perspective, these assumptions are unwarranted (Ashmore et al., 2004) and self-report data should not be collected and treated as untrammelled, unmediated representations of people's identities (Atkinson & Delamont, 2006). This example serves to highlight the importance of researchers prioritising coherence across these three domains.

What does this mean for clinical psychology researchers? One of the most fruitful first steps would be to orient researchers to the above questions. Clinical psychology researchers would benefit from reflecting on their assumptions and appreciating differing perspectives about what is real and what can be known, and familiarising themselves with a range of innovative qualitative research methodologies that can be employed to answer research questions deriving from these assumptions (Gough & Lyons, 2016). As discussed in Chapter 1, there are other ways of knowing about our identities and privileging only psychological theories constrains our understanding (Benwell & Stokoe, 2006). Embracing these perspectives will allow us to consider power and the politics of knowledge in ways that

diversify and expand our understanding, foster minority inclusion, and encourage interdisciplinary collaboration (Gergen et al., 2015; Gough & Lyons, 2016). The findings of Study 2 and critiques of the existing professional identity literature for ignoring issues of power and privilege (e.g., Volpe et al., 2019; Wyatt et al., 2021) provide a clear message that considering intersectionality and power relations must be a priority (see Cole, 2009 for guidance on considering intersectionality in psychology research).

7.4.3.1.1 Social Constructionism: Another way of understanding identities

Social constructionist informed research is *one* alternative to an objectivist epistemological position that clinical psychology researchers may draw upon that questions taken for granted assumptions about our identities, and has been taken up in academic medicine to research professional identities (Rees et al., 2020). For clinical psychology researchers to embrace social constructionism, our identities must be understood as being constructed and reconstructed through language as we interact with others and the world (see 'Identities: An interactional perspective' section in Chapter 1, page 64). The focus of social constructionist research is on *how* we construct reality and our identities, with the potential benefit of enabling us to engage more intentionally in this process to sustain norms and promote identities that we desire.

Embracing social constructionist research in clinical psychology to explore professional identities will require researchers consider their theorising on identities, influence of context, research questions, methodologies, and reflexivity (see 'Methodology' section in Chapter 1, page 39). Identities will need to be approached as a constantly changing and potentially conflicting understanding of oneself, and indivisible from the continual *process* of identification (Benwell & Stokoe, 2006; Monrouxe, 2010). Clinical psychologists' identities then become inseparable from any given context and interactions with others; each time they speak they lodge a claim regarding who they are in a specific time and place

(Bamberg, 2004b). Researchers must acknowledge that we are all born into and inherit a world of meaning, and therefore consider the hold and influence of context and culture on self (Crotty, 1998; Wetherell et al., 2001). This involves not equating *the sense we make of things (or ourselves)* with *the way things (or we) are*; any understanding of ourselves is continually changing as we interact with others and is not fixed or static (Crotty, 1998). Researchers can then turn to sites of interactions between people to understand how identities are constructed (as done in Studies 3 and 4) rather than trying to look inside people's minds and relying on self-report data (questionnaires, interviews etc.) which reflect only what people are willing, able and motivated to share. As seen in Studies 3 and 4, analysing everyday talk between trainees and supervisors allowed for a sophisticated analysis of how identities are constructed and reconstructed, and highlight how paying greater attention to ways of being and doing things (e.g., supervision) can make explicit that which might otherwise go unnoticed (Tracy, 2002). Indeed, interpretative and reflexive research paradigms play an important role in shedding insight into hidden curricula in education settings that influence identity construction (Cribb & Bignold, 1999).

Research questions then need to be adapted. Social constructionist research needs to ask social constructionist research questions (e.g., how and in what ways are professional identities constructed?). Such questions must be exploratory without assuming a fixed truth (Burr, 2015; Tracy & Robles, 2013). Suitable research methods then need to be selected to answer specific research questions. The range of methodologies consistent with social constructionist perspectives is broad and cross-disciplinary, and ultimately methods need to be selected for their *suitability* in answering the research questions (Smith & Sparkes, 2016).

Finally, rather than striving for objectivity, researchers will need to acknowledge that *every single one of us* brings who we are with us to the research process and findings, and consider the contribution of their own identities to the research process (Burr, 2015; Crotty,

1998). Instead of problematising and seeking to eliminate *researcher presence* (considered as problematic in positivist informed research), researchers will need to embrace the concept *of reflexivity* to account for their presence in research processes and findings (Gough & Lyons, 2016). It is worth noting that acknowledging researcher influence is *not* equitable to subjectivism; meaning arises out of an *interplay* between subject and object in social constructionism and is analysed critically, whereas meaning is uncritically *imposed* onto an object by a subject in subjectivism (Crotty, 1998).

By way of example, developments in narrative inquiry provide promising developments for researching identities from a social constructionist perspective (see 'Identities as Narratives' in chapter 2, page 59), with particular potential to integrate micro and macro oriented social constructionist research (Burr, 2015). Researchers across health professions investigating professional identities are increasingly drawing on narrative inquiry methods (see Clandinin et al., 2017 for commentary on the value of narrative inquiry in researching professional identities in medicine). The widely theorised links between narratives and identities has given rise to various approaches to analysing narratives as a method of identifying and interpreting identity work (Benwell & Stokoe, 2006; Smith & Sparkes, 2008). Underpinning these is a recognition that human life is storied; narratives are the warp and weft of who we are and what we do (Sparkes & Smith, 2008). As discussed in Chapter 2, narrative approaches are moving away from analysing *big story* narratives (lives as told by a speaker) towards analysing *small story* narratives (how people construct a sense of who they are in day-to-day interactions) (Bamberg & Georgakopoulou, 2008); a shift towards social constructionist informed analysis of language (Bamberg, 2004; Burr, 2015). Much of this shift has involved the incorporation of positioning theory and positioning analysis (also utilised in the studies of this thesis) to explore identities in the making in in-situ interactions (Bamberg & Georgakopoulou, 2008). Although this is beyond the scope of this

research, using interactionally oriented narrative-based approaches to studying identities through narratives offer a promising way forward for researchers (De Fina & Georgakopoulou, 2015), with potential to explore identity construction in a range of interactional contexts (e.g. teaching, therapy, clinical discussions etc.).

7.5 Limitations and Strengths

There are several limitations and strengths to this research. Depending on the reader's orientation, a perceived limitation may be the absence of final, definite and generalisable *truth claims* which then precludes tangible, prescriptive recommendations. The findings put forward are tentative and represent one perspective (albeit a perspective arrived at after careful consideration of the findings from theoretically informed and methodologically robust research). Taking seriously theoretical-methodological coherence (Crotty, 1998) necessitates this, however, and research grounded in social constructionist thinking must acknowledge that any research and knowledge produced by it is itself a construction (Burr, 2015; De Fina & Georgakopoulou, 2015). Given that knowledge is constantly being transformed in this way, recommendations must be put forward tentatively so as not to contradict this assumption. Related to this is the inherent difficulty with definitively stating what is an *optimal* or *desirable* professional identity for clinical psychologists; a natural question arising out of the research findings and reflections. As asked by Mount et al. (2022): who is to say one process or construction of professional identity is better than another? Notwithstanding this constraint, I have advocated for professional identities that align with and support reforms in mental healthcare service delivery. I do so fully acknowledging this is my perspective and influenced by my interest in advancing reforms in mental healthcare services and systems (as described in my author position statement in Chapter 1, page 42).

A different set of limitations pertains to the *focus* of the research itself. Study 2 clearly indicated issues of intersectionality are highly relevant to the construction of clinical

psychologists' professional identities and existing critiques of the professional identity literature criticise the general lack of consideration of intersectionality and related issues pertaining to power (e.g., Volpe et al., 2019; Wyatt et al., 2021). A limitation of this research is that Studies 3 and 4 went on to explore professional identity construction in supervision in a way that did not specifically pursue this often-overlooked line of inquiry. Not only is this issue overlooked in professional identity research, but clinical psychology has been critiqued for overlooking issues pertaining to race, ethnicity, gender and so on in ways that perpetuate bias and disadvantage (Patel, 2003). This limitation is partially attributable to the constraints of the study sample used in Studies 3 and 4. The majority of clinical psychology trainee participants were white, able-bodied females aged 20-30 years (i.e., the hegemony in clinical psychology; Norcross & Karpiak, 2012). This is arguably an indicator of broader, systemic issues within the profession that favour and privilege certain groups of people over others (and are therefore over-represented in training programs). A critique could also arise from this sample as being small and constrained to one training clinic precisely because it impedes on the generalisability of findings. In the face of this possible criticism, I defer back to the inappropriate application of quantitative criteria being applied to social constructionist qualitative research (Crotty, 1998; Denzin & Lincoln, 2011). A more legitimate limitation is that Studies 3 and 4 succumbed to the tendency in professional identity research to focus on the education years (Mount et al., 2022), a concern perhaps particularly notable given the finding in Study 2 that the professional identities of clinical psychologists continue to transform across the professional life space beyond education. Although I maintain that exploring professional identity construction of clinical trainee clinical psychologists in education settings offers rich insights into how socialisation process influence this process, caution needs to be made against assuming that the nuance and complexities of professional

identity construction cease upon graduation and are therefore not worthy of exploration (Mount et al., 2022).

