Learning Through Lived Experience in Doctoral Clinical Psychology Education: A Mixed-Methods Study of Expert by Experience Involvement, Impact, and Improvement Priorities

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Chapter 1

The Lived Experience of Clinical and Counselling Psychologists: A Systematic Review of Impacts on Wellbeing, Identity, and Clinical Practice

Prepared in accordance with the author requirements for Frontiers of Psychology; Frontiers in Psychology | Psychology for Clinical Settings

Abstract

Background and Aims: Psychologists are not exempt from difficult mental health experiences despite their expertise in supporting others, reflecting broader trends recognising psychological distress across the healthcare workforce. This systematic review examines how trainee and qualified clinical and counselling psychologists make sense of their own lived mental health experiences (LMHE) and how this shapes wellbeing, identity, and clinical practice.

Method: Four databases (PsycINFO, CINAHL, MEDLINE, and EMBASE) were searched in September 2025. Google scholar, and forwards and backwards citations were additionally searched. Study quality was assessed using the Critical Appraisal Skills Programme Tool, and a thematic synthesis was conducted.

Results: Ten studies were included in the review. Fourteen descriptive themes were synthesised and organised into five analytical themes: (1) personal struggles carried into professional roles; (2) reframing distress through professional knowledge; (3) coping as a process of trial and error; (4) living in two worlds: negotiating clinician and service-user identity; and (5) harnessing lived experience to enrich practice.

Conclusion: Findings highlighted that psychologists made sense of their LMHE in ways that both supported and challenged their wellbeing. LMHE often deepened empathy, built rapport, and enhanced reflective capacity, yet also induced emotional strain, and fears of stigma or reduced competence. Organisational cultures normalised distress and contributed to how safe psychologists felt to integrate their experiences and identities. Overall, the findings outline how LMHE influences psychologists' professional identity and practice in complex, context-dependent ways, highlighting the need for training and healthcare settings to cultivate psychologically safe environments that validate lived experience, reduce stigma, and support its meaningful integration into clinical practice.

Keywords: Clinical Psychology, Counselling Psychology, Lived Experience, Mental Health, Identity, Wellbeing

Introduction

Healthcare professionals are increasingly recognised as facing significant mental health challenges. Over the past year, 6.4% of the NHS Scotland workforce was absent (NHS Scotland, 2025). While causes are not specified, evidence suggests mental health is a major contributor, with NHS staff estimated to be two to three times more likely to take mental-health-related leave than the average UK worker (Blaaza et al., 2024). For the purposes of this thesis, Lived Mental Health Experience (LMHE) refers to past or present personal experience of mental health-related distress, or of supporting a loved one experiencing such distress, with or without engagement with mental health services. Mental health-related distress refers to persistent experiences that extend beyond transient or developmentally normative emotional responses, for example, ongoing anxiety rather than fleeting anxiety associated with situational stressors or prolonged grief reactions that would meet criteria for a diagnosable condition such as prolonged grief disorder, rather than expected responses to negative life events. Beyond signifying the presence of distress, LMHE may also shape identity, professional meaning, and how health care professionals position themselves within both personal and clinical contexts.

Psychologists play a central role in supporting individuals with emotional, psychological, behavioural and neurological difficulties (The British Psychological Society, 2025). Despite their mental health expertise, many clinical and counselling psychologists report personal experiences of mental health difficulties or of supporting loved ones through them. A critical review of the literature reports lifetime rates of psychiatric disorders among clinical psychologists as high as 81% (Patterson-Hyatt, 2016). Supporting this, a UK study found that 62.7% of clinical psychologists had experienced mental health difficulties at some point in their lives (Tay et al., 2018). Research from the USA and Canada similarly indicates that 62% of counselling psychologists have experienced depression, and approximately 80% of faculty members and doctoral clinical and counselling psychology students reported personal mental health histories, with 48% disclosing a diagnosis (Gilroy & Carroll, 2002; Victor et al., 2022). Commonly reported difficulties included depression, anxiety, and suicidal thoughts or behaviours. The limited evidence base in this area likely reflects the sensitivity and complexity of being both a mental health professional and an individual with lived mental health experience (LMHE).

Lived Mental Health Experiences are also evident across other healthcare and frontline professional groups. A recent review estimated an overall prevalence of mental health problems among nursing students of 27%, with depression and anxiety each affecting approximately 29% of this population (Efstathiou et al., 2025). Similarly, a review by Johns et al. (2022) reported comparable prevalence rates among doctors, with depression affecting 20.5% and anxiety affecting 25.8% of individuals. Among police officers, prevalence estimates for depression and generalised anxiety disorder have been reported at 14.6% and 9.6%, respectively (Syed et al., 2020). Whilst psychologists are not the only professional group affected by mental health difficulties, prevalence rates appear comparatively higher than those reported in several other professions. A particularly concerning finding is that psychologists have been identified as the fourth highest occupational group for suicide among healthcare professionals in the United States, following psychiatrists, physicians, and dentists (Li et al., 2022). This suggests that mental health experiences may be associated, at least in part, with the emotional and occupational demands inherent in the profession.

LMHE may be present on entry into the profession, emerge during practice, or be exacerbated by professional demands. The Job Demands-Resources model (Demerouti et al., 2001) suggests that mental health outcomes are shaped by the balance between occupational demands and available resources, with research highlighting the role of moral injury (Anastasi et al., 2025), job satisfaction (Quesada-Puga et al., 2024), and workplace incivility (Hasannie et al., 2025) in contributing to mental health outcomes among healthcare professionals. Among Trainee Clinical Psychologists, indirect exposure to client trauma is a significant predictor of trauma symptoms psychologists (Makhadia et al., 2017). While this indicates that vicarious traumatisation is a potential risk, exposure does not necessarily lead to vicarious traumatisation or mental health difficulties. Furthermore, a systematic review reported that burnout and stress are prevalent among psychologists (McCormack et al., 2018); linked to factors such as excessive workload, increasing professional demands, time pressures, and public sector challenges. Burnout can emerge in psychologists prior to qualification and assuming full professional responsibilities (Rico & Bunge, 2021). Professional dynamics may also worsen existing difficulties: fear of judgement and stigma following LMHE disclosures can intensify distress, with trainees reporting doubts about perceived competence and feeling unsupported following disclosure (Bailey et al., 2023).

In addition to organisational influences, intra-personal factors may also be relevant. Personality traits such as perfectionism have been shown to predict burnout among physicians (Martin et al., 2022), while traits including neuroticism and low self-confidence have been associated with poorer mental health outcomes among nurses (Yang et al., 2024). Such traits may interact with professional expectations and internalised norms, potentially increasing vulnerability to distress within healthcare roles. From an intrapersonal perspective, models of self-stigma emphasise how negative societal beliefs about mental health can become internalised and applied to the self, shaping identity and behaviour (Corrigan & Watson, 2002). Internalised concerns about competence, credibility, and professional identity may inhibit disclosure and engagement with support, contributing to delayed or absent help-seeking, which may further contribute to the persistence of mental health difficulties among mental health professionals. Despite professional awareness of the benefits of support, many psychologists do not seek help. A recent systematic review of mental health professionals, including psychologists, identified time constraints, competing professional demands, financial cost, stigma, and concerns about confidentiality as the most common barriers (Crisp & Bartel, 2025). Among trainees, barriers include limited support within programmes, affordability, and perceived stigma (Klein et al., 2022). Some psychologists also question the value of engaging in therapy given their own clinical expertise (Bearse et al., 2013). Disclosure-related processes may similarly influence mental health outcomes. A recent review reported that negative consequences of mental health disclosure among healthcare professionals outweighed positive outcomes (Hudson et al., 2025). Reported consequences included a lack of emotional and practical support, delayed career progression, and negative emotional experiences such as embarrassment, anxiety, or disappointment in response to colleagues' reactions. Both disclosure and non-disclosure may function as stressors within healthcare workplace contexts, with the potential to exacerbate mental health difficulties.

Justification for the Current Review

This systematic review synthesises research on what it means to experience mental health difficulties as a psychologist, and how experiences shape wellbeing, identity, and clinical practice. A focus on qualitative research enables an in-depth examination of lived experiences and facilitates understanding of how individuals make sense of these within their

personal and professional lives. Findings may contribute to mitigating practitioner impairment; defined as compromised professional functioning that may harm service users, and is often preceded by distress (Munsey, 2006) by offering insights that can inform curriculum design and organisational policy to promote workforce health, prevent burnout, and support retention. Synthesising evidence may normalise lived experience (LE) and reduce isolation and stigma; in a field historically marked by limited diversity, doing so supports wider inclusion and access.

Review Questions

The review will explore key aspects of LMHE among trainee and qualified psychologists:

1. How do trainee and qualified psychologists experience and make sense of their own mental health challenges, or of supporting a loved one with theirs
2. In what ways does lived experience influence psychologist's professional identity and practice?

Methods

This review was conducted as a qualitative systematic review, synthesising findings from qualitative studies to address the review aims. A qualitative approach was selected because the review focuses on understanding how psychologists experience, interpret, and integrate mental health difficulties within their personal and professional lives. Qualitative research is particularly suited to addressing questions of meaning, context, and identity within existing literature as methods allow for detailed accounts of experience and reflection, supporting exploration of perspectives that are not readily accessible through quantitative designs.

Registration

The systematic review protocol was registered with PROSPERO International Prospective Register of Systematic Reviews (CRD 420251133769) on 25 August, 2025 in accordance with PRISMA reporting guidelines.

Search Strategy

Existing systematic reviews on burnout and self-disclosure prompted a focus on psychologists wider lived experiences. The search strategy was developed with a specialist university librarian. The Sample, Phenomenon, Interest, Design, Evaluation, Research framework was utilised, which is considered appropriate for qualitative research (Cooke et al., 2012). A detailed description of the search terms is included in Appendix B. Four databases (PsycINFO, CINAHL, MEDLINE, and EMBASE) were searched on 14 September, 2025. A date (2005-2025) and English language limit were applied across databases. Google scholar was searched to identify additional articles, grey literature and theses using Boolean operators to map key concepts. Forward and backwards citation searching of included articles was completed and reference lists were searched.

Eligibility Criteria

Inclusion Criteria

- Articles published in peer-reviewed journals
- Grey literature: dissertations including empirical data
- Studies exploring the views and experiences of qualified and trainee clinical and counselling psychologists with LMHE
- Studies using qualitative research methods
- Studies published in English language
- Articles published since 2005
- Studies conducted in any geographic location and cultural context

Exclusion Criteria

- Non-empirical data
- Quantitative studies. While quantitative research provides valuable information regarding the frequency and correlates of mental health difficulties among psychologists, such approaches do not offer insight into how psychologists make sense of these experiences. Quantitative designs are also limited in their capacity to capture the perceived impact of

mental health difficulties on professional identity and clinical practice, which are central to the aims of this review

- Studies not published in English
- Articles published more than 20 years ago were excluded, as stigma surrounding LMHE among mental health professionals has evolved significantly over time. Older literature may not accurately reflect current experiences or the current impact of LMHE on professional identity and practice. Furthermore, during scoping searches, no relevant studies published prior to 2005 were identified, providing additional justification for restricting the search period to the previous 20 years
- Articles specific to experiences of burnout or disclosure

Screening and selection of studies

The review followed a two-stage screening process consistent with PRISMA guidance. All records retrieved from database searches were imported into EndNote for deduplication and articles identified through google scholar and reference lists were screened in Excel. Titles and abstracts were screened against the eligibility criteria, and the full texts of all records deemed potentially eligible were subsequently assessed for inclusion. To enhance reliability, a second reviewer (a Trainee Clinical Psychologist) independently screened 10% of titles and abstracts and 50% of full-text articles against the eligibility criteria. The process of study identification and selection is outlined in the PRISMA flow diagram shown in Figure 1.

Data Extraction

For each included study, the following information was independently extracted: author, year, title, country of origin, aims, sample characteristics, the nature of LMHE examined, design and methodological approach, data-analysis procedures, and key qualitative findings. Extracted data were recorded in a structured Excel spreadsheet. The results and findings from each article were extracted into a Microsoft Word document, including quotations, descriptive summaries, and the authors' interpretations of results.

Critical Appraisal

Quality appraisal was conducted using The Critical Appraisal Skills Programme (CASP) qualitative studies checklist (2023), a widely applied tool for health-related qualitative evidence syntheses (Long et al., 2020). The checklist comprises ten items designed to evaluate the methodological quality and rigour of qualitative studies, with particular strengths in assessing the transparency of reporting and the procedural aspects of study design. This tool is endorsed by the Cochrane Library further supporting its appropriateness for this review. All studies were appraised by the first author, and a random sample of five articles (50%) was independently assessed by the second reviewer to ensure consistency and reliability of the quality appraisal process. There were minor differences in ratings for two papers; these were discussed and resolved.

Method of Synthesis

A thematic synthesis approach, as outlined by Thomas and Harden (2008), was selected for its systematic focus on individuals' perspectives and experiences. This approach enabled an inductive approach to analysis of studies exploring psychologists' LMHE. Given the exploratory nature of the review question focusing on how individuals make sense of their experiences and the implications for personal and professional identity an inductive approach that allowed themes to emerge from the data was considered most appropriate, as opposed to alternative, deductive approaches such as Framework synthesis (Oliver et al., 2008) which applies predefined categories to data. This decision was reached through consultation with a qualitative academic researcher, and additional guidance that thematic synthesis is the recommended approach for novice reviewers (Fleming & Noyes, 2021). This process involves three iterative stages: line-by-line coding, development of descriptive themes, and generation of analytical themes. In the first stage, data were coded line by line. Initial codes were largely descriptive, keeping interpretations close to the original meaning and content. Thematic synthesis follows an inductive approach, meaning codes and themes were developed directly from the data rather than applying a pre-existing framework. This allowed patterns and insights to emerge naturally, ensuring the synthesis remained grounded in participant perspectives. Codes were generated for each study and applied across others, creating new codes as necessary. All codes were examined and organised into related groups to form descriptive themes, enabling the translation of concepts across studies. Finally, analytical themes were developed by interpreting the descriptive themes in relation to the

review questions, moving beyond the original data to generate deeper insights and explanations. See Appendix D for a visual representation of how themes developed.

Researcher Reflexivity

The researcher is a Trainee Clinical Psychologist with familial LMHE and therefore shares some identities with the psychologists included in this review. This close relationship to the topic may shape interpretations, particularly around issues of wellbeing, disclosure, and training culture. Reflexive notes (see Appendix F) and discussions during research supervision were used to minimise potential bias and maintain transparency throughout the review process.

Results

The PRISMA flow diagram is shown in Figure 1. A total of 3088 records were screened and 3048 were excluded. Of the remaining 40 studies, 36 of these were further excluded as not meeting inclusion and exclusion criteria, leaving 4 studies. An additional 18 papers were identified through citation searching, of which 12 did not meet eligibility, leaving a total of 10 included studies. Table 1 (below) summarises the characteristics of the included studies providing details of study aims, participant characteristics, nature of lived experiences, design, analysis and themes. The studies comprised 111 participants in total (mean 11.1 participants) who were largely female (n=96, 86.5%). Details of other characteristics such as sexuality, disability, and ethnicity were inconsistently reported.

Study and Participant Characteristics

Figure 1

PRISMA Flow Diagram of Study Selection Process

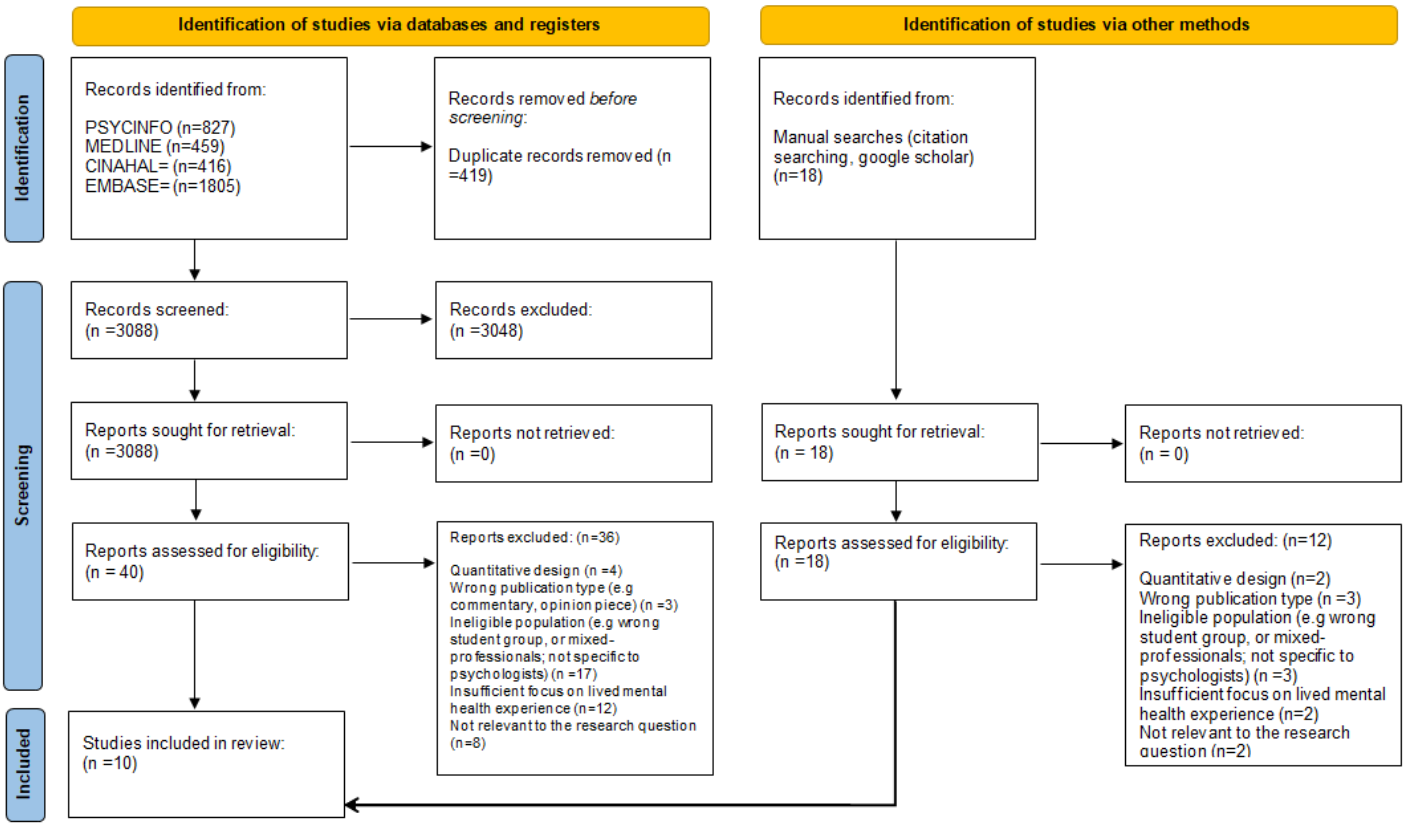


Table 1

Study Characteristics

Author, Year & Country	Aims	Sample Characteristics: (Mean age, gender, ethnicity & occupation)	Nature of Live Experience	Design and Method	Data Analysis	Qualitative Findings (Core Themes)
Bamber et al. (2025) **UK**	To explore how Trainee Clinical Psychologists with LMHE navigate doctoral training	n=12 (F=12) Trainee Clinical Psychologists with personal LMHE (n=6), and those with LMHE and carer role (n=6)	Personal or carer LMHE Trauma, depression, anxiety, eating disorders, personality disorder, OCD, psychosis, substance use difficulties, insomnia, neurodevelopmental disorders, postnatal depression, bipolar disorder	Individual semi-structured interviews	Constructivist Grounded Theory	1. The Pressured System 2. Narratives about LMHE within the Profession 3. Developing Trainee Identity and Sense of Self 4. Disclosing LMHE within the Professional Context 5. Building a Safe, Balanced and Reciprocal Relationship with Other Professionals 6. Drawing Upon LMHE within Clinical Practice
Becker (2024)	To understand the	n=17 (F=17)	Personal	Individual	Moustaka'	1. Feeling sad and heartbroken

USA	LE of doctoral trainees with personal trauma histories working with patients with trauma histories	Clinical or counselling doctoral trainee students 28 years Black: n=2 White: n=10 Asian: n=2 Hispanic: n=2 Other: n=1	experience of childhood trauma	semi-structured interviews	s (1994) Phenomenological Framework	2. Emotional fatigue and bringing work home 3. Instigates personal trauma 4. Enhanced empathy, connection, and understanding 5. Draws from personal experience to inform approach 6. Mindful of how personal trauma is brought into the room 7. Feeling incompetent 8. Compartmentalising 9. Self-care and taking time to process 10. Supervision 11. Difficulty maintaining boundaries 12. Rewarding experience: instilling pride, hope, and inspiration 13. Recognition of clinical growth areas
Burrows et al. (2023) **UK**	To explore psychologists' experiences of caring and its impact on clinical practice	n=11 (F=9, M=2) Assistant n = 2, trainee counselling psychologist n = 1, trainee clinical psychologist n = 5, qualified clinical psychologist n = 2, qualified counselling psychologist = 1	LE of caring for relative/friend with a mental health diagnosis Psychosis, depression, bipolar, addiction, dementia	Individual semi-structured interviews	Thematic Analysis	1. Personal and Professional Role 2. The Emergence of a Carer Identity 3. Carer Stress and Strain 4. Impact on Professional Practice 5. Dual Positioning

		35 years Indian : n=1 Middle Eastern: n=1 White: n=9				
Charlemagne-Olde et al. (2012) **UK**	To understand Clinical Psychologists experience of distress	n=11 (F=9, M=2) Clinical Psychologists	Personal experience of significant distress Mental health diagnosis: n=6 Anxiety, depression, anger, and bipolar	Individual semi-structured interviews	Interpretive Phenomenological Analysis	1. Manifestations of distress 2. Making sense of personal distress 3. Role and affect of others 4. Experiences of help/support 5. Using experiences of distress
Davidson (2013) **UK**	To explore how previous mental health problems affects clinical and counselling psychologists' approach to practice	n=10 (F=5, M=5) clinical (n=6) and counselling psychologists (n=4)	Personal LMHE Diagnosis of depression, anxiety, depression and anxiety, psychotic episode, schizophrenia	Individual semi-structured interviews	Interpretive Phenomenological Analysis	1. Use of Personal-Self of Psychologist 2. Ambivalence 3. Identity as Psychologist 4. Psychologists as Agents of Change 5. Finding Meaning in Suffering

Flanery (2023) **USA**	To examine the experience of clinical psychology doctoral students with prior and current experience of mental health concerns as they navigate clinical training.	n=14 (F=12, M=1, Gender Queer=1) Clinical psychology doctoral student	Personal LMHE Anxiety, depression, eating disorders, substance use, and suicidality	Individual semi-structured interviews	Phenomenological approach with a social constructivist framework	1. Heavy emotional experiences 2. Advisor/Mentor 3. Disclosure 4. Unique relationships with psychotherapy 5. Resiliency
Phrydas (2014) **UK**	To examine how trainee counselling psychologists experience the phenomena of having a relative/friend with a self-reported mental health condition	n=8 (F=8) Trainee Counselling Psychologists	Friend/Family experience LMHE	Individual Semi-Structured interviews	Interpretive Phenomenological Analysis	1. Negotiating roles: personal identity versus therapy identity 2. Continuing a therapy role within a personal space: personal impact 3. Personal influence within a professional role 4. A space for personal development
Reid (2023) **UK**	To investigate individual stories an narratives to develop deeper understanding of lived mental health experiences among	n=10 (F=8, M=1, non-binary=1) Trainee Clinical Psychologists 28.4years	Personal LMHE	Narrative non directive interviews	Narrative analysis (holistic-form and categorical-content approache	1. Personal meanings 2. Appraisal and understanding from others 3. Navigating training with LE 4. Education providers and surrounding systems 5. Holding a LE identity

	trainee clinical psychologists	Ethnicity unknown			s)	6. Reflections
Rhinehart (2023) **UK**	To explore how clinical psychologists navigate dual identities as service users and service providers	n=12 (F=11, M=1) Clinical Psychologists 37 years	Personal LMHE	Individual semi-structured interviews	Narrative Analysis	1. Prologue 2. Chapter One: Separation of Identities 3. Chapter Two: Negotiation of Identities 4. Chapter Three: Co-Existence of Identities 5. Epilogue.
Svoboda (2025) **UK**	To explore how trainee counselling psychologists with pre-training mental health difficulties perceive these in relation to their evolving professional identities	n=6 (F=4, M=1, Gender queer=1) Trainee Counselling psychologists Varied ethnic origins, including Eastern Europe, North Africa, and South Asia	Personal LMHE Depression, neurodiversity, anxiety, past suicidal ideation	Individual Semi structured interviews	Interpretive Phenomenological Analysis	1. Navigating stigma: The challenges of sharing mental health difficulties in training 2. The illusion of the 'perfect' psychologist 3. The course as a catalyst for change: Embracing authenticity and integration 4. Cultivating a culture of openness and genuine support

Information captured where available

Quality Appraisal

Table 2

CASP Ratings

Study	Clear statement of aims?	Appropriate qualitative methodology?	Appropriate research design	Recruitment strategy?	Data collected to address research issue?	Positionality addressed?	Ethical Issues?	Rigorous data analysis?	Clear statement of findings?	Valuable research?
Bamber et al. (2025)	✓	✓	–	✓	✓	×	–	✓	✓	✓
Becker (2024)	✓	✓	✓	✓	–	✓	–	–	✓	✓
Burrows et al. (2023)	✓	✓	✓	–	✓	–	✓	✓	✓	✓
Charlemagne-Olde et al. (2012)	✓	✓	✓	✓	–	×	–	✓	✓	✓
Davidson (2013)	✓	✓	–	✓	–	–	✓	✓	✓	✓
Flannery (2023)	✓	✓	✓	✓	–	–	✓	–	✓	✓
Phrydas (2014)	✓	✓	✓	✓	✓	✓	✓	✓	–	✓
Reid (2023)	✓	✓	✓	✓	✓	✓	✓	✓	–	✓
Rhinehart (2023)	✓	✓	–	✓	–	–	–	✓	✓	✓
Svoboda (2025)	✓	✓	✓	✓	✓	✓	✓	✓	–	✓

Yes= ✓ No= × Can't tell= –

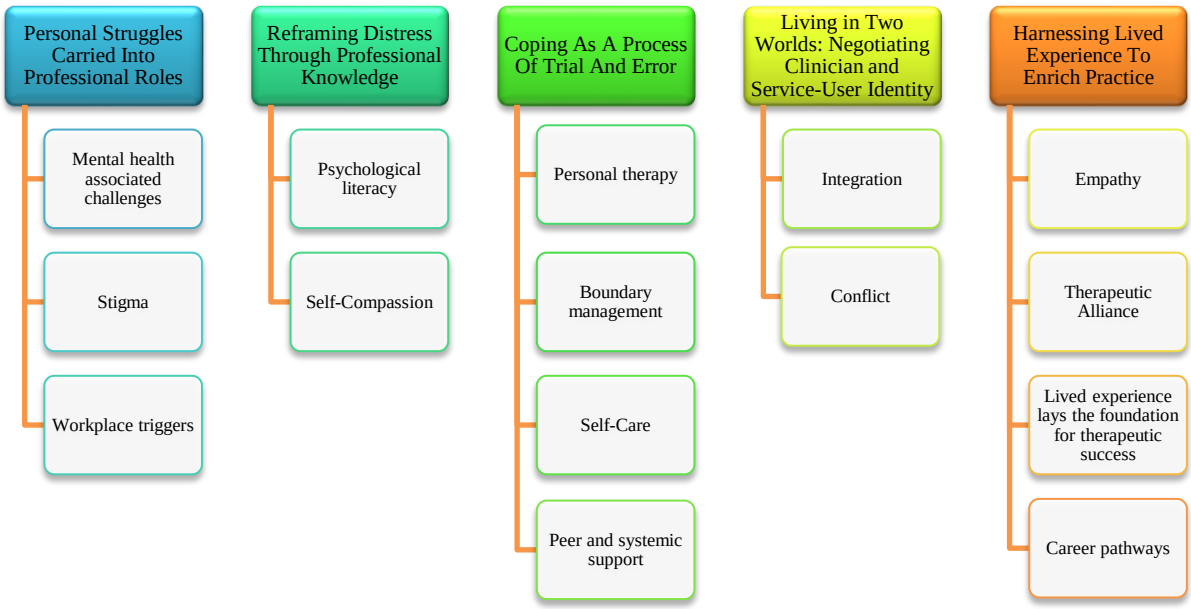
Overall, the appraisal revealed sound methodological practices in most studies, particularly in recruitment, data analysis and clearly presented findings, but highlighted limitations in justification of methodological choices, transparency of analytic processes, and researcher reflexivity. The CASP checklist does not provide guidance on interpreting appraisal results or a standardised scoring system to classify study quality. Based on this review, the main issues were under-reporting of methodological decisions and limited detail on credibility checks (e.g., member checking, triangulation), which may reflect journal and thesis word count restrictions rather than major methodological weaknesses. All studies demonstrated sufficient methodological rigor to be considered medium-to-high quality. Further appraisal information is provided in Appendix C.