A notable strength of this research was the interdisciplinary supervisory team, theorising on identities incorporated into the research, and methods utilised. The research team spanned clinicians, researchers and educators across three distinct health care professions (medicine, nursing and clinical psychology) with a wide variety of theoretical, methodological and professional expertise and experience. This resulted in a less siloed approach, guaranteed taken for granted assumptions were challenged, and ensured the research and findings drew upon knowledge not otherwise considered within clinical psychology (e.g., nursing's emphasis on professional socialisation and medicine's emphasis in professional identity formation). In this way, this research rose above linguistic miscommunications between professions and benefitted from knowledge within these disciplines that ultimately investigates very similar phenomenon (see Volpe et al., 2019 who suggested the research across professions utilises different terminology but fundamentally explores similar phenomenon). This interdisciplinary approach ensured an expansion beyond constrained psychological theories of identities (Benwell & Stokoe, 2006; see critiques of psychological theorising on identities in Chapter 2, page 55) and resulted in the adoption of more sophisticated, discursive theorising on identities situated within a social constructionist epistemological perspective. A commitment to theory-method coherence (Crotty, 2009) resulted in the use of sophisticated qualitative research methods that overcame problematic dualisms between strictly micro and macro social constructionist approaches to researching identities (Burr, 2015). This allowed for attention to be paid at the micro level to the use of language in specific interactions alongside macro level considering how broader discourses, social structures and power relations influence and constrain professional identity construction. The above ultimately ensured that this research did not succumb to the tempting

but ultimately unhelpful tendency towards solutionism in professional identity and health care profession education research (Ajjawi & Eva, 2021). Learning from the critiques of models of professional identity (particularly in medicine and nursing) that result in speculative recommendations for educators (Monrouxe, 2016), this research instead drew on existing theories to shed light on the day-to-day ways in which professional identities and constructed and reconstructed.

7.6 Final Thoughts

Endings are communicatively challenging; difficult to get right. Although they form a part of everyday communication, there is also an expectation of significance by thoughtfully drawing out implications from what has previously been discussed (Tracy & Robles, 2013). To this end, I offer three final thoughts pertaining to clinical psychologists' professional identities: expanding our understanding of identities, embracing a critical lens with a consideration of power relations, and recognising the hopefulness in appreciating that professional identities are interrelated with the realisation of mental healthcare system reforms.

First, the social constructionist underpinnings of this research meant exploration of the question '*who am I as a clinical psychologist?'* could not originate from the notion of a fixed, singular and definable identity as grounds for investigation. Accepting the multiplicity, fluidity and complexity of identities opened up new empirical territory for exploring how and in what ways clinical psychologist's actively construct and negotiate who they are (Bamburg, 2011). There is much to be gained from this. Aspects of interactions that are usually invisible become visible; the forever incomplete ways in which talk and interactions shape who clinical psychologists are and become is able to be put under the spotlight. I am convinced that becoming more aware of that which often remains unseen can only be a good thing.

Second, clinical psychology has been critiqued for devaluing its derivation from and relation to the social order with the unintended effect of perpetuating the status quo and ways of knowing (Patel, 2003). When we recognise that our identities both *create* and are *created by* our social, cultural and political context; we are forced to engage in critical reflection of our own professional identities and how they create and serve the existing social order. Being unapologetically political requires attending to power relations – how sanctioned ways of knowing and being are produced and reproduced – so that we might be better placed to consider new and more promising ways of knowing and being.

Third, my motivation for and hope with this research was that it would perturb any complacency in clinical psychology. If our professional identities are constantly being created and renegotiated in the social world amidst moving discourses and interactions, then who we are is dynamic and never a settled matter. This is a powerfully hopeful realisation. If we as a profession are willing to look inwards, ask difficult questions, and reconsider ways of being and doing things, we have the potential to support tomorrow's clinical psychologists to acquire identities that contribute towards better clinical services for those who need them. This is not a selfish pursuit: how we define and work with the *other* (clients) is inherently bound up in our understanding of *ourselves* (Schrewe et al., 2017). We therefore owe it to them to pay careful attention to who we are and how we work so that we can do better.

Attempts to find answers – particularly regarding a matter as complex as our identities and who we are – inevitably generates further questions (Tsuman-Caspi, 2012). Solutionism is tempting but ultimately unhelpful (Ajjawi & Eva, 2021). What is presented is not the end of the discussion nor the only way of exploring this issue. Rather, this is a starting point for entering into the messy terrain of understanding clinical psychologists' professional identities. My hope is that reflections for the profession, educators and researchers in this thesis will support this process moving forward.

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Appendices

Appendix A

Chapter Three: Transformations to Professional Identity and the Implementation of Open Dialogue (Study 1)

Appendix A.1

Letter confirming Human Research Ethics Committee Approval

Research Integrity & Ethics Administration
Human Research Ethics Committee

Monday, 16 July 2018

Prof Niels Buus

Faculty of Nursing & Midwifery; Faculty of Medicine and Health
Email: niels.buus@sydney.edu.au

Dear Niels

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from **16 July 2018** to **16 July 2022.**

Project title: Changes to professional identity of mental health clinicians in implementing Open Dialogue

Project no.: 2018/506
First Annual Report due: 16 July 2019

Authorised Personnel: Buus Niels; Buus Niels; Rhodes Paul; Schubert Samantha Lorna;

Documents Approved: Date Uploaded	Version number	Document Name
08/07/2018	Version 2	Semi-structured Interview Guide
08/06/2018	Version 1	Email to interested participants
19/05/2018	Version 1	Participant Consent Form
19/05/2018	Version 1	Participant Information Statement
08/06/2018	Version 1	Verbal script to introduce study

Condition/s of Approval

- Research must be conducted according to the approved proposal.

- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.

- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
- ➢ Serious or unexpected adverse events (which should be reported within 72 hours).
- ➢ Unforeseen events that might affect continued ethical acceptability of the project.

- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).

- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.

- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.

- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.

- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.

- The Ethics Office may conduct audits on approved projects.

- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely

Associate Professor Michael Skilton

Chair, Health Review Committee (Low Risk) The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007).

Appendix A.2

Semi-structured Interview Guide

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Niels Buus
Chief Investigator

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Exploring the professional identity of mental health clinicians during implementation of Open Dialogue

SEMI-STRUCTURED INTERVIEW GUIDE

- Please tell me about your professional training and your qualifications. What is your current role? What is your current workplace?

- What are your experiences working with mental health service users? Which models of care have you primarily worked with throughout your career? Which model do you believe has the best fit with your current role?

- Please tell me about your current professional role. What are the most important competencies of someone in your role?

- How do you understand Open Dialogue following the training? In particular, how do you make sense of and understand the relevance of Open Dialogue in the context of your training and current work context?

- How do you understand the possibilities and impossibilities of implementing Open Dialogue in your training and current work context? In particular, how do you experience the implementation of Open Dialogue in your training and current work context?

- How do you make sense of or respond to Open Dialogue given your professional training and role? In particular, how does implementing Open Dialogue relate to your understanding of your work, training and professional identity?

- Thank you. Do you have anything to add to what we have been talking about? Do you have any questions to ask?

The interview guide is flexible any may therefore change according to the actual interview context. The interview will be actively constructed and specific questions will be developed according to participant responses to ensure exploration of the above topics.

Appendix A.3

Email to Interested Participants

THE UNIVERSITY OF SYDNEY

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Exploring the professional identity of mental health clinicians during implementation of Open Dialogue

EMAIL TO INTERESTED PARTICIPANTS

Dear _____

Thank you for expressing your interest in taking part in a research study by the University of Sydney investigating the experience of mental health clinicians in the initial stages of implementing Open Dialogue. The project aims to explore the professional identity of NSW mental health clinicians across inpatient and outpatient settings as they begin the initial process of learning about and implementing Open Dialogue.

This email is to thank you for your interest in participating and to pass on further information about the study.