Results of Thematic Synthesis

Fourteen descriptive themes were grouped and interpreted to produce five analytical themes that directly address the review question. For the theme frequency table, see Appendix E.

Figure 2

Theme Hierarchy



Themes

1. <u>Personal struggles carried into professional roles</u>

Participants described the challenge of navigating LMHE in their professional roles. Although many attempted to maintain clear boundaries between their personal experiences and their clinical responsibilities, LE still shaped their emotional responses, sense of identity, and interactions within the workplace.

<u>Mental health associated challenges</u>

Challenges in bringing LE into professional roles were frequently reported. In a study of trainee counselling psychologists, one participant reflected: *"I got the worst (exam) result; it's not really a surprise, given what was going on at home"* (Phydras, 2024), illustrating how caring responsibilities can interfere with academic performance.

Clinical psychologists in another study described reduced motivation when they felt unsupported or when their own needs were unmet: *"I was looking for a way of getting out of the constant demands for attention to other people's problems because I felt so neglected myself… I just couldn't be bothered"* (Charlemagne-Olde et al., 2012). This emotional depletion limited their capacity to engage fully in their roles. This was evident across trainee psychologists who reported struggles to maintain their professional functioning: *"I think perhaps, especially as I'm training, there's this feeling of, who am I to help this person when I couldn't get out of bed yesterday?"* (Flanery, 2023). While imposter syndrome is common among trainees, this account suggests that mental health difficulties can intensify self-doubt and prompt individuals to question their professional competence.

Work as a trigger

Across studies, the workplace itself was described as a trigger for emotional distress or deteriorating mental health. Participants reported that the demands, culture, and emotional labour of clinical roles could exacerbate existing difficulties or contribute to the emergence of new distress. For some, professional encounters evoked unresolved experiences: *"I would have so many reactions to what she was sharing… I would have flashbacks in a way of my own experiences that maybe I hadn't thought about in a long time"* (Becker, 2024). This account highlights how clinical work can trigger past trauma and heighten emotional distress.

Participants described how aspects of training and professional culture contributed to deteriorating wellbeing. Anxiety was often normalised: *"You get a fair amount of pretty anxious people overall in the program… Whenever you're like, this person's got anxiety. It's like, okay. Water's wet"* (Flanery, 2023). This sense of inevitability was reinforced by expectations to work intensively and appear competent, reflected in the remark: *"You don't have lunch, and work nine hours nonstop… It's a projection of our ideal which is not reality… if you're not able to manage the stress… you're not good*

enough" (Charlemagne-Odle, 2012). These narratives suggest that systemic norms within training and practice may perpetuate distress and discourage openness about vulnerability.

For some trainees, the structure and intensity of training were experienced as detrimental from the outset: *"I then found the experience of the doctorate has very much impacted on my mental health quite negatively and kind of from pretty much the word go"* (Bamber et al., 2025). In more severe cases, participants reported active suicidal ideation related to training pressures: *"I became completely suicidal… it was scary that I so quickly got back to that place"* (Flanery, 2023). Additionally, factors associated with commencing training, such as relocating away from support networks and experiencing loneliness contributed to distress. Collectively, these accounts indicate that both the nature of clinical work and the broader conditions of training can serve as triggers for significant mental health difficulties.

Stigma

Across studies, participants described experiencing stigma within professional and training contexts. One participant recalled: *"The doctor patted me on the head and said 'oooh a depressed psychologist now that's not very good is it?"* (Charlemagne-Odle, 2012), while another noted: *"… (someone) in my cohort said that it's a really bad idea for people who have had difficulties to help other people"* (Rhinehart, 2023). Participants also reported internalised stigma shaped by performance pressures within training: *"As trainees, so much of our lives is scrutinised… everything's graded…I think I was like: 'I don't want to reveal any of this'"* (Svoboda, 2025). Fear of judgement, jeopardising their training and how competent they were perceived to be, contributed to reluctance to disclose difficulties. These accounts highlight how stigma operates externally and internally, creating conditions where silence acts as a protective strategy.

However, stigma was not universal. Some participants expressed gratitude for their lived experiences: *"I almost feel quite privileged that I've been through it… it allows me to… not see those people as different from me"* (Davidson, 2013), reflecting a

perspective in which lived experience is viewed as an asset to the psychologist's role, rather than something to conceal.

2. Reframing distress through professional knowledge

Across studies, participants described how psychological knowledge helped them interpret, reframe, and make sense of LEs.

Psychological Literacy

Developing psychological literacy provided a conceptual framework for understanding complex experiences and supported processes of meaning-making. For some, professional insight enabled access to previously unacknowledged emotions: *"I think being a psychologist created this insight and unlocked the feelings which were then unable to be expressed"* (Charlemagne-Odle et al., 2012). Others actively applied therapeutic models to their own difficulties: *"I tried to apply a therapeutic model to myself and that's how I've learnt how to get through it…using ACT"* (Davidson, 2013). Similarly, learning formulation skills allowed participants to reframe distress in others: *"Now I have this understanding of how being abused as a child has impacted on him"* (Burrows et al., 2023).

However, increased psychological insight could also evoke discomfort. One participant described the emotional impact of learning about attachment theory: *"it's good to know, to understand in order to be able to change, but it's also painful when these things come"* (Phydras, 2014). These accounts depict professional knowledge as a double-edged sword; one that can facilitate making sense of, and navigating mental health-related distress, yet also could provoke painful realisations.

Self- Compassion

Participants described how their professional roles supported the development of self-compassion, helping psychologists respond to their own struggles with kindness and acceptance. This often involved reframing LE as meaningful aspects of identity that could strengthen, rather than diminish, clinical practice.

For some, training reduced shame and facilitated self-compassion: *"I don't feel the same sense of weight or shame attached to it...and it sort of started with the course"* (Svoboda, 2025). Others described a shift from shame to pride and recognition of the value their experiences brought to their work: *"There's something about the process of moving from my shame to being proud of it"* and *"I realised that actually there are, not silver linings, but so many important points about my experiences that help me to be the psychologist that I am"* (Rhinehart, 2023).

Self-compassion was also emerged through therapeutic encounters, with clients acting as mirrors that highlighted the importance of caring for oneself. Increased understanding through training, theory, clinical exposure, and the normalisation of distress appeared to underpin this shift, reinforcing that it is possible to be both a clinician and someone with LE.

3. **Coping as a process of trial and error**

This theme encapsulates psychologist exploration of coping strategies in their personal and their professional lives, ranging from engaging in personal therapy, using supervision, and practicing self-care, to more informal methods such as exercise or social support. The narratives shared by participants highlight that coping was a process of continuous learning, aimed at finding strategies that helped them maintain their professional functioning while navigating personal challenges.

Personal Therapy

Both trainee and qualified psychologists described using personal therapy to manage distress arising in training and practice. Therapy was described as a space to explore uncomfortable emotions and process experiences: *"I've accessed personal therapy again privately and I think that's really helping me to have that space to kind of discuss things and to bring some of these things that feel really uncomfortable and explore them a bit more"* (Bamber, 2023). Similarly, a trainee reflected on its importance during training: *"I do like it and I think it is extremely useful to me, especially with the training bringing up so much stuff, it's quite important to be in therapy to work them out"* (Phydras, 2014).

Some participants received practical or financial support from families or universities (Reid, 2023), whereas others encountered financial barriers limiting their access to therapy despite subsidised fees (Flanery, 2023). Therapy was sometimes viewed as emotionally demanding, leading some to delay seeking help or to consider medication as an easier option: *"My inclination was to take something because I think well that's easier isn't it? ...psychological therapy is bloody hard work, like all my clients I want a magic wand"* (Charlemagne-Odle et al., 2012).

Boundary Management

Participants described difficulties maintaining boundaries at work and in their personal lives. They reported overextending themselves, becoming emotionally over-invested, and experiencing heightened stress due to workload demands. Some found it hard to disengage from their professional role at home, slipping into a therapeutic stance with family: *"I think unfortunately I do try to fix them… I still try to keep the balance and remember that I'm still their daughter or brother or sister… but… I do put my needs aside quite often"* (Phydras, 2014).

Over time, participants recognised the need to protect their wellbeing by establishing clearer boundaries. One psychologist described negotiating limits around emotionally difficult conversations: *"Last year I had a frank conversation with her about my ability to cope… we've come to a collaborative agreement as to when it's becoming too much"* (Burrows et al., 2023). Others highlighted conserving emotional resources and using practical strategies to separate work and home life, such as symbolic transitions: *"I would always take off my badge before leaving the building to really signify for myself 'I'm done with my work for the day'"* (Becker, 2024). Overall, managing boundaries was described as an ongoing effort, required to protect personal and professional selves.

Self-Care

Participants made a conscious effort to protect wellbeing and reported a range of strategies including rest (Svoboda, 2025), relaxation and exercise (Charlemagne-Odle, 2014), and engaging in meaningful or enjoyable activities such as baking or watching

television. Some participants reported cancelling sessions when feeling emotionally fragile (Flanery, 2023).

In one study, self-care was expressed through intentional breaks after emotionally demanding sessions: *"I think something relatively small that I've done is taking a break after that session. Like intentionally getting up from my office that I'm currently sitting in and going outside and just giving myself a break, even if I don't feel I need it"* (Becker, 2024). Self-care strategies were often perceived as a protective measure.

Peer and Systemic Support

Peer and systemic support were described as key coping resources. Connecting with colleagues who shared similar experiences reduced isolation and fostered a sense of safety and normalisation: *"(my friends) and the LE group… helped me feel connected and valued and just normal… they made it safe for me… they totally normalised it"* (Bamber, 2024).

Support embedded within training programmes and supervisory structures also played an important role. For some, this support was transformative, enabling wellbeing and effective engagement in training: *"I actually think my mental health is in a really good place right now, thanks to the support I've had from supervisors and from the course… the support has helped me thrive instead of just battling through"* (Reid, 2023). However, experiences of supervision differed. Some participants feared judgement and avoided discussing mental health (Becker, 2024), while others sensed supervisors discouraged reflection on personal challenges, even when clinically relevant (Charlemagne Odle et al., 2014).

Overall, peer support offered consistent validation, normalisation, and emotional safety. Systemic support was more variable, at times enabling growth, yet sometimes feeling unsupportive.

4. Living in Two Worlds: Negotiating Clinician and Service User Identity

Participants frequently described the tension of navigating personal and professional identities. Adjusting to these identities was portrayed as a gradual, reflective process

shaped by personal history, training environments, and professional expectations. While many viewed their LE identity as a source of strength, accounts varied in how integration was approached; some encouraged integration, whereas others preferred separation.

Integration

For many participants, LE was described as an inescapable and integral aspect of their identity**:** *"It's just such an integral part of my experience and identity… It's an integral part of reflection and being able to learn"* (Svoboda, 2025). Several accounts emphasised the importance of authenticity: *"The biggest thing that's impacting my mental health is this feeling like you have to be something you're not and constantly having to wear a mask. The more opportunities there are to take that mask off and be your real and authentic self, the better. There needs to be some opportunities to do that"* (Bamber et al., 2024). This suggests that psychologists value opportunities to integrate their identities within professional contexts, while also highlighting that such opportunities may be limited.

Others noted that separating identities felt unrealistic and unnecessary: *"I find it really difficult to separate, because I don't think you can… it's so intertwined because it's your experience and part of who you are as a person… it's just impossible because I'm here now and that's what's happened and that's part of my journey"* (Reid, 2023). Integration was therefore understood as an automatic process; however, some felt that integration required time and emotional processing. One participant described this gradual shift: *"It took a long time for me to be able to process my personal pain enough to get to the point that they could slot in together and actually become integrated"* (Rhinehart, 2023). Overall, participants welcomed identity integration, yet highlighted obstacles that made moving between their two worlds complex.

Conflict

For many psychologists, living with two identities was described as challenging and unpleasant: *"At the moment, I kind of have both hats and I think in teaching it felt like I kind of had to try and put that 'expert by experience hat' away and just be the expert by profession…But, that felt really uncomfortable with me"* (Bamber, 2024). Some felt

that integrated identities could 'get in the way' of clinical work, particularly in maintaining objectivity: *"There are times where I want to say, 'Yes, I agree with that, I understand that feeling,' and go into how I'm feeling, but that's not the place to do that… trying to separate what's happening in session with my own life sometimes can be difficult"* (Becker, 2024).

Perceived stigma was described as a barrier to comfortably integrating identities: *"I hold quite a few different intersections. It feels like I have to pick which I talk about because I feel like too much otherwise…"* (Reid, 2023). This suggests that self-disclosure is implied when integrating identities and perceived stigma around disclosures influence how psychologists managed these. Rather than openly embracing all aspects of their identity, some felt compelled to selectively share certain parts while withholding others to avoid being seen as 'too much'. These accounts highlight that both integration and separation could cause tension, with participants navigating discomfort, professional boundaries, and the challenge of balancing authenticity with clinical responsibility.

5. Harnessing LE to Enrich Practice

Across studies, LE was widely viewed as a valuable resource that enhanced empathy, deepened understanding, strengthened therapeutic relationships, and shaped career paths.

Empathy

Many participants described how similar lived experiences enabled a deeper understanding of what clients were going through, resulting in increased confidence in supporting them: *"It's definitely been helpful to know what a panic attack feels like to know what that patient is going through… It's different to say it will pass and you're going to be fine when you've also been through it and know what it's like to think it's not going to be fine"* (Flanery, 2023). Participants also spoke of an intuitive understanding that went beyond theoretical understanding: *"I don't have to think about it logically. There's more of an intuitive sense of kind of getting where someone's coming from"* (Davidson, 2013).

However, not all accounts were positive. Some participants described how personal struggles reduced their capacity for empathy: *"I feel like there's less empathy coz I can't reach a deeper level inside me …when I feel like I'm reaching burnout, I feel like I can't do that coz I'm very on the surface, I feel like I'm quite closed coz of what's going on for me"* (Phyrdas, 2014). This quote highlights that maintaining empathy despite personal experiences is challenging, and sometimes burnout limits the ability to engage effectively with clients.

Therapeutic Alliance

Participants frequently described how LE strengthened the therapeutic alliance. Participants felt their deeper understanding of clients' experiences made engagement more meaningful: *"It just allows a different energy in the room or a different therapeutic alliance because there's a difference between reading about something and knowing about it"* (Flanery, 2023). Others highlighted how truly understanding became a powerful relational tool: *"I have learned that kind of 'getting it'… has been so influential and has been such a tool to connect"* (Becker, 2024).

Similarity in experience was also perceived to support bond-building: *"I think it helped me bond with them a bit more because there is that similarity"* (Becker, 2024). Together, these accounts suggest that LE enriched the therapeutic journey by fostering authenticity, shared understanding, and stronger rapport.

LE as the foundation for therapeutic success

This descriptive theme captures the general ways participants felt LE enhanced their clinical work. Experiencing therapy as a client helped psychologists appreciate the experience of the process for clients and recognise the therapeutic benefits. It also provided practical insights they could apply in practice: *"Having done my own therapy, sometimes I borrow some things from that… it gives me a different depth to my clinical work that maybe I wouldn't have if I hadn't experienced therapy myself"* (Flanery, 2023).

Participants often described this depth of understanding as unmatched by those without similar experiences, reinforcing the unique contribution of LE to clinical practice. In

addition to empathy and rapport, LE built confidence, helping psychologists feel better equipped to meet clients' needs: *"…(it's) given me such a depth of experience to really support other people… it doesn't faze me; in fact, I'm really open and confident to help them, far more than before"* (Davidson, 2013).

Self-disclosure was another way participants felt LE strengthened therapeutic work. One trainee explained how sharing aspects of their experience normalised clients' difficulties and improved the therapeutic relationship: "They put it as one of their main bits of feedback that they'd really appreciated that I'd self-disclosed and it really helped with the relationship" (Bamber, 2024). Overall, LE was perceived to meaningfully enhance therapeutic practice.

Career pathways

Participants frequently described how LE influenced their career. A career in psychology was positioned as a pathway that allowed them to make sense of their own experiences while fostering a deeper understanding of other people: *"Psychology seemed a way to do it… I'd always be fascinated by how people think and why… my mum's depression is possibly what made me think about that… are there different ways of thinking that might be more helpful?"* (Phyrdas, 2014). Conversely, others avoided certain areas of practice, concerned that their experiences might affect objectivity or boundaries: *"On purpose I avoided adult mental-health as a chosen career path… I might not be able to distance myself… I might make assumptions about them based on my own experiences…"* (Davidson, 2013).

Experiences with mental health services were also powerful motivators. Some wanted to replicate the care they had received: *"…having experienced how helpful it was to be heard… I would really like to be able to offer that to people in the future"* (Rhinehart, 2023). Others were driven to provide care they had lacked: *"Part of the reason why I became a therapist… is because I want to be the person for others that I needed for myself"* (Becker, 2024). Overall, LE shaped career trajectories in varied ways, motivating dedication to psychology, influencing specialty choices, and fostering a commitment to improving care for others.

Discussion

This review highlights that psychologists have diverse lived experiences that influence wellbeing, identity, and clinical practice. Participants reported experiences with varied presentations including: anxiety, depression, eating disorders, schizophrenia, and, in some cases, suicidal ideation; consistent with evidence that suicidality among psychologists is not uncommon (Kleespies et al. 2011). Psychological knowledge shaped how individuals understood and managed distress; for some, therapeutic models and strategies supported coping, while for others they introduced emotional strain. Personal therapy was generally regarded helpful. Wilson et al. (2015) similarly identified benefits such as increased self-understanding and professional growth, alongside costs including emotional discomfort, mood and sleep issues, affecting personal and professional functioning. The present review extends these findings, indicating that psychological insight whether developed through training, self-reflection, or therapy can facilitate coping and development, though its impact varies across contexts and may heighten vulnerability at times of distress.

Coping strategies were seen as essential for maintaining professional functioning, echoing the view that *'self-care is a personal challenge and professional imperative that every psychologist and trainee must consciously confront'* (Ziede & Norcross, 2020, p. 1). Zinn's (2022) review identified essential self-care skills among psychologists that closely align with the current review, including self-monitoring, self-assessment, utilising support, cognitive strategies, maintaining balance and boundaries, and physical self-care. Together, these findings indicate that psychologists engage in an ongoing process of identifying coping strategies that support wellbeing and professional practice. Mental health-related distress appeared to be normalised, characterised by heavy workloads and demanding training and workplace cultures, and exposure to peers. While shared LE among peers reduced isolation, the broader normalisation of distress raises concerns. Professional and organisational cultures may inadvertently frame gruelling conditions as acceptable, reinforcing harmful norms and diverting attention from addressing structural drivers of poor mental health. Findings suggest that organisational responses must extend beyond individual coping to address contextual and structural contributors to distress.

The review also identifies tensions between LMHE and perceptions of professional competence. Assumptions that resilience and emotional stability are prerequisites for competence can imply that LE undermines professional credibility. Such narratives risk perpetuating stigma and discouraging openness, sustaining a professional culture in which vulnerability is seen as incompatible with competence rather than recognised as a valuable aspect of professional identity. LE enhanced professional practice, fostered empathy, strengthened therapeutic rapport, and helped to effectively support clients; however, also limited psychologist's emotional capacity to engage fully in their role, reporting feelings of depletion, resentment, or reduced empathy towards clients. Research suggests empathy is a finite resource (Watson et al., 2025); indicating LMHE may be beneficial up to a certain threshold of emotional capacity. Victor (2022, p.1626) argues*, "People with LE of psychopathology should not be viewed as professionally 'inferior' to those without"* and emphasises that diverse perspectives are essential for a profession that seeks to understand and serve diverse populations. Consistent with this, the current review suggests that LE is neither inherently harmful nor helpful; rather, its influence on professional identity and practice is shaped by contextual, relational, and organisational factors.

The review highlights the complexity of holding dual identities as both clinician and person with LE. Tensions between personal vulnerability and professional expectations often heightened self-doubt, particularly within performance-oriented training contexts. Yet for some, psychological knowledge and self-reflection supported a more integrated professional identity. Integration, however, was impacted by perceived stigma and concerns about disclosure; resulting in carefully identity separation. Overall, the findings position personal and professional identity as a negotiated and adaptable process shaped by individual meaning-making and the cultural and structural context of training and practice.

Strengths and Limitations

To the author's knowledge, this is the first systematic review synthesising qualitative research on LMHE among trainee and qualified clinical and counselling psychologists. Research in this area may help to normalise dual identities in psychologists with LMHE, reducing perceived barriers to the profession and fostering the belief that one can hold these identities and maintain professional functioning. The review generates

practical implications for training programmes and healthcare organisations: specifically, how to create conditions that enable psychologists to draw on LE constructively (such as through reflective practice, supportive supervision, clear disclosure pathways and psychological safety), rather than feel encumbered by it. Findings further highlight the importance of robust, proactive support structures and working environments to prevent the emergence or exacerbation of distress. Collectively, these insights can inform policies and practices that strengthen practitioner wellbeing, sustain professional functioning, and widen inclusion across the psychology workforce. The review adhered to PRISMA guidelines, which support quality by promoting transparent reporting of search strategies, inclusion criteria, and synthesis methods. This transparency enables readers to evaluate the trustworthiness and applicability of findings, supports reproducibility, and strengthens confidence in the conclusions drawn (Page et al., 2021). Additionally, the use of a second rater during the screening and critical appraisal phases, alongside consultation with research supervisors during synthesis helped to mitigate bias and ensure agreement on the interpretation of findings.

A criticism of the current review is that the thematic synthesis was conducted solely by the primary researcher, and despite efforts to exercise reflexivity, the translation and interpretation of themes across studies may have been influenced by the researcher's positioning and interpretive lens. Furthermore, although themes were discussed within the research supervision team, there was a missed opportunity to involve trainees and clinicians with lived mental health experience outside the research team in the synthesis process, which may have enriched the analysis, and enhanced credibility, by adding depth and better reflecting the realities of those with lived mental health experience. Furthermore the review may receive criticism due to including a substantial amount of grey literature, with seven out of ten studies falling into this category due to there being limited published, qualitative research in this area. Research on LMHE among psychologists is largely led by trainee psychologists, which may reflect the emerging interest in this topic area.

A further limitation of this review relates to the characteristics of the studies and the sample of the included studies. The majority of studies did not require participants to provide evidence of a formal mental health diagnosis. Consequently, it is unclear

whether all participants would have met the clinical threshold for the reported difficulties, which may have implications for interpreting the findings. However, in some studies, authors noted that this approach was intentional, as the focus was on the LE of mental health challenges rather than their severity. Furthermore, geographic representation was limited. 8 of the studies were conducted in the UK, and the remaining 2 were conducted in the USA, thus limiting transferability to other cultural and health-system and training contexts. Differences in healthcare systems, professional training pathways, and cultural expectations may shape psychologists' LMHE, access to support, and disclosure practices, and consequently influence how they make sense of their LMHE and how this influences identity and practice. UK clinical and counselling psychology training and workplace structures are over emphasised in the current review and are likely not comparable to those in other countries, and therefore findings should be interpreted with recognition that they are most applicable to UK healthcare and training contexts rather than globally transferable. Further research conducted across broader cultural contexts, particularly in non-western settings would be advisable. Although only three of the included studies focused specifically on counselling psychologists, this reflects the current state of the literature rather than a methodological limitation of the review. In an already under-researched area, there appears to be greater emphasis on clinical psychologists compared to counselling psychologists, highlighting an imbalance in the evidence base and the need for further research exploring lived mental health experiences within counselling psychology.

Implications for Clinical Practice and Training

Overall, the review findings highlight that LE can enrich personal and professional development, while also creating risks such as burnout, emotional exhaustion, and the emergence or worsening of mental health difficulties. These insights emphasise the need for systemic and individual supports across training and workplace contexts. The findings suggest that psychologists benefit from access to reflective spaces, supportive supervision, and strong peer networks that help them process experiences and maintain resilience, and that they also require accessible personal therapy and self-care resources, supported by a culture that normalises their use. Training programmes, and NHS organisations may wish to reflect on how to more effectively support wellbeing within their structures, for example by fostering realistic expectations, manageable

workloads, protected reflective time, and policies and resources that facilitate rest, compassion, and access to mental health support; creating systems that support psychologists with lived mental health experience, and those who may encounter mental health challenges throughout their careers. However, the realities of working and training within the NHS, an organisation operating under considerable constraints and pressure, mean that meaningful structural change can be difficult to achieve, creating a tension between what would be most beneficial for supporting mental health, and what may be feasible in the context of resource and organisational limitations.

Beyond reactive support once individuals are already in training or post-qualification, the findings also raise ethical questions regarding preparation for the profession. Given evidence that clinical work is associated with vicarious traumatisation, burnout, and compassion fatigue in mental health professionals (Velasco et al., 2025), it may be ethically appropriate to ensure that prospective psychologists are more fully informed of these potential occupational risks prior to entering training. Addressing this through transparent communication at selection, training, and employment stages could enable applicants to make more informed decisions about entering the profession. Such information could be formally acknowledged within training and employment contracts. Furthermore, while occupational health assessments are typically offered when a prospective employee discloses a health concern during pre-employment checks, it may be advisable for employers to routinely offer comprehensive occupational health assessments focused on mental health for all prospective trainees and employees. This could help identify potential risk factors, reasonable adjustments, or additional support needs prior to sustained exposure to clinical distress or stressful working conditions, which may support indivudals to stay well, or prevent emergence of mental distress.

Accountability for lived mental health experiences must not lie solely on the systems psychologists work in. It is reasonable to expect both trainee and qualified psychologists to engage actively with self-care practices, make effective use of supervision, and monitor early signs of distress. Positioning wellbeing as a shared responsibility held jointly by individuals and the systems in which they work may help avoid the difficulties that are driven by system pressures from being seen as individual failures, while still acknowledging personal responsibility and ethical awareness.

Further Research

The review identifies several implications for training and practice; however significant barriers to implementing these changes within complex systems such as the NHS exist. Further research is needed to understand not only the experiences of psychologists with LMHE but also the organisational, cultural, and systemic conditions that shape how such experiences are supported. There is a clear need for universities and NHS organisations to examine existing approaches to wellbeing, workload, supervision, and access to support, as well as the broader organisational and resource constraints that may hinder meaningful change. To facilitate progress, universities and NHS organisations should undertake critical reviews of policies governing workload, reflective practice, and mental health support. Policy development should follow a multi-stakeholder, evidence-based approach that includes trainees, clinicians, educators, service leads, and policymakers. Drawing on implementation science will be essential to ensure that any interventions developed are feasible, sustainable, and effective within resource-constrained healthcare and training systems.

Conclusion

This review summarises the limited evidence on LMHE among trainee and qualified psychologists, examining how these experiences are understood, managed, and how they shape professional identity and practice. It highlights both the benefits of lived experience and concerns surrounding implications in the workplace, highlighting the need for stronger structures and support within universities and services. Such supports can enable psychologists to draw on LE safely, protecting wellbeing and fitness to practise while allowing its value to inform their work.

In summary, the review shows that psychologists understand and navigate LMHE in diverse and complex ways. Lived experience influences meaning-making, emotional engagement, and identity negotiation, shaping professional identity and practice without inherently enhancing or impairing professional competence.