Attached is a Participant Information Sheet and Participant Consent Form for you to view. The Participant Information Sheet explains who is running the study, what is involved, the process for withdrawing from the study if chosen, and how information from the study will be shared and used. As explained in the Participant Information Sheet, I'd like to emphasise that this study is completely voluntary and your decision whether to participate will not affect your relationship with the researchers or anyone else at the University of Sydney or any other organisation. *Please note you are not required to do anything with these forms at this stage*.

Following this email, I will be arranging times to conduct individual interviews. If you still wish to be involved, *could you please respond to this email indicating you have understood the information and your preference for when and how to be contacted to arrange an interview time*.

If any of this information is unclear, Professor Niels Buus is available to discuss the study with you further and answer any questions you may have. He can be contacted at niels.buus@sydney.edu.au or on 0429 835 019. Alternatively, you are welcome to respond to this email with any questions you have. I look forward to hearing from you.

Kind regards,

Samantha Schubert and Professor Niels Buus

Appendix A.4

Participant Consent Form

ABN 15 211 513 464

Professor Niels Buus
Chief Investigator

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Exploring the professional identity of mental health clinicians during implementation of Open Dialogue

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- ✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- ✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- ✓ The researchers have answered any questions that I had about the study and I am happy with the answers.
- ✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my participation in the consumer research training program or my relationship with the researchers or anyone else at the University of Sydney or any other organisation, now or in the future.
- ✓ I understand that I can withdraw from the study at any time.
- ✓ I understand that I can terminate the interview at any time if I do not wish to continue. I also understand that it will not be possible to withdraw my comments once the data from interviews has been deidentified and analysis of the information has begun.
- ✓ I understand that personal information from me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I

understand that information will only be told to others with my permission, except as required by law.

✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- Participating in a 60-90 minute interview.

Would you like to receive an audio file copy of your interview?

YES ☐ **NO ☐**

If you answered **YES**, please indicate your email below to send you this file:

Email: _____

.....

Signature

.....

PRINT name

.....

Date

Appendix A.5

Participant Information Statement

THE UNIVERSITY OF SYDNEY

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Exploring the professional identity of mental health clinicians during implementation of Open Dialogue

PARTICIPANT INFORMATION STATEMENT

What is this study about?

You are invited to take part in a research study by the University of Sydney investigating the experience of mental health clinicians in the initial stages of implementing Open Dialogue. The project aims to explore the professional identity of NSW mental health clinicians across inpatient and outpatient settings as they begin the initial process of learning about and implementing Open Dialogue.

You have been invited to participate in this study because you are a mental health clinician and participated in a one-week Open Dialogue training delivered by The Centre for Family-Based Mental Health Care and the University of Sydney.

This Participant Information Statement tells you about this research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

This copy of the Participant Information Statement is for you to keep.

Who is running the study?

The study is being carried out by the following researchers:

- Professor Niels Buus, Sydney Nursing School, The University of Sydney
- Ms Samantha Schubert, School of Psychology, The University of Sydney
- Associate Professor Paul Rhodes, School of Psychology, The University of Sydney

What will the study involve for me?

If you agree to participate in this study, you will be asked to participate in a 60-90 minute semi-structured interview with one of the researchers. This interview will explore your understanding of your professional identity and Open Dialogue, how you understand Open Dialogue following the training, your experiences of initially implementing Open Dialogue, and the impact this has had on your clinical work and sense of professional identity.

The interview will take place either in Sydney or Wollongong depending on your location at a time that is convenient for you. This time will be arranged directly between you and one of the researchers.

How much of my time will the study take?

The interview will last about 60 - 90 minutes and you do not have to prepare for it.

Who can take part in the study?

NSW Mental health workers who participated in the one-week Open Dialogue training and pre-training in Sydney (April 2018) or Wollongong (May 2018) are able to participate in this study.

Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect any current or future relationship with the researchers or anyone else at the University of Sydney or any other organisation.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time without giving a reason. There are no consequences for withdrawing from this research study.

You can withdraw from participating in the interview at any time, however, it will not be possible to withdraw individual responses once the data has been collected as all data collected will be de-identified.

You are also free to stop participating at any stage during the interview, and you do not have to answer all of the questions.

Signing the consent form is an indication of your consent to participate in the study.

Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study. All questions will be concerned with your experience and views on your sense of professional identity and initial experience of implementing Open Dialogue. On the small chance that you did become upset as a result of your participation in the study, the researchers will be able to assist you in contacting the NSW mental health line for further support.

Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from being in the study. However, possible benefits may include increased understanding of your personal experience with

implementing Open Dialogue, and satisfaction with contributing to understanding of how to implement this way of working in NSW mental health contexts.

What will happen to information about me that is collected during the study?

By participating in the focus groups, you are agreeing to us collecting personal information from you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

Interview data will be securely stored at Sydney Nursing School, The University of Sydney, and any identifying information will be kept strictly confidential, except as required by law. This will occur in order to analyse the data and storage will comply with the provisions of Australian privacy law. Only Professor Niels Buus and Ms Samantha Schubert will have access to identifying data. All other named researchers will have access to de-identified data, including Associate Professor Paul Rhodes. Interview data will be stored for 5 years, where upon it will be destroyed permanently. Study findings may be published, but you will not be individually identifiable in these publications.

Can I tell other people about the study?

You can talk to other people about what happened at interview.

What if I would like further information about the study?

When you have read this information, Professor Niels Buus will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Professor Niels Buus, Sydney Nursing School at niels.buus@sydney.edu.au, Phone: +61 (0) 429 835 019.

Will I be told the results of the study?

You have a right to receive an audio file of your interview from this study. You can tell us that you wish to receive audio file of the interview by ticking the relevant box on the consent form. You will receive this audio file after the study is finished.

What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney (Project Number: 2018/506). As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

Telephone: +61 2 8627 8176 **Email:** ro.humanethics@sydney.edu.au **Fax:** +61 2 8627 8177 (Facsimile)

Appendix A.6

Verbal Script to Introduce Study

THE UNIVERSITY OF SYDNEY

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Exploring the professional identity of mental health clinicians during implementation of Open Dialogue

VERBAL INTRODUCTION OF STUDY TO PARTICIPANTS

We would like to invite you to take part in a research study by the University of Sydney investigating the experience of mental health clinicians in the initial stages of implementing Open Dialogue. The project aims to explore the professional identity of NSW mental health clinicians across inpatient and outpatient settings as they begin the initial process of learning about and implementing Open Dialogue.

You are being invited to participate in this study because you are a mental health clinician and because you have participated in a one-week Open Dialogue training delivered by The Centre for Family-Based Mental Health Care and the University of Sydney.

The study is being run by Professor Niels Buus (Sydney University Nursing School, The University of Sydney), Ms Samantha Schubert (School of Psychology, The University of Sydney) and Associate Professor Paul Rhodes (School of Psychology, The University of Sydney).

If you agree to participate in this study, you will be asked to participate in a 60-90 minute semi-structured interview with one of the researchers. This interview will explore your understanding of your professional identity and Open Dialogue, how you understand Open Dialogue following the training, your experiences of initially implementing Open Dialogue, and the impact this has had on your clinical work and sense of professional identity.

The interview will take place either in Sydney or Wollongong depending on your location at a time that is convenient for you. This time will be arranged directly between you and one of the researchers.

Being in this study is completely voluntary. Your decision whether to participate will not affect any current or future relationship with the researchers or anyone else at the University of Sydney or any other organisation. If you decide to take part and then change your mind, you are free to withdraw at any time without giving a reason. There are no consequences for withdrawing from this research study.

If you are interested in participating in this study, and would like to receive an email with further information please provide your name, role, organisation and email address to the organisers of the training and you will be contacted directly.

Please note the information above will be provided verbally with opportunity for questions.