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Chapter 2

Learning Through Lived Experience in Doctoral Clinical Psychology Education: A Mixed-Methods Study of Expert by Experience Involvement, Impact, and Improvement Priorities

Prepared in accordance with the author requirements for Frontiers of Psychology; Frontiers in Psychology | Psychology for Clinical Settings

Plain Language Summary

Title: Learning Through Lived Experience in Doctoral Clinical Psychology Education

Background: Experts by Experience (EbE) are people with lived experience of mental health difficulties. EbE are becoming more and more involved in the training of clinical psychologists on doctoral university courses. However, there are no clear, consistent guidelines on how this should be done, which means different training programmes involve EbE in very different ways. Research so far shows that having EbE involved can be helpful, but it also brings some challenges, and overall there is still not much available evidence about the best way to do it. This study looked at how EbE are currently involved in training, how both trainees and EbE feel about these experiences, and what could be improved. The aim was to understand what is working well, what isn't, and how EbE involvement can better support trainee learning while also ensuring a positive experience for the EbE themselves.

Aims and questions

1. To understand how EbE help on doctoral psychology courses
2. To explore what training clinical psychologists, EbE and course directors think about this
3. To explore how training programmes can make involving EbE even more helpful for training psychologists, and even more enjoyable for EbE themselves

Methods: This study used a mix of online surveys and one-to-one interviews. Trainee clinical psychologists, Experts by Experience and training course directors completed surveys about their experiences, how useful they found EbE involvement, the difference it made to training, and how satisfied they were with current approaches.10 Trainee psychologists also took part in interviews so they could talk in more detail about what they found helpful and what they thought could be improved about EbE involvement. The survey results were summarised using basic descriptive statistics, and the interview recordings were analysed using thematic analysis, which looked for key themes, patterns, and shared experiences in what people said.

Results and Conclusion: 5 themes were found. Involving EbEs in clinical psychology training is seen as very valuable by both trainees and EbEs, helping trainees understand mental health problems more deeply and giving EbEs a sense of personal growth. However, both groups also felt that current approaches could be improved. While EbE involvement supports understanding and learning clinical skills, there are still challenges, such as not enough support for trainees and EbE, and not many different kinds of people with mental health difficulties coming to help the training programme. There are also times when EbE are not fully appreciated. Overall, the study shows clear benefits but highlights the need for changes to make the experience better for everyone involved. The researcher has made 14 recommendations for changes training programmes could make.

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Abstract

Background and Aims:

Research on Expert by Experience (EbE) involvement in doctoral clinical psychology training is limited but indicates both benefits and challenges, alongside varied practices likely reflecting insufficient regulatory guidance. This study aimed to explore current approaches to EbE involvement, examine perceptions and experiences of this involvement, and identify key areas for improvement to enhance learning and optimise the overall EbE experience.

Method:

This mixed-methods study combined surveys with individual semi-structured interviews. Trainee clinical psychologists, EbE and course directors completed surveys assessing perceived value, impact, and satisfaction with current EbE practices. Trainees participated in interviews to provide deeper insights regarding their views and experiences. Survey data were analysed in SPSS using descriptive statistics, and interview data were analysed using reflexive thematic analysis.

Results:

Both components of the study highlighted a range of challenges and benefits associated with involvement. Thematic analysis generated five main themes and fifteen subthemes: (1) Learning through lived experience, (2) Evolving perspectives, (3) What we take with us, (4) Challenges to EbE involvement, and (5) Distress arising from EbE involvement. Survey findings indicated that EbE involvement was perceived as extremely important to clinical psychology training by both EbEs and trainees. However, both groups also indicated that moderate improvements to current EbE practices are needed.

Conclusion:

Findings highlight clear benefits to EbE involvement, including: greater empathy, competency development, and a deeper understanding of the patient journey. Barriers included limited diversity and representation among EbEs and practices that risk undervaluing their contributions. Fourteen recommendations are proposed for programmes to help maximise the benefits of involvement for both groups.

Keywords: Lived Experience, Clinical Psychology, Mental Health, Expert by Experience, Doctoral Education

Introduction

The value of involving people with lived experience in shaping health and social care services is increasingly acknowledged, with a growing emphasis on shifting power towards service users. Emerging evidence shows that meaningful involvement can make policy and practice more responsive, relevant, and empowering, better reflecting the needs of communities (Health and Social Care Alliance Scotland, 2022). Experts by experience (EbE), defined by the Care Quality Commission (CQC, 2023) as people with recent personal experience of using or caring for someone who uses health or social care services, increasingly contribute to professional training programmes. Their involvement spans disciplines including mental health, social care, nursing, medicine, psychology, and occupational therapy. A recent review (Seetharaman et al., 2025) found that EbE involvement is well established across these educational fields in the United Kingdom, Europe, Australia, and the United States, with reported benefits including enhanced empathy, improved reflective practice, stronger links between theory and practice, and greater empowerment for lived experience educators. Within nursing education, students have perceived EbE involvement to provide unique teaching insights that could not otherwise be learned, alongside deepened understanding and enhanced reflection (Happell et al., 2022). Benefits were also reported for experts by experience themselves, including support in achieving personal goals, as well as for academic staff. Academics reflected that EbE involvement prompted recognition of previously tokenistic practices and facilitated a more meaningful commitment to future involvement. EbE involvement was perceived to have an impact not only at the individual level, but also on broader organisational cultures. Students and academics reported developing deeper respect for EbE contributions, alongside critical reflection on their own values and judgements, which were often challenged through engagement with EbE. In another discipline, EbE involvement has been shown to have a positive impact on social work student's socio-personal skills and to advance their professional development (Planas-Lladó & Palliser, 2024). Students reported that EbE involvement supported reflection on adapting language and communication, strengthened active listening skills, and improved their ability to manage their own emotional responses when working with distressing cases. It also prompted reflection on the weight of professional responsibility and consideration of how professional actions can shape individuals' life trajectories.

The Doctorate in Clinical Psychology (DClinPsy) is a doctoral-level training programme that prepares graduates to become clinical psychologists through integrated academic teaching, clinical placements, and research. Across the UK and Northern Ireland; regulatory and accreditation standards require meaningful integration of service users and carers within DClinPsy training (Health and Care Professions Council (HCPC), 2017; The British Psychological Society, 2025). There is a limited evidence base regarding the role and outcomes associated with EbE in clinical psychology training, however, available research indicates that involving EbE in DClinPsy training provides substantial benefits for both trainees and people with lived experience. Trainee benefits include enhanced clinical preparedness, deeper personal and professional reflection, and progress towards key competencies. EbE have also described the process as mutually beneficial, at times drawing value from the therapeutic skills demonstrated by trainees (Norwood et al., 2019). However, a UK survey of programme staff and EbE identified several barriers to meaningful involvement, including limited representation and insufficient resources. Practical issues such as the potential impact of payment on benefits entitlement, further limit participation (Howarth, 2018). Furthermore, EbE have reported emotional distress when sharing personal experiences and feeling devalued when their contributions are overlooked (Hill et al., 2022). Trainees have described emotional challenges ensuing EbE-led teaching, alongside tensions related to poorly managed power dynamics (Kerry et al., 2023). Howarth (2018) explored how DClinPsy programmes currently implement EbE. The most commonly reported activities included participation in reference groups, involvement in trainee selection, coordination roles, and contributions to research development and feedback, and participation in teaching. However, the low participation rate restricts the extent to which the findings can be considered representative of current practice.

The HCPC outlines expectations for involving people with lived experience in clinical psychology training, identifying a broad range of areas including admissions, teaching, assessment, programme governance, and quality improvement. Similarly, the BPS requires programmes to embed EbE involvement across programme design, delivery, curriculum development, trainee selection, co-delivery of teaching, contributions to assessment, and participation as valued members of the programme team, supported with appropriate training, payment, and resources. However, neither body specifies the

frequency, depth, or minimum level of involvement required. For example, there is no stipulation that EbE must contribute to a defined number of assessments or teaching sessions, leaving the guidance open to interpretation and flexible for programmes. This likely contributes to variation in practice.

Regulatory guidance offers limited direction regarding how involvement may influence training learning and development. Understanding the potential impact of EbE involvement therefore requires consideration of theoretical frameworks relating to contact and learning. Allport's contact hypothesis (1954) suggests that meaningful, structured contact with people from stigmatised groups can reduce stereotyped beliefs and improve attitudes. Pettigrew and Tropp (2008) further proposed that these improved attitudes occur because intergroup contact reduces anxiety and increases empathy between groups. In parallel, Kolb's experiential learning theory (2006) suggests that learning is most effective when individuals engage in a cycle of experience, reflection, and applying new understanding
. EbE involvement may therefore be conceptualised both as a form of meaningful contact between trainee clinical psychologists and people with lived experience that influences trainee attitudes and as an experiential learning process that supports reflection and learning beyond traditional didactic teaching methods such as engaging in role plays.

Valuing lived experience within healthcare education is a relatively recent development, and the limited evidence base reflects its emerging role in clinical psychology training. . This study addresses a gap in understanding and knowledge by providing an updated overview of EbE involvement and investigates how it is understood and experienced by stakeholders involved in both the delivery and receipt of the training. The Division of Clinical Psychology requires for programmes to identify and reduce barriers to involvement, therefore research is needed to determine whether previously reported barriers persist and how they shape meaningful participation. Findings may inform evidence-based recommendations to support meaningful and consistent involvement across programmes, thereby strengthening the quality of such involvement. Consequently, improved EbE contributions to training may increase the likelihood of positive downstream impacts on patient care, including stronger therapeutic alliances, enhanced empathy and validation, and reduced

experiences of stigma. Greater sensitivity to issues of trauma, power, and vulnerability may also enhance patient safety and trust, increase engagement with services, and reduce the risk of iatrogenic harm, such as experiences of feeling silenced, dismissed, or re-traumatised. If these outcomes are to be achieved, it is essential to understand how, why, and under what conditions EbE involvement is most effective, including identifying circumstances in which poorly managed or resourced, or tokenistic involvement may risk unintended harm, or be counterproductive. Therefore, research in this area is both ethically necessary and clinically relevant, and aligns with broader healthcare priorities centred on improving patient experiences and outcomes.

Research Aims

The study aimed to:

1. Examine how DClinPsy programmes currently implement EbE
2. Explore trainee and EbE perceptions of the value and impact of these practices
3. Identify improvements that could enhance involvement to support trainee learning and enhance EbE experience

Methods

Design

Quantitative research is primarily concerned with identifying measurable patterns and answering questions about what is happening, whereas qualitative research seeks to uncover underlying meanings, motivations, and experiences to understand why these patterns occur (Barnham, 2015). Adopting both approaches allows greater depth and understanding than possible when using either approach in isolation (Almaki, 2016). Therefore, a mixed-methods design combining electronic surveys and individual semi-

structured interviews was chosen to capture both the breadth of EbE practices and views, and the depth of participants' experiences and interpretations.

Reflexive Thematic Analysis (RTA) was used following Braun and Clarke's (2006) framework, a flexible and widely adopted method for identifying and interpreting patterns within qualitative data. RTA was selected because it allows for both systematic pattern identification across participants and interpretive engagement with meaning, making it well suited to research aiming to examine current EbE practices, explore shared perceptions, and identify areas for improvement. RTA emphasises the active role of the researcher in generating themes, enabling analytic depth while remaining sensitive to participants' accounts (Ahmed, 2025). This approach was particularly appropriate given the study's focus on complex, subjective experiences situated within institutional contexts, as it supports analysis beyond surface-level description toward theoretically informed interpretation. The analysis was guided by the philosophical framework of critical realism (CR) (Bhaskar, 2013). CR assumes that observable events are shaped by deeper, unobservable mechanisms; therefore, understanding the social world requires examining both what is seen and the hidden structures that generate it. CR challenges traditional views that qualitative research is solely exploratory and not generaliseable, arguing instead that qualitative approaches can produce causal knowledge by theorising the underlying mechanisms and structures that contribute to observed experiences.

Interpretative Phenomenological Analysis (IPA) was considered as an alternative analytic approach, as it emphasises personal experience and individual's subjective meaning-making rather than producing objective descriptions (Smith et al. 2021). While IPA aligned with the study's aim of exploring doctoral trainees lived experiences of receiving EbE input, its idiographic focus and emphasis on depth within a small number of cases were less well suited to the broader aims of the study. The study sought to identify patterns across participants' experiences and to consider the contextual and structural factors shaping EbE involvement, such as organisational or institutional factors. Therefore, RTA, informed by a critical realist lens, was deemed the most appropriate analytic approach, as it enabled integration of participant's subjective accounts of EbE involvement with theoretically informed interpretation of the structural conditions shaping those experiences.

Participant Recruitment

In phase one recruitment targeted three groups:

1. Trainee Clinical Psychologists
2. Experts by Experience actively contributing to the DClinPsy
3. Course Directors.

34 programmes were invited to participate. Participants volunteered by responding to an advertisement distributed through doctoral programmes, social media, and trainee networks. Invitations were emailed to programme administrators for distribution to each group. In phase two, TCP participated voluntarily. At the end of the survey participants could register their interest to participate in an interview.

Inclusion and Exclusion Criteria

All trainees enrolled on a UK DClinPsy programme were eligible to participate. EbE were eligible if they had been actively involved in the programme for at least one year to ensure perspectives reflected typical involvement across a full academic year. DClinPsy course directors or an appropriately qualified staff-member able to discuss EbE involvement within the programme were eligible to participate. Programmes in the Republic of Ireland were excluded as they are regulated by the Psychological Society of Ireland. Different accrediting bodies may hold differing views on EbE involvement, and excluding these programmes ensured a fair and consistent comparison across the sample.

Sample Size

Thematic analysis has no minimum sample size, though Braun and Clarke (2022) recommend setting a pragmatic range guided by research aims and resources. Evidence suggests as few as 5–6 interviews can provide rich data (Creswell & Poth, 2017). Following consultation with research supervisors, a target of 8–10 participants was agreed. Based on an approximate UK population of 3,348 trainee clinical psychologists (Clearing House, 2024) and an anticipated response rate of 20%, the projected trainee

sample size was 670. Because the number of EbE involved varies widely across programmes, no recruitment target was set. All course directors for all 34 UK DClinPsy programmes were invited to participate.

Data Collection

Electronic surveys were used to measure EbE involvement within DClinPsy programmes and to quantify views on its value and impact. Three surveys were distributed, one per participant group. The TCP and EbE surveys followed a similar structure to capture contrasting perspectives on value, impact, and satisfaction. The course director survey captured current EbE practices and related feedback. Individual semi-structured interviews were selected for qualitative data collection because they provide both flexibility and depth. This approach balances standardisation with adaptability, enabling exploration of themes within a naturally flowing conversation (Chand, 2025). Core questions ensured coverage of key topics, while the flexible format allowed the interviewer to follow emerging insights. This approach was considered appropriate for capturing rich, nuanced accounts of participants' experiences. The study was interested in obtaining in-depth accounts of participants' experiences; therefore interviews were preferred over focus groups.

Materials

Surveys were co-developed with the University of Glasgow's Carers and Users of Services Group (CUSP) (See Appendix M) Additionally, a small group of TCP from the researchers' cohort consulted on the survey design. Minor amendments were made to enhance clarity and ensure sensitivity to the topics addressed. A topic guide was created to provide a structured framework for interviews, ensuring that key themes were covered while allowing flexibility for follow-up questions (See Appendix N).

Procedure

Phase One

The researcher contacted programme administrators via email, providing an overview of the project and included invitations for distribution to three separate participant

groups, a link to the survey, the participant information sheet and consent form (See Appendix J & K). After reviewing the study information, participants decided whether to participate. Following initial circulation, recruitment plateaued. Recirculation was requested and the study was advertised on LinkedIn and a Facebook group widely used by TCP.

Phase Two

At the end of the TCP survey, participants could provide their email address if they wished to be contacted for a follow-up interview. Due to the low number of expressions of interest, all interested participants were invited. The researcher emailed interested participants a research invitation, participant information sheet, a link to an electronic consent form, and access to an online booking system to schedule an interview. 10 interviews were conducted, recorded and transcribed using Microsoft Teams. Interview transcripts were reviewed for accuracy and anonymised by removing any personally identifiable information prior to analysis. Survey data were exported to Microsoft Excel and subsequently imported into SPSS for descriptive statistical analysis

Ethical Considerations

Ethical approval was granted by the University of Glasgow College of Medical, Veterinary & Life Sciences Ethics Committee (Ref: 200240387; Appendix I). Study information was communicated via the participant information sheet, which outlined the purpose of the research and confidentiality limitations, including the need to report malpractice or harm to others if this was disclosed. Participants were informed that disclosures of malpractice or harm to others would require reporting to relevant authorities. A contingency plan was in place: if such an issue arose, the researcher would consult the clinically qualified research supervisor to develop an appropriate response in line with professional and regulatory guidance. In accordance with the BPS Code of Human Research Ethics, data were anonymised to respect dignity and privacy. Survey responses were assigned unique ID numbers. Interview transcripts were anonymised by replacing names with participant numbers and removing identifying details such as university or geographical references. Confidentiality was maintained through secure storage of all data on an encrypted file within the lead researcher's University of Glasgow OneDrive account; a secure, encrypted cloud-based platform

managed by the University's IT Services. Survey participants were debriefed on the final page of the survey, and interview participants were emailed a debrief sheet following their participation (See Appendix L).

Analysis

Survey data were analysed in SPSS using descriptive statistics. Means, medians, modes, ranges, and standard deviations were calculated to summarise response patterns and identify commonly selected options. RTA was initially considered for the open-text responses, which sought to capture RTA was initially considered for the open-text responses, which aimed to capture feedback related to EbE involvement. However, to enhance clarity, responses were summarised and presented in tabular form (See Appendix R). This format allowed comments to be organised by participant group, making the source of each contribution visible and supporting clearer interpretation without loss of detail.

Interview data were analysed using Braun and Clarke's (2006) six-phase process for RTA. In phase one, the researcher familiarised themselves with the dataset by listening to recordings, reading transcripts, and noting down initial ideas. The researcher then generated systematic codes, capturing both semantic content and latent meanings (See Appendix N for an example of the coding process) .In the third phase, codes were grouped into clusters reflecting shared meanings and developed into initial themes. In line with a critical realist approach, the researcher stepped beyond the surface content of the data to consider what underlying structures, mechanisms, or social conditions might explain the observed patterns Analysis was iterative, with ongoing refinement of codes and themes. In phase four, themes were reviewed against the full dataset and refined for coherence and distinctiveness. Two coded transcripts were reviewed by the supervision team, who advised further differentiation between two closely related themes; definitions were subsequently refined to clarify their conceptual boundaries. Phase five involved finalising and naming themes. Agreement on the thematic structure was confirmed with the supervision team. The final phase focused on writing up the analysis, incorporating illustrative extracts to demonstrate how interpretations were grounded in participants' accounts.

Researcher Reflexivity

The researcher held ‘insider’ status as a current TCP, sharing the identity of one participant group. This likely supported rapport-building during interviews and helped participants feel comfortable, knowing the researcher understood their context. However, it also introduced the risk of assumptions or bias shaped by the researcher’s own experiences of EbE involvement. These influences were most likely to shape interpretation during analysis. The researcher remained aware of the risk of overlooking important data or overemphasising elements that reflected her own experiences. Reflective journaling (See Appendix S) was used to critically examine decisions, assumptions, and challenges throughout the research process and analysis. This practice supported ongoing reflexivity by encouraging the researcher to explore underlying assumptions and consider why particular responses or interpretations emerged.

Results

Surveys

In total, 30 EbE were recruited from 14 programmes. The final survey sample of trainee clinical psychologists consisted of 101 participants across 17 programmes. 17 trainee clinical psychologists registered their interest for phase two of the study and were invited to interview, however only 10 were successfully recruited from 7 universities. Comparison with UK trainee population data (Clearing House, 2024) indicates that women, white trainees, and those with LMHE are overrepresented in both the trainee clinical psychologist survey and interview samples (See table 1).

Please see Appendix T for Course directors' survey insights.

Table 1

Sample compared to UK TCP population (N=101)

Demographic Variable	Category	Survey Sample, *n* (%)	TCP Population (%)
Gender	Female	92 (91.1%)	83.6%
	Male	8 (7.9%)	15.5%
	Prefer Not To Say	1 (1%)	0.9%
Ethnicity	White (British, Irish, And Any Other White Background)	92 (91.1%)	73.3%
	Black/ Black British (African, Caribbean, Any Other Black Background)	2 (2%)	4.9%
	Mixed/ Multiple Ethnic Origins (White And Black Caribbean, White And Black African, White And Asian, Any Other Mixed/Multiple Ethnic Background)	4 (4%)	5.8%
	Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any Other Asian Background)	3 (3%)	10.1%
Lived Mental Health Experience	Yes	85 (84.2%)	2.8%
	No	15 (14.9%)	*Not captured*
	Prefer Not To Say	1 (1%)	*Not captured*

Table 2

Expert by Experience Sample Demographics (N=30)

Demographic Variable	Category	n (%)	Percentage (%)
Gender	Female	19 (19%)	66.3%
	Male	9 (9%)	30%
	Nonbinary	1 (1%)	3.3%
	Transgender	1 (1%)	3.3%
Ethnicity	White (British, Irish, And Any Other White Background)	27 (27%)	90%
	Black/ Black British (African, Caribbean, Any Other Black Background)	2 (2%)	6.7%
	Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any Other Asian Background)	1 (1%)	3.3%
Age Range	18-25	1 (1%)	3.3%
	25-30	1 (1%)	3.3%
	30-35	2 (2%)	6.7%
	35-40	1 (1%)	3.3%
	40-45	2 (2%)	6.7%
	45-50	4 (4%)	13.3%
	55+	19 (19%)	66.3%

Reports of EbE involvement varied across the three groups; however involvement predominantly involved contributing to teaching sessions, research consultation, developing resources and academic developments. With regards to teaching, trainees most commonly reported EbE involvement in adult, psychosis, or ‘other’ lectures. EbE most frequently reported involvement in adult, ‘other’, or health-related presentation teaching.

Figures 1-2 present the frequency that participants reported either observing EbE involvement across different areas of training, or being involved with. As participants could endorse multiple responses indicating involvement in different areas, these frequencies reflected reported presence rather than the magnitude of EbE contributions within the DClinPsy curriculum. The figures therefore illustrate the range of EbE engagement, rather than the relative extent of engagement in each area.

Figure 1

Areas of Doctoral Clinical Psychology Programme Engagement Reported by Experts by Experience

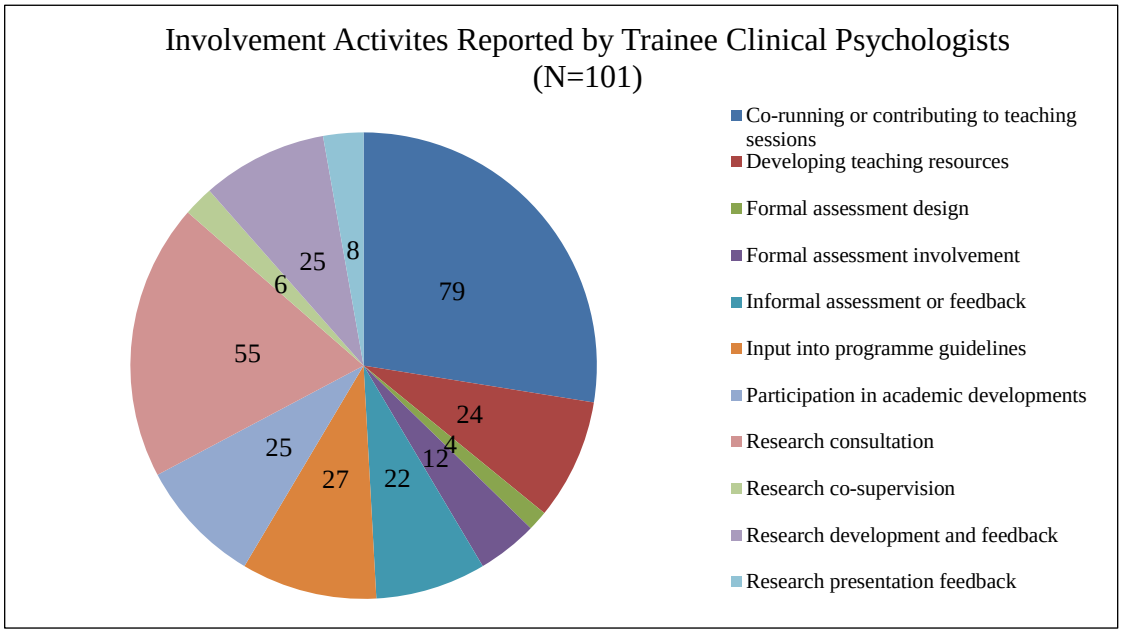

Figure 2

Areas of Doctoral Clinical Psychology Programme Engagement Reported by Trainee Clinical Psychologist

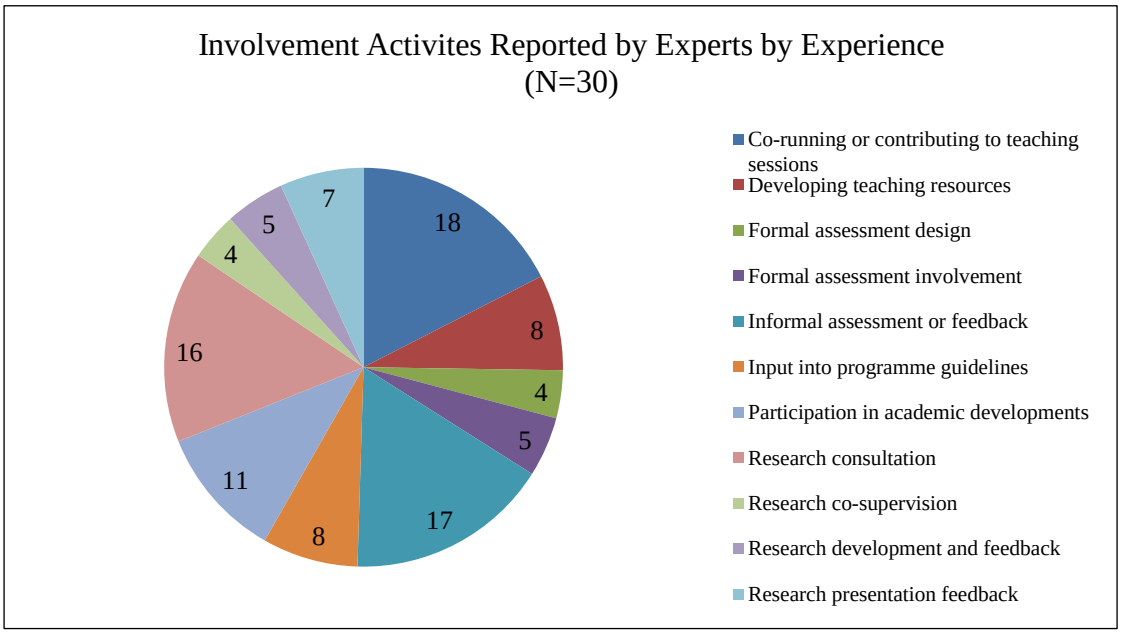

Table 3

Trainee's Survey Results (N=101)

Item	Range	Mean	Standard Deviation	Median
How important do you think it is for clinical psychology training to include the perspectives of experts by experience? *(1=Not at all important- 5= Extremely important)*	2.0	4.8	3.9	5.0
How helpful has EBE involvement been in aiding your understanding of the unique challenges faced by service users, families and carers? *(1=Not at all helpful-5= Extremely helpful)*	4.0	4.5	0.9	5.0
How satisfied are you with the integration of experts by experience (EBE) into the curriculum of the DClinPsy training program? *(1= Very dissastisfed-5= Very satisfied)*	4.0	3.0	1.1	3.0
How would you evaluate your personal experience with, or your view of, the current involvement of experts by experience (EBE) in the program? *(1=Extremely negative- 5= Extremely positive)*	3.0	3.8	1.0	4.0
How has the involvement of experts by experience (EBE) influenced your confidence in working with patients, families, and carers upon qualification? *(1= Not at all-5= Extremely)*	4.0	3.4	1.1	3.0
Has involvement with experts by experience (EBE) helped deepen your understanding of clinical problems compared to traditional learning methods such as textbooks or lectures?*(1=Not at all or less than-5= More than or sig. more than)*	2.0	2.7	0.5	3.0
How has the involvement of experts by experience (EBE) influenced your development of the core competencies required for your professional role as a clinical psychologist? *(1=Not at all, 5= Extremely)*	4.0	3.2	1.1	3.0
How have your interactions with experts by experience (EBE) influenced your attitudes toward individuals experiencing mental health difficulties? *(1= Negative*	1.0	2.6	0.5	3.0

change-3= Positive change)				
To what extent do you believe improvements are needed to enhance the involvement of experts by experience in training? *(1= No improvements needed- 5= Significant improvements needed)*	3.0	3.6	1.0	3.0

Overall, trainees highly valued the inclusion of EbE in clinical psychology training. 85% indicated that incorporating EbE perspectives was extremely important, and 73% reported that EbE input helped to deepen their understanding of clinical problems beyond what traditional teaching methods offered. In addition, 63% reported that EbE involvement enhanced their understanding of challenges faced by people with lived experience.