Appendix A.7

Supplementary Figure 1 (available online with published manuscript): Interview transcript from participant 2

1	P2	When I first stated working I had a client ↑ (.) that I did (.) that [boundaries] (.) with↑
2		where I was very (1.5) "no::: (.) you don't know.." >not "you don't know me"< but
3		you know like "that's transference" and "that's not real emotion" (.) and (.) a:fterwards
4		I reali::sed that (.) ↑ If he had known stuff about me that transference (.hh) >that bullshit<
5		wouldn't have happened (.) because it was like he had these (.) thoughts about me being
6		single and >all this other stuff< that wasn't tru::e (.) that (.) that same >like he would have
7		had a reaction< (.) but it probably wouldn't have been the same (.) and (.) and it felt
8		really cru::el ↑ to just be like (.) "that's it (.) boom" (.) you know (.) someone feels like
9		you have saved their life and you are like "that's it (.) no more" like "see you later" (.)
10		and it is also impossible ↓ (.) it is a li:e ↑ to think that you are not going to leak (.) you
11		are going to leak stuff (.) we leak emotions all the ti::me ↓ (.) we leak (.) you know
12		>even if you< (.) you leak (.) your spirit somehow into what's happening in any
13		interaction ↓ (.) so (.) I don't know (.) I feel like they are cheating >that's the other
14		consideration< (.) I feel like people are cheating a bit when they are like "yeah
15		relationship is important but (.) don't be yourse::lf in some way ↑ " (.) it is like
16		>"you ca::n't have it both ways"< (1.0) Either if the relationship is important then you
17		need to be really invested in it (1.0) or it's (.) or you're (.) a hypocrite (.)

Conventions used in transcripts: (.) indicates pause < 1 second, (x.0) indicates pause in x seconds, = indicates latching between utterances, [indicates interruption – and] end of simultaneous speech, ::: indicates stretching of sound, @ indicates laughter, .h indicates audible inhalation, hh indicates audible exhalation, emphasis, "spoken quieter", >spoken quicker<, ↑indicates rising or falling ↓ intonational shift.

Participant 2 is a clinical psychologist who works in a high-risk adolescent day unit. As seen in Supplementary Figure 1 she presents a 'now that I am wiser' narrative as she reflects on a past challenging experience trying to maintain strict professional boundaries. She positioned herself as necessarily prioritising the relationships with clients given the therapeutic importance of relationship modelling. She described the personal investment required in her role and how she draws upon her personal self to build and maintain therapeutic relationships. She described increasingly rejecting suggestions during clinical training that encouraged her to maintain strict professional boundaries with clients prior to the exert in Supplementary Figure 1.

She shifts back in time and draws on an earlier encounter with a client (line 1). She quotes her inner dialogue towards the client at that time in an exaggerated fashion (line 2) before correcting herself to emphasise the gravity of what is spoken about. Quoting herself again using professional terminology (line 3) maintains a safe proximity with the profession and deems her a reliable source. Shifting forwards in time, she emphasises the realisation she had (line 4). Her emphasis on "realisation" signals a change; at first she uses technical language ("transference") before quickly

interjecting and replacing this with profanities (line 4). She speaks rapidly with emotion before quickly moderating herself by providing a slower, tempered description of the situation (lines 5-6). She speaks quickly to provide a qualifier for what she is saying by admitting there would have been some reaction (lines 6-7), allowing her to ward of criticisms from others who might take her stance to an extreme. She returns to her point by at first predicting the reaction might have differed (line 7), but then shifts to how it felt cruel for her on a more personal level (line 8). The emphasis and stretching of "cruel", as well as the intonation, indicate this may be a new label applied to the situation. She quotes her past professional self in mockery (lines 8-9). Juxtaposing the depth of a person believing a clinician has saved their life with the casual farewell greeting from a clinician (line 9) seems dismissive and jarring. Afterwards, participant 2 shifts thoughts and introduces a new truth about the impossibilities of not "leaking" in relationships. She extends 'impossible' into a "lie" (line 10) and in doing so alludes to intentionality on someone's part to perpetuate this idea and possibly sets the tone for becoming increasingly confrontational. She restates the impossibility of not leaking with brief, sharp statements that increase the intensity before she arrives at her conclusion: we leak emotions into interactions (line 11). "Emotions" is upgraded to "spirit" to punctuate her point (line 12) and she extends this beyond clinical relationships to *all* human interactions. She hesitates as she regains her thoughts (line 13) and shifts to a new proposition. She briefly scaffolds this idea as a related thing to consider (lines 13-14), and then talks about her own feelings as if responding to the lies alluded to earlier (line 10). The liars become cheaters (line 14) and she quotes them directly, and with exaggeration, to highlight their strict instructions for clinicians not to be themselves (lines 14-15). Speaking with escalating emotion and rapidly so as to prevent interruption, she confronts these cheaters based on their illogical demands (line 16). Pausing, once again after an emotional escalation, she asserts clear options the demand clinicians to invest themselves into relationships they consider important, or else be labelled a "hypocrite" (line 17).

Appendix A.8

Supplementary Figure 1 (available online with published manuscript): Interview transcript from participant 2

1	P3	Especially before the session started it was kind of like "well (1.0) we really want this to
2		>you know< consideration prescribing medication" (.) .h and >medication had already
3		been recommended< (.) from Westmead >like Olanzapine< so (1.0) and I am not the sort
4		of person who:: ↓ (2.5) like (.) that's generally not my default ↑ Cause I kind of feel =
5	I	= Medication?
6	P3	Yeah so I'm kind of feeling put in this situation that (.) > almost like your hands are
7		cuffed a bit you know < (.) >"this is what we really need you to do"< @@ and ↑ I sort
8		of thought ↑ "well, that's fine I'll just prescribe it" >you know< (.) "Westmead
9		recommended it and they are experts so (.) not a big deal" ↓ (1.) ↑ I guess asking people
10		"let's talk about the medication" and the way the girl responded and she wasn't so happy
11		(.) to have it (.) then asking others what they think (.) in the back of my mind I am
12		thinking (.)↑ "Oh:: are they (.) are they thinking" >you know< >"He really should do it"<
13		>"What's he doing?"< >"He's got to be quite firm about this"< and (.) I had been
14		worried about what they were thinking as well (.) but then getting them to talk and say
15		what they were thinking openly (.) to know exactly (.) you know (.) I guess (.)↑ that was
16		quite reassuring I suppose (.) and anxiety alleviating (.) and then (1.5) ↑ I guess also
17		feeling that the >sort of< the weight of the manner of respectfully asking each person's
18		opinions and (.) um (.) and finding in the end that we all were actually able to agree ↑
19		(.) on (.) >you know< on a plan that didn't include medication to be prescribed that day
20		(.) but >you know< seven days later.
21	I	You look surprised when you say that.
22	P3	↑ Yeah (.) I was yeah because very much the frame before had been like >you know<
23		she had gone to ED two or three times (.) there was a lot of >you know< anxiety and
24		concern that the police had been called and >you know< @@ (.) so it was (.) there
25		was really a lot of pressure (2.0) to do that (1.0) so (1.5) ↑ yeah (.) so it was kind of nice
26		to be able to (.)↑ and >I guess< I kind of like (.) quite reaffirming for my sense of not
27		wanting to be just seen as a prescriber (.) >you know< but someone with >you know<
28		expertise in therapy or family therapy as well so I guess that was validating from that
29		view as well.

Participant 3 is a psychiatrist who openly discussed his reservations about Open Dialogue after training extensively in Systemic Family Therapy because he felt his expertise was being threatened. He wished to be seen as a family therapist rather than medication prescriber. He spoke of an impromptu Open Dialogue session with a young girl with a severe eating disorder displaying aggressive behaviour and how this resulted in family dialogue that resulted in not needing to immediately medicate the girl against her will. He reported receiving the referral from the emergency department with a recommendation to medicate as seen in Supplementary Figure 2.

Participant 3 begins by articulating the voices of clinicians generating the referral and their suggestion to medicate (lines 1-2) and clarifying that medication had already been recommended (lines 2-3). He contrasts this with his personal stance and distinguishes himself as defaulting to other models of care (line 4). His pauses and false starts indicate escalating apprehension. He alludes to

other clinicians *doing something to him* as a psychiatrist; imposing expectations to medicate (line 6) and positions himself as feeling constrained by expectation (lines 6-7). Introducing the voice of these pressuring clinicians invites the listener closer to his experience (line 7). Nervous laughter (line 7) suggests possible embarrassment in his ceding to these requests. Splitting his current self off from his inner dialogue at the time, he shares his thoughts at the time which minimise the importance of the situation and position other clinicians as the expert and absolve him of responsibility (lines 8-9). A slight pause and change of tone shift the conversation to his approach of asking the girl about her preferences (line 10) and he admits her reluctance, before rapidly shifting again to other voices in his mind aware of how colleagues perceive his judgement. The inflexion and ensuing rapid dialogue between his inner voices (lines 12-13) emphasise the intrusive and undermining quality of these voices and how he perceives other's expectations of him as a psychiatrist. Quickly composing himself and shifting to the present, he describes these worries. Hesitations (line 15) indicate his escalating anxiety culminating in what appears to be the critical point: an admission that *he* felt reassured and *his* anxiety alleviated (line 16). A long pause gives rise to an emerging reflection. Hesitations and pauses appear as he realises and acknowledges that respectfully asking questions to elicit opinions gave rise to an alternative outcome: agreement on a plan without immediate medication (lines 16-19). The emphasis on agreement and shift in tone suggest surprise. He clearly affirms his surprise (line 22) before shifting back in time and recounting the dramatic features of the presentation to justify his experience of pressure (line 25). Emphasis on pressure followed by a long pause and distancing himself from the act of medicating through the use of "that" (line 25) signals further attempts to distance himself from the role of medicator. Shifting and hesitating with pauses and re-starts, his tone softens and he displays a glimpse of vulnerability talking about feeling "nice" (line 25). Short lived, he quickly self-corrects and re-directs with still some hesitancy about his own preferred identity as a psychiatrist being reaffirmed (line 26). Emphasis on and use of the identity label "prescriber" introduces a sense of his role being reducible to one of simple medication prescription (line 27). Hesitations signal emerging self-consciousness as he reflects on how the experience validated him as a psychiatrist: in positioning him as beholding the one thing he seeks recognition for; therapeutic expertise.