Perceptions of current practice were mixed. While 39% viewed current EbE involvement positively, 42% expressed dissatisfaction with existing approaches, and 38% of trainees believed that moderate improvements were required. Regarding perceived impact, 36% reported that EbE involvement had a moderate influence on their confidence in working with mental health difficulties, and 33% reported a moderate contribution to their development of core competencies. 57% reported that interactions with EbE positively influenced their attitudes towards mental health difficulties.

Table 4
EbE Survey Results (N=30)

Item	Range	Mean	Standard Deviation	Median
How satisfied are you with the extent of your involvement in DClinPsy training programme? *(1=Very dissatisfied-5=Very satisfied)*	3.0	3.2	0.8	3.0
Do your feel your time, efforts and experienced are respected and valued by the programme team and students? *(1= Not at all respected or valued- 5=Completely respected or valued)*	2.0	2.7	0.5	3.0
Do you feel able to share your expert contributions in an appropriate and effective way? *(1=Not at all able-5= Completely able)*	4.0	4.3	1.0	4.50

How important do you think it is for clinical psychology training to include the perspectives of experts by experience? *(1= Not at all important, 5=Extremely important)*	1.0	2.0	0.2	2.0
How valued do you feel your expert contributions are by Trainees and the programme team? *(1= Not at all valued-5= Highly valued)*	3.0	3.6	0.7	4.0
How meaningful do you feel your contributions as an expert by experience are to the DClinPsy courses? *(1=Not at all meaningful, 5= Extremely meaningful)*	3.0	3.4	0.8	4.0
To what extent do you believe your involvement with the course has contributed to your personal growth? *(1= Not at all-5= Significantly)*	4.0	4.4	1.0	5.0
How achievable do you believe it is for your expert contributions to lead to significant learning and understanding among trainees? *(1= Not at all achievable, 3= Completely achievable)*	2.0	2.6	0.6	3.0
To what extent do you feel your contributions as an expert by experience shape trainees' attitudes towards individuals with mental health conditions? *(1=No impact-5=Very significant impact)*	2.0	2.1	0.7	2.0
To what extent do you believe improvements are needed to enhance the involvement of experts by experience in training? *(1= No improvements needed-10= Significant improvements needed)*	4.00	3.0	1.2	3.0

Overall EbE satisfaction with involvement in the DClinPsy was mixed. The most commonly selected responses were neutral (40%) and satisfied (40%). When asked whether they felt respected and valued by programme teams and trainees, 73% indicated a neutral position. 50% of the sample reported feeling completely able to share their expertise appropriately and effectively. Despite variations in their experiences of involvement, 97% rated EbE contributions with DClinPsy training as extremely important. Perceptions of how valued EbE felt were largely positive: 67% reported feeling valued by trainees and programme staff. Contributors generally viewed the significance of their role positively. 53% described their contributions as very meaningful, and 57% perceived their involvement as contributing significantly to their personal growth. Similarly, 60% believed it was completely achievable for their contributions to lead to significant learning and understanding among trainees. Views

were more varied in relation to impact on trainee attitudes. 50% felt their input somewhat shaped trainees' attitudes toward individuals with mental health conditions. Finally, 37% of contributors indicated that moderate improvements were required to enhance EbE involvement.

Interviews

10 Trainee Clinical Psychologists voluntarily participated in interviews.

Table 5

TCP Interview Sample compared to TCP population

Demographic Variable	Category	Interview Sample, *n* (%)	TCP Population (%)
Gender	Female	8 (80%)	83.6%
	Male	2 (20%)	15.5%
	Prefer Not To Say	0 (0%)	0.9%
Ethnicity	White (British, Irish, And Any Other White Background)	10 (100%)	73.3%
	Black/ Black British (African, Caribbean, Any Other Black Background)	0 (0%)	4.9%
	Mixed/ Multiple Ethnic Origins (White And Black Caribbean, White And Black African, White And Asian, Any Other Mixed/Multiple Ethnic Background)	0 (0%)	5.8%
	Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any Other Asian Background)	0 (0%)	10.1%
Lived Mental Health Experience	Yes	8 (80%)	2.8%
	No	2 (20%)	*Not captured*
	Prefer Not To Say	0%	*Not captured*

Table 6

Characteristics of study participants

Participant ID	**Gender**	**Ethnicity**	**LMHE**	**Year of Training**
Participant 1	Female	White (British, Irish, and any other white background)	Y	3
Participant 2	Female	White (British, Irish, and any other white background)	Y	2
Participant 3	Male	White (British, Irish, and any other white background)	N	1
Participant 4	Female	White (British, Irish, and any other white background)	Y	2
Participant 5	Female	White (British, Irish, and any other white background)	Y	1
Participant 6	Female	White (British, Irish, and any other white background)	Y	2
Participant 7	Female	White (British, Irish, and any other white background)	Y	1
Participant 8	Female	White (British, Irish, and any other white background)	Y	3
Participant 9	Male	White (British, Irish, and any other white background)	Y	2
Participant 10	Female	White (British, Irish, and any other white background)	Y	3

Thematic analysis generated five main themes and fifteen subthemes.

Table 7

Theme Table

Theme	Subthemes
1. Learning Through Lived Experience	1.1 More Than Just a Textbook 1.2 Getting the Full Picture 1.3 Preparing for Clinical Practice
2. Evolving Perspectives	2.1 Appreciating the Patient Experience 2.2 Demystifying Mental Health 2.3 We Need You Too
3. What We Take With Us	3.1 Getting Lived Experience Involvement Right 3.2 Hope
4. Challenges to EBE Involvement	4.1 Conditions That Undermine Respect 4.2 Lack of Diversity 4.3 Tokenism 4.4 'They're There, but They're Not There' 4.5 Unclear Purpose and Misalignment with Trainee Needs
5. Distress Arising from EbE Involvement	5.1 Emotional triggers 5.2 Navigating shared lived experience

1. Learning through lived experience

This theme captures how learning through lived experience transformed trainees' understanding of clinical work, with EbE contributions bringing theoretical material to life and supporting trainees' preparedness for practice

1.1 More Than Just a Textbook

This subtheme captures the unique contribution of EbE in bridging the gap between theory and practice. Trainees recognised that theoretical knowledge alone was insufficient, and emphasised learning the importance of relational and interpersonal qualities in shaping service users' experiences. As one participant reflected: *"It wasn't, oh, they did CBT and it was great and they did this technique. It was… I felt heard and felt really safe and understood; they took their time with me, they communicated with me in this way… it's not just about reading an ACT textbook and just regurgitating that"-Participant 2.*

Hearing experiences from EbE, both occasions when they felt unheard or dismissed, and times when they felt validated and understood also prompted trainees to reflect on their approach to clinical encounters and what truly matters within them: *"It's more important for me to hear rather than how to treat (condition) in XYZ way"-Participant 4.*

In addition to influencing clinical practice, participants valued the distinctive insights EbE brought to research, which helped broaden their thinking. As one trainee described: *"Having that conversation with the member of the group that I spoke to was helpful. He made me think of some things that I probably wouldn't have considered"- Participant 5.*

Overall, EbE input supported trainees to consider how therapeutic work unfolds in practice, rather than as a set of linear steps learned from a manual, and encouraged them to 'think outside the box' in other aspects of their work, such as research. This suggests that EbE contributions foster a deeper understanding of the needs of patients, both in clinical practice and in research contexts.

1.2 Getting the full picture

Participants described how hearing about the stages of accessing services such as GP visits, referrals, and prior treatments helped them appreciate the complexity of patients' experiences and situate their own role within a broader care pathway, fostering respect for patients significant efforts to access NHS therapy: *"I guess you don't think about what a person's been through- seeing the GP, the referral; the whole patient journey. You're only one section of the patient journey…You almost forget that people have got experiences before they see you"- Participant 3*

Participants also emphasised the importance of hearing from EbE offering a more nuanced and realistic understanding of the systems trainees will work within. Notably, hearing about negative experiences was constructive, and encouraged trainees to reflect on how to avoid contributing to poor experiences: *"I think it's really easy when we have teaching, to look at things from a negative perspective. It was nice to have balance from somebody coming along, talking about the positive experiences that they've had and some of the challenges…but how they've got through them"*-Participant 2.

Participants also gained a fuller appreciation of the practical, everyday challenges faced by people with lived experience. One trainee reflected: *"They talked a lot about things I didn't know, like how their diagnosis of schizophrenia affects their mortgage, or insurance. I didn't know that. It made me become more aware about not just the impact on their health, but also their life, relationships, or opportunities in general"- Participant 8.*

This subtheme illustrates how exposure to the full patient journey and diverse lived experiences helped trainees gain a more realistic and nuanced understanding of the systems they work within, as well as a mixed and authentic representation of patient experiences. These insights appeared to support the development of interpersonal skills and reflective practice.

1.3 Preparing for clinical practice

This subtheme explores how instrumental EbE involvement was preparation for clinical practice. Participants highlighted that EbE-led activities provided unique opportunities to develop practical skills, gain feedback, and build confidence.

Specifically, role plays offered valuable opportunities to receive constructive feedback. On placements participants described rarely receiving feedback from patients and instead relying on supervisors' observations. The opportunity to hear from individuals with lived experience was welcomed: *"(role-play) prepared and helped me. It's something you don't really get an opportunity to do on placement-to ask your patients how you're coming across; it was really good to get direct feedback from people who've been through these services and know what's important in how we present"- Participant 9.*

Exposure to different patient populations was regarded an important aspect of preparing for future clinical work. Several participants described apprehension about commencing placements in unfamiliar services and uncertainty regarding how to engage effectively with clinical populations they held no prior experience with. EbE mitigated these anxieties by providing experiential insights into what trainees might

expect and how psychologists can offer meaningful support: *"I think we all actually said to the lecture that we would all feel more comfortable and a bit more interested in working with substance users in the future and less daunted by the prospect"- Participant 3.* Trainees reported feeling better equipped to work with these patient groups, with greater confidence and understanding of their presentations and needs. This exposure was seen as instrumental in developing both confidence and clinical skills and becoming a 'better' psychologist.

2. Evolving Perspectives

This theme captures participants' new depths to understanding the patient experience and changing attitudes toward mental health, as well as evolving views towards the contributions people with lived experience bring to training and services.

2.1 Appreciating patient vulnerability

This subtheme reflects participants' growing awareness of the emotional and practical challenges patients face when accessing services. Hearing from EbE highlighted how stigma, shame, and systemic barriers can make seeking help both difficult and distressing, increasing the sense of vulnerability involved in accessing psychological support

Participants described gaining a deeper appreciation of the emotionally demanding nature of therapy, and awareness that psychologists may be perceived as intimidating: *"Because we do this as a career we forget how hard it is to see a psychologist. It's normal to us. We forget how hard it is to sit and cry in front of someone, to be vulnerable and share your story because we're so used to it. I sometimes catch myself realising- this is actually a really big thing…. you don't feel like that in the moment"*- Participant 3.Trainee's admiration for clients encouraged them to consider how they might mitigate these challenges through their approach and engagement. This was seen as essential for building empathy, fostering rapport, and creating a sense of safety in therapeutic relationships.

For some trainees, hearing from EbE who had experienced services during times when they were less compassionate or even harmful was particularly powerful. One

participant reflected on the significance of this: *"Seeing how they were willing to let themselves kind of re-enter services in modern day and kind of trust a profession that had been part of that abuse system was a really important and powerful part of our teaching"- Participant 7.* This insight highlighted the considerable courage required for individuals to re-engage with systems that had previously contributed to distress. This deeper awareness encouraged trainees to consider their responsibility in creating conditions where such vulnerability is met with sensitivity and respect.

2.2 Demystifying mental health

Interactions with EbE provided trainees with richer, more humanised understandings of mental health and helped challenge negative biases and stigma. EbE input enabled trainees to move beyond diagnostic labels and stereotypes, increasing awareness that mental health difficulties can affect anyone: *"You realise there isn't a one type of person who is the poster of mental health… when we've had experts come in who have had neurosurgery or traumatic births or addictions or are a family member of someone who has a learning disability… it's made me see, these things can happen to anyone"- Participant 6.*

EbE-led teaching counteracted the overly clinical framing often associated with traditional teaching, making mental health difficulties feel less overwhelming and more relatable: *"When you have teaching from a clinician and there's lots of facts on the screen and graphs and diagrams, it can give you a really cold understanding of a clinical difficulty, which I think can make things seem bigger, scarier and less human. I think having EbE teaching has helped me see things through more of like a normal human lens rather than a cold clinical lens"- Participant 9.*

Some trainees acknowledged previously feeling reluctant to work with certain patient groups due to negative stereotypes or uncertainty. EbE involvement helped reduce these anxieties by providing practical insights and normalising diverse presentations: *"When I went to day centres I didn't feel completely out of place and really awkward, and like I didn't know what's happening. Like if I'm thinking someone's shouting, but actually that's just their communication style" Participant 6.* Overall, these experiences made varied mental health presentations feel less intimidating and more human and

relatable, helping trainees see presentations for what they are rather than how they are stereotyped.

2.3 We need you too

This subtheme captures participants' shifting perspectives on the role of patients, highlighting a growing recognition of the value they bring to shaping services, informing practice, and contributing to clinicians' development. Trainees reflected on how involvement of EbE challenged traditional power dynamics: *"it's made me realise how much I can learn from clients and not to view them in a position where I'm feeling like I'm here to help and they're in a position of being helpless because actually I can see a lot of strength in people who bring forward their experiences. It helps me see clients on an even playing field; actually somebody's coming in with a problem but I can learn from them and they can learn from me… we can learn from each other"- Participant 2.*

Participants reflected on the systemic implications of this shift, emphasising the importance of positioning service users as active contributors rather than passive recipients: *"It's a perspective that our health system rarely sends, that message to people we need you-not only you need us, because the power dynamic is usually you need us as a client…It's a very vulnerable position, but I think we can balance that as a system by saying; well actually we also need you as active agents in the system. You can also contribute and that is so valuable because it makes me grow as a professional. It makes me better for my next client"- Participant 1.* Overall, EbE involvement prompted trainees to reflect on the importance of lived experience in training and future service development, recognising its potential to rebalance power and improve clinical practice.