Appendix B

Chapter Four: Scoping Review Exploring the Professional Identities of Clinical Psychologists (Study 2)

Appendix B.1

Blaxter (2013) Criteria for the Evaluation of Qualitative Research

Item	Description
1	Are the methods of the research appropriate to the nature of the question being asked?
2	Is the connection to an existing body of knowledge clear?
3	Are there clear accounts of the criteria used for the selection of subjects for study, and of the data collection and analysis?
4	Is the selection of cases or participants theoretically justified?
5	Does the sensitivity of the methods match the needs of the research questions?
6	Has the relationship between fieldworkers and subjects been considered, and is there evidence that the research was presented and explained to participants?
7	Was the data-collection and record keeping systematic?
8	Is reference made to accepted procedures for analysis?
9	How systematic is the analysis?
10	Is there adequate discussion of how themes, concepts and categories were derived from the data?
11	Is there adequate discussion of the evidence both for and against the researcher's
12	arguments?
13	Have measures been taken to test the validity of the findings?
14	Have any steps been taken to see whether the analysis would be comprehensible to the participants, if this is possible and relevant?
15	Is the research clearly contextualised?
16	Are the data presented systematically?
	Is a clear distinction made between the data and it's interpretation?
17	Is sufficient of the original evidence presented to satisfy the reader of the relationship
18	between the evidence and conclusions?
19	Is the author's own position clearly stated?
20	Are the results credible and appropriate?
	Have ethical issues been adequately considered?

Appendix C

Chapters Five and Six: Interrogations in Clinical Supervision (Study 3) and Fragilising Clients in Clinical Supervision (Study 4)

Appendix C.1

Letter confirming Human Research Ethics Committee Approval

Prof Caroline Hunt

Thursday, 14 January 2021

Psychology; Faculty of Science
Email: caroline.hunt@sydney.edu.au

Dear Caroline,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application. I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows: **Project No.:**	**2020/788**
Project Title:	**Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters**
Authorised Personnel:	**Hunt Caroline; Buus Niels; Schubert Samantha Lorna; Monrouxe Lynn;**
Approval Period:	**14/01/2021** to **14/01/2025**
First Annual Report Due:	**14/01/2022**

Documents Approved:

Date Uploaded	Version Number	Document Name
17/12/2020	Version 2	Supervisor Demographics Questionnaire
17/12/2020	Version 2	Supervisor Participant Info Statement
17/12/2020	Version 2	Email to Supervisors and Trainees
17/12/2020	Version 2	Trainee Demographics Questionnaire
17/12/2020	Version 2	Trainee Participant Information Statement
17/12/2020	Version 2	Trainee Participant Consent Form
17/12/2020	Version 2	Supervisor Participant Consent Form
17/12/2020	Version 2	Email to Psychology Clinic Director

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.

- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate immediate risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the National Statement on Ethical Conduct in Human Research, the Australian Code for the Responsible Conduct of Research, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Associate Professor Carolyn Maccann
Chair
Psychology Review Committee (Low Risk)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's Australian Code for the Responsible Conduct of Research (2018)

Appendix C.2

Supervisor Demographics Questionnaire

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

Room 316
M02F 88 Mallett Street
Camperdown
NSW 2006 AUSTRALIA
Telephone: +61 2 9114 4340
Email: caroline.hunt@sydney.edu.au
Web: http://www.sydney.edu.au/

Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

DEMOGRAPHIC QUESTIONNAIRE (Supervisors)

Please complete the below questions. If you would prefer not to answer a specific question, then please select the option 'prefer not to say'. This information will be kept confidential and de-identified.

Participant name: _____

(1) What gender do you identify as?
- ○ Female
- ○ Male
- ○ Other (if other, please specify): _____
- ○ Prefer not to say

(2) What is your age?
- ○ 30-35 years old
- ○ 35-40 years old
- ○ 40-45 years old
- ○ 45+ years old
- ○ Prefer not to say

(3) Please specify your ethnicity:
- ○ Caucasian
- ○ Asian
- ○ Pacific Islander
- ○ Hispanic or Latino
- ○ African
- ○ Black or African American
- ○ Mixed
- ○ Other (if other, please specify): _____

- Prefer not to say

(4) Do you consider yourself to be:

- Heterosexual or straight
- Homosexual
- Bisexual
- Other (if other, please specify): _____
- Prefer not to say

(5) Do you identify as Aboriginal or Torres Strait Islander?

- Yes
- No
- Prefer not to say

(6) Do you identify as a person with a disability?

- Yes
- No
- Prefer not to say

(7) What is the highest level of education you have attained?

- Bachelor's degree
- Master's degree
- Doctorate degree of Doctor of Philosophy
- Prefer not to say

(8) How long have you been a supervisor for trainee clinical psychologists?

- 0-5 years
- 5-10 years
- 10-20 years
- 20+ years
- Prefer not to say

(9) How would describe your current *primary* theoretical orientation?

- Cognitive behavioural
- Dialectical behavioural
- Humanistic
- Rogerian or client centered
- Existential
- Psychoanalytic
- Psychodynamic
- Attachment based
- Systemic / family systems
- Interpersonal
- Eclectic / integrative
- Other (if other, please specify): _____
- Prefer not to say

Appendix C.3

Supervisor Participant Information Statement

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

Room 316
M02F 88 Mallett Street
Camperdown
NSW 2006 AUSTRALIA
Telephone: +61 2 9114 4340
Email: caroline.hunt@sydney.edu.au
Web: http://www.sydney.edu.au/

Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

PARTICIPANT INFORMATION STATEMENT (Supervisor)

What is this study about?

You are invited to take part in a research study by the University of Sydney exploring the professional identity of trainee clinical psychologists. The project aims to explore the development of professional identity amongst trainee clinical psychologists in the context of clinical supervision. The findings of this research will be relevant to supporting the training and development of clinical psychologists.

You have been invited to participate in this study because you are a supervisor at the Psychology Clinic at the University of Sydney. This Participant Information Statement tells you about this research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

This copy of the Participant Information Statement is for you to keep.

Who is running the study?

The study is being carried out by the following researchers:

- Professor Caroline Hunt, School of Psychology, The University of Sydney
- Ms Samantha Schubert, School of Psychology, The University of Sydney
- Professor Niels Buus, Sydney Nursing School, The University of Sydney

- Professor Lynn Monrouxe, School of Health Sciences, The University of Sydney

Samantha Schubert is conducting this study as part of a Master of Clinical Psychology/Doctor of Philosophy at the University of Sydney. This will take place under the supervision of Professor Caroline Hunt, Professor Niels Buus and Professor Lynn Monrouxe.

It is acknowledged that Professor Caroline Hunt is the Head of the Clinical Psychology Unit and has a pre-existing relationship with the Psychology Clinic at the University of Sydney. For this reason, Professor Caroline Hunt will not be participating in this study as a supervisor and will not be involved in analysing any data before it has been de-identified. Professor Caroline Hunt will have no access to any identifiable data at any stage throughout the research process or after the research has been completed.

What will the study involve for me?

If you agree to participate in this study, we will be asking you to complete a demographic questionnaire and have supervision sessions recorded with trainees in the clinic (one session per trainee that you supervise who agrees to participate in this research).

The demographic questionnaire will be used to gather basic demographic data for the study. You will be asked to indicate your age (range), gender, ethnicity, sexual identity, identity as an Aboriginal or Torres Strait Islander person, and whether you identify as a person with a disability, so that we can understand the diversity of the sample collectively. This is because there is an underrepresentation of certain identities in student and teaching cohorts within psychology and we want to be transparent about the sample from which the findings are drawn. There is an option to select 'prefer not to disclose' for any question you would prefer not to answer. This data will be deidentified prior to analysis of the data gathered from supervision sessions. This data will also be amalgamated so that identifying features are not reported on individually.

We will also ask you to agree to record one supervision session with select trainees in the clinic who also agree to participate in this study. Recordings will only be made of sessions where both supervisors and trainees have provided written consent. You do not need to do anything differently in this session than would otherwise occur in supervision. We will ask you to record the entire 60-minute supervision session using an audio recorder that will be provided by the research team.

One of the researchers will contact you with notice of when the audio recordings can be made. On the day of the recording, Samantha Schubert will attend the beginning of the supervision session to obtain oral consent and start recording the session using a hand-held audio recorder. You will be asked to stop this recording at the conclusion of the supervision session once the trainee has left. Once the audio recording has been made arrangements will be made to return the audio recording device to Samantha Schubert immediately afterwards.

You will also have the opportunity to participate in a debrief interview with Samantha Schubert after the data has been collected if you wish. This can be done in person or over Zoom. This is an unstructured interview and not part of the data collection process but will be available for you if you have any reflections or concerns about the research.

You will also have the opportunity to review preliminary findings of this study prior to the preparation of a manuscript. These findings will not disclose specific identifiable features of supervision but cover

the overall findings of the research. You can indicate you wish to receive a copy of these preliminary findings on the consent form.

How much of my time will the study take?

The demographic questionnaire should take no more than five minutes to complete and can be completed online securely using an online survey platform. The recording will not take any additional time and can be made during your pre-arranged supervision sessions.

Who can take part in the study?

Supervisors and trainees within the Psychology Clinic at the University of Sydney during Semester 1 2021 will be eligible to participate. No exclusion criteria to supervisors will be applied. The only exception is that Professor Caroline Hunt and the trainees she supervises will not be eligible to participate in this research if she is supervising in the Psychology Clinic at this time given her involvement in this research.

Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect any current or future relationship with the researchers or anyone else at the University of Sydney or any other organisation.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time without giving a reason. There are no consequences for withdrawing from this research study.

You can withdraw from having the supervision sessions recorded at any time, however, it will not be possible to withdraw individual responses once the data has been de-identified and the analysis has commenced. This is because it will not be possible to trace individual contributions to the data set.

You are also free to turn off the recorder at any time during the supervision sessions.

Signing the consent form is an indication of your consent to participate in the study.

Are there any risks or costs associated with being in the study?

We do not expect that there will be any risks or costs associated with taking part in this study. As the supervision sessions being recorded will be occurring irrespective of the recording taking place, we do not anticipate any costs in relation to time. We appreciate having supervision sessions recorded may feel unfamiliar but hope the training orientation of the clinic and pre-existing recording of client sessions means trainees are used to being recorded in the clinic. On the small chance you did become upset as a result of your participation in the study, the researchers will be offering a debrief interview and are able to assist you with making contact with suitable services or organisations.

Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from being in the study. However, a possible benefit may include increased satisfaction with contributing to research exploring

professional identity development with the intention of improving the education and training of clinical psychologists.

What will happen to information about me that is collected during the study?

By participating in this study, you are agreeing to us collecting some personal demographic information from you and audio recordings of supervision sessions for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

All data will be securely stored at the Clinical Psychology Clinic, The University of Sydney, and any identifying information will be kept strictly confidential, except as required by law. This will occur in order to analyse the data and storage will comply with the provisions of Australian privacy law.

Only Samantha Schubert will have access to identifying data. Audio recordings and interview transcripts will be de-identified before data analysis. A numerical coding system will be used to ensure de-identified data can be reidentified if needed for auditing purposes or data withdrawal, and this will be recorded in a password protected file, stored securely and accessible only by Samantha Schubert. This data will be stored on a secure electronic database recommended by the University of Sydney. No researcher except for Samantha Schubert will have access to any identifiable data.

Data will be stored securely for 5 years, where upon it will be destroyed permanently. Study findings may be published, but you and the Psychology Clinic at the University of Sydney will not be individually identifiable.

Can I tell other people about the study?

You can talk to other people about this study to the extent that doing so does not breach pre-existing confidentiality agreements between yourself and the trainees you supervise.

What if I would like further information about the study?

When you have read this information, Samantha Schubert will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Samantha Schubert at ssch4978@uni.sydney.edu.au.

Will I be told the results of the study?

You have a right to receive the audio file of your supervision session from the study if this is agreed by both you and the relevant trainee. You can tell us that you wish to receive an audio file of the interview by ticking the relevant box on the consent form. You will receive this audio file after the study is finished if the respective trainee has agreed to this. You can also indicate whether you consent to trainees receiving an audio file copy of their supervision session if requested.

You will also have the opportunity to receive a copy of the preliminary findings of the research via post or email. You will be able to indicate your preference for this on the consent form. These preliminary findings will not include information about individual supervision sessions but will outline an overall summary of the findings of the research.

What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney (protocol number **2020/788**). As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** ro.humanethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

Appendix C.4

Email to Supervisors and Trainees

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

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NSW 2006 AUSTRALIA
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Email: caroline.hunt@sydney.edu.au
Web: http://www.sydney.edu.au/

Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

PARTICIPANT RECRUITMENT EMAIL (supervisors and trainees)

Dear supervisors and trainees,

This email is to inform you about a study being conducted by Professor Caroline Hunt and Samantha Schubert (MCP/PhD candidate) here at the University of Sydney exploring the professional identities of clinical psychologists. The study is titled 'Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters'. This research builds on studies that have highlighted the highly idiosyncratic journeys of becoming therapists that require a developing sense of oneself as a therapist (see Rønnestad & Skovholt, 2013). It is hoped that the findings of this research will contribute to the education and training of clinical psychologists to support optimal professional identity development.

The purpose of this study is to explore how clinical psychologists develop within supervision. The purpose is *not* to evaluate competence or any other technical aspect of supervision, and participants will in no way be evaluated or assessed as part of this study.

You are being emailed to invite you to participate in this research.

Participation is voluntary and will involve two components:

i) completion of a brief demographic questionnaire, and
ii) audio recording of one supervision session per supervisor and trainee.

It is anticipated the completion of the demographic questionnaire will take less than five minutes, and recordings of supervision sessions will require no additional time commitment.

A confidential link to an online questionnaire will be sent to your email address. The questionnaire does ask about your gender, age, ethnicity, sexual identity, identity as an Aboriginal or Torres Strait Islander person, and whether you identify as a person with a disability. This is because we are interested in understanding the diversity of the sample collectively. This information will all be deidentified and there is also the option of selecting 'prefer not to disclose' for any question.

Recording of supervision sessions is expected to occur in January or February 20201. The audio recordings will be transcribed and will be completely confidential, de-identified and not shared with other staff or students. All data will be stored securely. Only Samantha Schubert will have access to any of the original identified data which means the rest of the research team will not have access to this information.

In order to participate in this study and have a supervision session recorded, written consent is required by both the supervisor and trainee. There are no exclusion criteria except that trainees must be in their final internal clinical placement as part of the Master of Clinical Psychology or Master of Clinical Psychology/Doctor of Philosophy. Trainees under the supervision of Professor Caroline Hunt will also not be eligible to participate given her pre-existing link with this research.

Attached is a Participant Information Statement and Consent Form (please note there are separate forms for supervisors and trainees). After reading the Participant Information Statement, if you would like to participate in this research then please complete the relevant consent form and return this to Samantha Schubert directly. You can email Samantha Schubert at ssch4978@uni.sydney.edu.au and arrangements can be made to return this form. Alternatively, consent forms can be returned to the clinic reception in a secure and non-identifiable envelope addressed to Samantha Schubert. These will be stored securely and collected by Samantha Schubert. After completing a consent form, you will be asked to complete a demographic questionnaire which will be able to be completed online and the link will be sent to you by Samantha Schubert. If both the supervisor and trainee provide written consent to participate in this research, you will be contacted by Samantha Schubert via email with further details to arrange the audio recording of a supervision session.

Samantha Schubert will be attending one of the weekly trainee and supervisor meetings in February 2021 to provide further information about this study and allow interested participants to ask any questions.

If you would like further information about this research, please email Samantha Schubert at ssch4978@uni.sydney.edu.au. Samantha Schubert is completing this research as part of her PhD and is available to answer any questions.

Thank you in advance for considering participating within this research. We hope that this research makes a meaningful contribution to understanding the development of the identities of clinical psychologists.

With kind regards,

Samantha Schubert (PhD student)

Appendix C.5

Trainee Demographics Questionnaire

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

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Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

DEMOGRAPHIC QUESTIONNAIRE (Trainees)

Please complete the below questions. If you would prefer not to answer a specific question, then please select the option 'prefer not to say'. This information will be kept confidential and de-identified.

Participant name: _____

(1) What gender do you identify as?

- ○ Female
- ○ Male
- ○ Other (if other, please specify): _____
- ○ Prefer not to say

(2) What is your age?

- ○ 20-25 years old
- ○ 25-30 years old
- ○ 30-35 years old
- ○ 35-40 years old
- ○ 40-45 years old
- ○ 45+
- ○ Prefer not to say

(3) Please specify your ethnicity:

- ○ Caucasian
- ○ Asian
- ○ Pacific Islander
- ○ Hispanic or Latino
- ○ African

- Black or African American
- Mixed
- Other (if other, please specify): _____
- Prefer not to say

(4) Do you consider yourself to be:

- Heterosexual or straight
- Homosexual
- Bisexual
- Other (if other, please specify): _____
- Prefer not to say

(5) Do you identify as Aboriginal or Torres Strait Islander?

- Yes
- No
- Prefer not to say

(6) Do you identify as a person with a disability?

- Yes
- No
- Prefer not to say

(7) What is the highest level of education you have attained?

- Bachelor's degree
- Master's degree
- Doctorate degree of Doctor of Philosophy
- Prefer not to say

(8) What degree are you enrolled in?

- Master of Clinical Psychology
- Master of Clinical Psychology/Doctor of Philosophy

(9) Please indicate the name of your current supervisor within the Psychology Clinic:

_____

Appendix C.6

Trainee Participant Information Statement

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

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Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

PARTICIPANT INFORMATION STATEMENT (Trainee)

What is this study about?

You are invited to take part in a research study by the University of Sydney exploring the professional identity of trainee clinical psychologists. The project aims to explore the development of professional identity amongst trainee clinical psychologists in the context of clinical supervision. The findings of this research will be relevant to supporting the training and development of clinical psychologists.

You have been invited to participate in this study because you are a trainee at the Psychology Clinic at the University of Sydney. This Participant Information Statement tells you about this research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

This copy of the Participant Information Statement is for you to keep.

Who is running the study?

The study is being carried out by the following researchers:

- Professor Caroline Hunt, School of Psychology, The University of Sydney
- Ms Samantha Schubert, School of Psychology, The University of Sydney
- Professor Niels Buus, Sydney Nursing School, The University of Sydney

- Professor Lynn Monrouxe, School of Health Sciences, The University of Sydney

Samantha Schubert is conducting this study as part of a Master of Clinical Psychology/Doctor of Philosophy at the University of Sydney. This will take place under the supervision of Professor Caroline Hunt, Professor Niels Buus and Professor Lynn Monrouxe.

It is acknowledged that Professor Caroline Hunt is the Head of the Clinical Psychology Unit and has a pre-existing relationship with the Psychology Clinic at the University of Sydney. For this reason, Professor Caroline Hunt will not be participating in this study and will not be involved in analysing any data before it has been de-identified. Professor Caroline Hunt will have no access to any identifiable data at any stage throughout the research process or after the research has been completed.

What will the study involve for me?

If you agree to participate in this study, we will be asking you to complete a demographic questionnaire and have one supervision session recorded with your supervisor in the clinic.

The demographic questionnaire will be used to gather basic demographic data for the study. You will be asked to indicate your age (range), gender, ethnicity, sexual identity, identity as an Aboriginal or Torres Strait Islander person, and whether you identify as a person with a disability, so that we can understand the diversity of the sample collectively. This is because there is an underrepresentation of certain identities in student and teaching cohorts within psychology and we want to be transparent about the sample from which the findings are drawn. There is an option to select 'prefer not to disclose' for any question you would prefer not to answer. This data will be deidentified prior to analysis of the data gathered from supervision sessions. This data will also be amalgamated so that identifying features are not reported on individually.

We will also ask you to agree to record one supervision session with your supervisor in the clinic who also must have agreed to participate in this study. Recordings will only be made of sessions where both supervisors and trainees have provided written consent. You do not need to do anything differently in this session than would otherwise occur in supervision. The entire 60-minute supervision session will be audio recorded using an audio recorder provided by the research team.

One of the researchers will contact you and your supervisor with notice of when the audio recordings can be made. On the day of the recording, Samantha Schubert will attend the beginning of the supervision session to obtain oral consent and start recording the session using a handheld audio recorder. Your supervisor will be asked to stop this recording at the conclusion of the supervision session once you have left. Once the audio recording has finished, arrangements will be made to return the audio recording device to Samantha Schubert immediately afterwards. The audio recording will not be accessed by or listened to by any other person.

You will also have the opportunity to participate in a debrief interview with Samantha Schubert after the data has been collected if you wish. This can be done in person or over Zoom. This is an unstructured interview and not part of the data collection process but will be available for you if you have any reflections or concerns about the research.

You will also have the opportunity to review preliminary findings of this study prior to the preparation of a manuscript. These findings will not disclose specific identifiable features of supervision but cover

the overall findings of the research. You can indicate you wish to receive a copy of these preliminary findings on the consent form.

How much of my time will the study take?

The demographic questionnaire should take no more than five minutes to complete and can be completed online securely using an online survey platform. The recording will not take any additional time and can be made during your pre-arranged supervision sessions.

Who can take part in the study?

Supervisors and trainees within the Psychology Clinic at the University of Sydney during Semester 1 2021 will be eligible to participate. No exclusion criteria to supervisors will be applied. The only exception is that Professor Caroline Hunt and the trainees she supervises will not be eligible to participate in this research if she is supervising in the Psychology Clinic at this time given her involvement in this research.

Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect any current or future relationship with the researchers or anyone else at the University of Sydney or any other organisation. It will have no implications for your performance during the internship or on the course.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time without giving a reason. There are no consequences for withdrawing from this research study.

You can withdraw from having the supervision sessions recorded at any time, however, it will not be possible to withdraw individual responses once the data has been de-identified and the analysis has commenced. This is because it will not be possible to trace individual contributions to the data set.

You are also free to request that your supervisor turn off the recorder at any time during the supervision session.

Signing the consent form is an indication of your consent to participate in the study.

Are there any risks or costs associated with being in the study?

We do not expect that there will be any risks or costs associated with taking part in this study. As the supervision sessions being recorded will be occurring irrespective of the recording taking place, we do not anticipate any costs in relation to time. We appreciate having supervision sessions recorded may feel unfamiliar but hope the training orientation of the clinic and pre-existing recording of client sessions means you will be used to being recorded in the clinic. On the small chance you did become upset as a result of your participation in the study, the researchers will be offering a debrief interview and are able to assist you with making contact with suitable services or organisations.

Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from being in the study. However, a possible benefit may include increased satisfaction with contributing to research exploring

professional identity development with the intention of improving the education and training if clinical psychologists.

What will happen to information about me that is collected during the study?

By participating in this study, you are agreeing to us collecting some personal demographic information from you and an audio recording of one supervision session for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

All data will be securely stored at the Clinical Psychology Clinic, The University of Sydney, and any identifying information will be kept strictly confidential, except as required by law. This will occur in order to analyse the data and storage will comply with the provisions of Australian privacy law.

Only Samantha Schubert will have access to identifying data. Audio recordings and interview transcripts will be de-identified before data analysis. A numerical coding system will be used to ensure de-identified data can be reidentified if needed for auditing purposes or data withdrawal, and this will be recorded in a password protected file, stored securely and accessible only by Samantha Schubert. This data will all be stored on a secure electronic database recommended by the University of Sydney. No researcher except for Samantha Schubert will have access to any identifiable data.

Data will be stored securely for 5 years, where upon it will be destroyed permanently. Study findings may be published, but you and the Psychology Clinic at the University of Sydney will not be individually identifiable.

Can I tell other people about the study?

You can talk to other people about this study to the extent that doing so does not breach pre-existing confidentiality agreements between yourself and your supervisor.

What if I would like further information about the study?

When you have read this information, Samantha Schubert will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Samantha Schubert at ssch4978@uni.sydney.edu.au.

Will I be told the results of the study?

You have a right to receive the audio file of your supervision session from the study if this is agreed by both you and your supervisor. You can tell us that you wish to receive an audio file of the interview by ticking the relevant box on the consent form. You will receive this audio file after the study is finished if your supervisor has agreed to this. You can also indicate whether you consent to your supervisor receiving an audio file copy of the supervision session if requested.

You will also have the opportunity to receive a copy of the preliminary findings of the research via post or email. You will be able to indicate your preference for this on the consent form. These preliminary findings will not include information about individual supervision sessions but will outline an overall summary of the findings of the research.

What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney (protocol number **2020/788**). As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** ro.humanethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

Appendix C.7

Trainee Participant Consent Form

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

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Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

PARTICIPANT CONSENT FORM (Trainee)

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- ✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- ✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- ✓ The researchers have answered any questions that I had about the study and I am happy with the answers.
- ✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney or any other organisation, now or in the future.
- ✓ I understand that I can withdraw from the study at any time.
- ✓ I understand that I can request my supervisor to stop the audio recording of my supervision session at any time if I do not wish to continue. I also understand that it will not be possible to withdraw data from the study once this has been deidentified and analysis of the information has begun.

- ✓ I understand that personal information from me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information will only be told to others with my permission, except as required by law.

- ✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- **Audio-recording** YES ☐ NO ☐

- **Being contacted about future studies** YES ☐ NO ☐

I would like to receive feedback about the overall results of this study YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal:
_____

☐ Email:
_____

Would you like to receive an audio file copy of the supervision session (consent also required from supervisor)?

YES ☐ NO ☐

If you answered **YES**, please indicate your email below to send you this file:

Email: _____

Do you consent to your supervisor receiving an audio file copy of the supervision session if requested?

YES ☐ NO ☐

.....

Signature

.....

PRINT name

.....

Date

Appendix C.9

Supervisor Participant Consent Form

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

Professor Caroline Hunt
Chief Investigator

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Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

PARTICIPANT CONSENT FORM (Supervisor)

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- ✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- ✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- ✓ The researchers have answered any questions that I had about the study and I am happy with the answers.
- ✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney or any other organisation, now or in the future.
- ✓ I understand that I can withdraw from the study at any time.
- ✓ I understand that I can stop the audio recording of supervision sessions at any time if I do not wish to continue. I also understand that it will not be possible to withdraw data from

supervision sessions once this has been deidentified and analysis of the information has begun.

✓ I understand that personal information from me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information will only be told to others with my permission, except as required by law.

✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- **Audio-recording** YES ☐ NO ☐
- **Being contacted about future studies** YES ☐ NO ☐

I would like to receive feedback about the overall results of this study YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal:
_____

☐ Email:
_____

Would you like to receive an audio file copy of the supervision sessions (consent also required from trainee)?

YES ☐ NO ☐

If you answered **YES**, please indicate your email below to send you this file:

Email: _____

Do you consent to trainees receiving an audio file copy of their supervision session if requested?

YES ☐ NO ☐

.....

Signature

.....

PRINT name

.....

Date

Appendix C.9

Email to Psychology Clinic Director

THE UNIVERSITY OF SYDNEY

ABN 15 211 513 464

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Chief Investigator

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Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters

EMAIL TO CLINIC DIRECTOR (Notification of Research)

Dear *[insert name of clinic director]*,

This email is to inform you about a study being conducted by Professor Caroline Hunt and Samantha Schubert (MCP/PhD candidate) here at the University of Sydney exploring the professional identities of clinical psychologists. The study is titled 'Becoming clinical psychologists: The construction of professional identities within trainee clinical supervision encounters'. This research builds on studies that have highlighted the personal and idiosyncratic development of therapists (see Rønnestad & Skovholt, 2013) and it is hoped that the findings will contribute to the training of clinical psychologists.

The purpose of this study is to explore how clinical psychologists develop within supervision sessions during their clinical trainee internships. The purpose is *not* to evaluate competence or any other technical aspect of supervision, and neither supervisors nor trainees who participate will be evaluated or assessed as part of this study. You are being emailed as the Director of the Psychology Clinic to inform you about the research as data will be collected from the supervision sessions within the clinic in Semester 1, 2021. I also hope to gain your assistance with recruitment by contacting potential participants through the clinic reception email, and by attending one of the trainee administration meetings and one of the supervisor meetings to provide further information about the studies.

Below I have provided some information about the research that might be helpful:

Data collection and storage: Data collection will involve the audio recording of individual adult therapy supervision sessions between supervisors and trainees (one session recorded per supervisee-trainee dyad). Approximately ten to twelve recordings will be made and no supervisor trainee dyad will be recorded more than once. The recordings and transcripts will be completely confidential, de-identified and not shared with other staff or students. All data will be stored securely and kept confidential. Professor Caroline Hunt will have no access to any identifiable data.

Participation requirements: Participation of supervisors and trainees will be voluntary and will involve two components:

iii) completion of a brief demographic questionnaire, and
iv) audio recording of one supervision session per supervisor and trainee.

It is anticipated the completion of the demographic questionnaire will take less than five minutes, and recordings of supervision sessions require no additional time commitment. The demographic questionnaire will be completed online confidentially using an online survey platform, and will ask participants to indicate their gender, age (range), ethnicity, sexual identity, identity as an Aboriginal or Torres Strait Islander person, and whether they identify as a person with a disability. This is to understand the diversity of the sample and all information will be de-identified. Participants will also have the option of selecting 'prefer not to disclose' for any question. Recording of supervision sessions is expected to occur in January or February 2021. In order to participate in this study, written consent is required by both the supervisor and trainee. There are no exclusion criteria except that trainees must be in their final internal clinical placement. Trainees under the supervision of Professor Caroline Hunt will also not be eligible to participate given pre-existing links with this research.

I was hoping to ask for your assistance in three ways with this research please. First, I am seeking the help of the clinic reception to send out an email to all supervisors and trainees in the clinic in Semester 1 2021 notifying them of the study and inviting them to participate. I am hoping this email can be sent in January 2021. I have a drafted email ready and am hoping this can be distributed on my behalf using the generic group email which includes supervisors and trainees in the clinic. Second, I hope that tapes and recording devices can be secured in the locked cupboard behind the Clinic reception until I am able to collect them for data transcription. Third, I am seeking your support in attending one of the weekly trainee administration meetings in January 2021 to talk to trainees about the study. I will similarly be attending one of the supervisor meetings in January 2021 to talk to supervisors about the study. Your help in attending these sessions and having a short period of time to provide information to potential participants about this research would be greatly appreciated.

I have attached the Participant Information Sheets (separate sheets for supervisors and trainees) and Consent Forms (separate forms for supervisors and trainees) for reference.

I would be very grateful if you could please support us with this research in the ways mentioned above. We hope this research will make a meaningful contribution to the literature exploring how trainee clinical psychologists develop their identities as therapists.

If you would like further information about this research or have any queries, please feel free to email me at ssch4978@uni.sydney.edu.au.

Thank you in advance for your support and assistance.

With kind regards,
Samantha Schubert (PhD student)

Appendix C.11 (Study 3)

Demographic Information About Participants

Participant Information	Trainees	Supervisors
Participant numbers	12	4
Gender		
Female	8	4
Male	4	-
Other	-	-
Age range		
20-25 years	4	-
26-30 years	5	-
31-35 years	1	-
36-40 years	2	-
41-45 years	-	1
46+ years	-	3
Race/ethnicity		
Caucasian	9	3
Asian	1	1
Hispanic or Latino	2	-
Disability		
Disability	1	-
Prefer not to say	1	-
Sexuality		
Heterosexual	10	4
LGBTIQ+	1	-
Prefer not to say	1	-
Education (highest level attained)		
Bachelors Degree	5	-
Masters Degree	5	2
Doctorate/PhD	2	2
Theoretical approach (supervisors)		
Interpersonal/relational	-	1
Attachment based	-	1
Cognitive behavioural	-	1
Eclectic/integrative	-	1
Supervision experience (supervisors)		
0-5 years	-	2
5-10 years	-	-
11-20 years	-	2

Appendix C.12 (Study 3)

Jeffersonian Transcription System (Hepburn & Bolden, 2017)

Symbol	Description
(.)	Pause < 1 second.
(x.0)	Pause of x seconds.
=	Latching between utterances.
[ ]	Square brackets indicate the start and end of overlapping speech.
↑↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech.
:::	Colons show degrees of elongation of prior sound (more colons indicate longer elongation).
@	Laughter.
.h	Audible inhalation.
hh	Audible exhalation.
underlining	Emphasis (extent of underlining indicates location of emphasis).
> <	Indicates phrases spoken at faster speed.
(( ))	Additional comments from the transcriber.

Note: The Jeffersonian transcription system (Hepburn & Bolden, 2017) was used to transcribe interrogation interactions.