3. **What We Take With Us**

This theme reflects the lasting takeaways participants associated with EbE involvement; how these experiences informed understandings of how to meaningfully and ethically include lived experiences in their future practice; and a sense of hopefulness about recovery and resilience.

3.1 Getting lived experience involvement right

While trainees valued EbE input, they also highlighted examples of poor practice that shaped their understanding of what effective involvement should look like. One participant described seeing an EbE treated dismissively during a teaching session, which prompted reflection on power dynamics and respect: *"The way he was interacting with the EbE felt quite belittling…sort of like: I'm running this session and you're just kind of adding things in…I think it's taught me that valuable lesson of what it shouldn't look like… Seeing it done badly can make you realise that actually this is not what we're trying to achieve"- Participant 2.*

Participants emphasised the importance of involving people with lived experience in ways that are thoughtful, respectful, and genuinely collaborative. They acknowledged the need to balance the potential benefits of involvement with sensitivity to the emotional burden it may place on those who have experienced harm within systems: *"It's driven home more of the importance of [involving EbE] in future leadership roles …sometimes it can feel like a little bit of an imposition, asking people who've been hurt by a system to come in and help-it feels quite burdensome. While it can be hurtful and you have to be careful about how you do that, it is important to get people's input on how a service runs"*- Participant 4.This suggests that trainees are beginning to consider how to embed these principles within their future practice and leadership roles.

3.2 Hope

EbE involvement instilled a sense of hope in trainees; both regarding the possibility of recovery and the meaningful role psychologists can play in supporting this process. Trainees reported that repeatedly seeing clients return in distress or relapse can highlight ongoing struggle and at times feel demotivating. EbE involvement offered a counterbalance by highlighting stories of growth and change: *"When you're working clinically a lot of the times you don't see people move on or if you see people they've come back into service and life's kind gone a bit tricky again. So being able to see those positive stories does instil that hope in a profession because it's not an easy job to have.*

Seeing this collection of people that have used what we've offered in their life and their life is different now. That's really inspiring"- Participant 7.

Participants reflected that hearing EbE accounts helped them recognise that recovery does not necessarily mean the absence of difficulties, but the ability to live a meaningful life despite ongoing challenges. This perspective encouraged trainees to appreciate patient resilience and contextualise their own clients' experience: *"EbE that still struggle sometimes has been one of the most important pieces of learning because I think it's shown that even though somebody can still deal with the same challenges they can create a meaningful life for themselves and they can handle those experiences"- Participant 2.*

4. Challenges to EbE Involvement

This theme explores participants' reflections on perceived challenges associated with involvement, including difficulties they had directly encountered, as well as issues they perceived from the perspective of EbE.

4.1 Conditions that undermine respect

Participants' observed structural and practical issues that compromised the dignity and wellbeing of EbE. Trainees expressed concern about poor working conditions, including lack of secure contracts, budget cuts reducing available roles, and instances where experts contributed without receiving payment. These conditions were perceived as inconsistent with valuing lived experience and raised ethical questions: *"(EBE) give all this time and are very passionate about helping us. Yet, they don't actually have the security of a job. Whilst it's great they come and teach us. Is that really ethical? Are we giving people the right resources, and conditions, are we actually treating them with dignity in order for them to feel valued?"*-Participant 8. Participants also highlighted concerns about lack of reimbursement for travel and other expenses, which they felt reflected poorly on universities: *"They don't compensate any of these people. I think that that's so embarrassing"- Participant 4.*

The lack of practical support for EbE during teaching sessions was recognised by participants. Several described situations where experts struggled with technology or

managing large cohorts without assistance, which negatively impacted the learning experience: *"It was very disappointing that it happened again (EBE becoming frustrated) and we told the university they need to provide support if they're leading a session, which wasn't provided. I could sense that this person was quite stressed and trying to run a session with a large group of people that they don't know, and we're also asking them really vulnerable questions about their mental health and that seems quite wrong"- Participant 10.* These reflections suggest that trainees were uncomfortable with the conditions under which experts were expected to contribute, highlighting circumstances that risk compromising the ethical integrity of EbE involvement.

4.2 Lack of Diversity

This subtheme highlights participants' concerns about the limited diversity among EbE involved in training. Participants felt that narrow representation both in terms of clinical presentations and demographic characteristics restricted the breadth and relevance of perspectives offered. One participant expressed disappointment that, despite extensive teaching on certain therapeutic models, there was no corresponding input from individuals who had experienced these interventions: *"We had so much CBT teaching and the amount of people that have had CBT in the UK is extraordinary, but we didn't have a single expert come and talk about it"- Participant 7.*

Others reflected on the limited demographic diversity among experts, particularly with regards to gender, ethnicity, and age: *"Representatives tend to come from certain services or populations. And we definitely noticed less male representatives, different age groups, or different ethnicities being presented…there is a dominant group that is represented"- Participant 1.* Participants also raised concerns about the recency of lived experience, observing that while historical accounts were valuable, they sometimes felt less applicable to current service contexts: *"It would be nicer to have a bit more of a mix of people than just those whose experiences were 30 years ago, a lot has changed in that time. Whilst lots of things that they say are still valuable…how much can I take from what you're saying and apply it to the system I am working in now?"*- Participant 5.Participants indicated that limited diversity limits the potential benefits of EbE involvement, reducing opportunities for trainees to engage with a wide range of perspectives and experiences relevant to their practice.

4.3 Tokenism

Participants often described experiences where EbE involvement appeared more symbolic than meaningful. From a critical realist viewpoint, these point to deeper structures and processes shaping how involvement happens*: "The next year we had those exact same sessions again… it feels very much like this pretence, right? Oh, we care, but let's just get the same people in again this year. It just feels really icky"- Participant 4.* This repetition suggests that involvement may be driven by pressures to meet accreditation standards; being seen to be doing what is required, rather than genuine co-production. When the same content is repeated without development, it risks being perceived as a 'tick-box' exercise rather than a meaningful learning experience.

Another participant described a session where an EBE was barely involved: *"They were only asked a few questions at the end…it felt really shallow and unhelpful"- Participant 9.* Here, the EbE's passive role points to structural constraints, such as rigid teaching plans or professional hierarchies that limit their ability to contribute. When EbE are not fully integrated into the teaching process, trainees are likely to feel this involvement is tokenistic. These accounts highlight that tokenism relates to underlying mechanisms such as institutional routines, accreditation pressures, and power dynamics that shape how involvement is organised. These mechanisms tend to produce outcomes that look inclusive but lack depth, leaving trainees questioning the authenticity of the process.

4.4 'They're There, but They're Not There'

Participants expressed disappointment about the limited and fragmented engagement with EbE throughout their training. Many had expected more continuous and accessible involvement, and expressed disappointment when this did not materialise: *"It feels quite separate, right? It very much feels quite distant. They come in, they sit in the front, they do their presentations, then they leave. There's no interactions"- Participant 4.*

Another concern was accessibility. Trainees typically only encountered EbE during scheduled teaching and hoped for opportunities to engage beyond these sessions*:*

"they're not at the university floating around regularly… I've not really seen them in second-year apart from one or two random slots. So it feels like they're there, they've got a university email-but they're not there that much, actually"- Participant 6.

One participant also questioned the lack of EbE presence across the whole training journey, particularly given their role in candidate selection: *"They're kind of at the start assessing our readiness for training, but where are they in assessing our progression through the course? If the system trusts them to say yes or no about who gets a place, there should be more consideration about how they assess us formatively"- Participant 7.*

These accounts suggest that while EbE are formally included, involvement often feels episodic rather than integrated. This pattern may reflect that deeper structural factors such as curriculum design and resource limitations impact opportunities for sustained engagement, resulting in a gap between the perceived value of EbE and the actual experience of trainees, and missed opportunities for meaningful learning.

4.5 Unclear Purpose and Misalignment with Trainee Needs

Trainees described feeling uncertain about the purpose of including EbE in some teaching sessions, raising questions about whether their presence added value: *"There have been times when it's felt frustrating. Like, what's the added value here? Are the university just popping them into this lecture because it looks good? or is there something really relevant and important to add?"- Participant 5.*

Others noted that the way sessions were structured sometimes made EbE involvement feel disconnected from the core learning objectives*: "Sometimes it feels like it kind of misses the point a little bit. And sometimes teaching is set up in such a way that I just think there's no way that somebody has been consulted in this because it's not well structured. It's not asking the questions that I would be interested in or it's very theoretical and maybe not really engaging with like what's happening on the ground"- Participant 2.* Taken together, these accounts suggest that clarity of purpose and thoughtful integration are critical to ensuring that EbE involvement is experienced as meaningful rather than performative.

5. Distress arising from EbE involvement

Alongside the challenges associated with EbE involvement, participants described instances where this engagement resulted in emotional distress for both trainees and EbE.

5.1 Emotional triggers

This subtheme captures how trainees experienced emotional triggers themselves and observed distress among EbEs during teaching sessions.

One trainee reflected on feeling unexpectedly overwhelmed during a lecture that touched on sensitive topics related to their own lived experience. They described feeling unprepared to manage these emotions: *"...the topics that are being approached can evoke really strong emotions. I felt myself welling up in a session and I thought, oh my god, what do I do now? And I wasn't the only one-we were all in a panicky mode because we haven't really discussed this"- Participant 1.* Another participant relayed an experience where they became distressed by hurtful comments made by an EbE regarding a specific disorder that trainees within the cohort had shared lived experience of: *"A parent basically blamed their (child's) condition on vaccines and then also said that it causes (gender -related experience) in those words… the way that it was spoken about, there was no intervening. You're putting people into really uncomfortable situations by hearing those opinions that are that are really unacceptable"- Participant 4.*

Other participants noted occasions where EbE appeared visibly uncomfortable or distressed. For example, one trainee described a session where an EbE was leading without lecturer support, struggling with technology and managing a large cohort. This resulted in displays of anger and raised voices, which left the trainee feeling unsettled: *"I imagine she went away from that session feeling quite frustrated, disempowered and angry because it's a really emotive subject for her. And I think for the course-well, at least I did-went away feeling a bit frustrated that the session hadn't gone the way I wanted it to and a bit frustrated that we weren't being taught effectively. It felt kind of unfair for the person leading the session and unfair for us"- Participant 9.*

These accounts highlight that while EbE involvement can enrich training, it also introduces emotional complexity. Without proactive planning and emotional safety and support measures, these mechanisms can involvement can result in distress for trainees and EBE, undermining the intended benefits.

5.2 Navigating shared lived experience

This subtheme explores how trainees and EbE navigate the complexities of sharing lived experience within EbE-led spaces. While some trainees felt that EbE involvement created opportunities for openness around trainee lived mental health experiences others reported feeling that such disclosures were not always welcomed or valued.

Several participants described feeling that their own lived experiences were not embraced in the same way as those of EbE: *"A hope for courses for me would be for them to value (trainee LMHE) more. In my course it doesn't seem like it's valued or encouraged, and people certainly don't feel safe to talk about it"- Participant 8.* This reflects a sense that trainee LMHE is sometimes stigmatised within training culture, creating a noticeable inconsistency given that lived experience is actively valued when it is shared by EbE.

Other trainees highlighted power dynamics within EbE spaces that made sharing their own experiences challenging. One participant expressed that: *"Sometimes the EbE group may not be taking into account that lots of us have our own lived experience. So they're coming in thinking 'I am the expert in this so therefore you have to learn from me', but actually I come with my own experience. What you're saying is very valuable, but there can be a differing opinion and that can also be valuable. Sometimes it's felt a little bit like we're not allowed to do that because we have to be just respectful-like what they say is right"- Participant 5.*

These accounts suggest that lived experience is not equally valued when shared by trainees and EbE, and that this imbalance can create challenges around identity and power within these spaces. This may relate to professional norms that discourage

trainee disclosure and to the perception that EbE own the right to share lived experience in these settings, making it harder for trainees to do the same.

Discussion

Drawing on combined survey and interview data, the findings indicate that EbE involvement offers substantial benefits, while also revealing ongoing challenges. Survey findings indicated both TCP and EbE hold broadly positive attitudes toward involvement and consistently rated EbE contributions as extremely important within DClinPsy programmes. Interview findings indicated that trainees viewed EbE involvement as enhancing their clinical learning. They reported greater confidence in working therapeutically with people experiencing mental health difficulties and a deeper understanding of varied presentations. Survey analysis revealed that the majority of trainees perceived EbE involvement to moderately influence their confidence, and contribute to the development of their core competencies. This supports previous findings that service-user and carer involvement can strengthen clinical knowledge and preparedness (Schreur et al., 2015), together, suggesting that EbE may play a formative role in bridging theoretical learning with real-world clinical practice. From an experiential learning perspective (Kolb, 1984), EbE involvement may provide trainees with concrete and emotionally salient experiences that can enhance learning through reflection and integration with existing clinical knowledge, consequently supporting the translation of abstract, lecture-taught theory into applied clinical practice.

During interviews TCP described positive shifts in how they viewed clients and their emerging professional identities. Survey data mirrored this, indicating improved attitudes toward mental health difficulties. These results are consistent with Taylor and Gordon (2022), who found that lived-experience teaching improves recovery-focused attitudes and reduces stigma. Although causality cannot be assumed, the alignment between these findings suggests that EbE involvement may help cultivate compassionate attitudes toward mental health. These findings are consistent with Allport's contact hypothesis (1954), which proposes that supportive and structured contact with individuals from stigmatised groups can reduce stereotyped beliefs and promote more positive attitudes. EbE involvement may therefore function as a form of

meaningful contact within training contexts, supporting attitude change and fostering greater understanding between trainee clinical psychologists and people with lived experience, which may also contribute to reducing perceived power differentials between trainees and EbE.

The lasting emotional and professional impact of EbE involvement was prominent. Trainees described feeling hopeful, inspired, and more connected to the values underpinning psychological practice. These experiences were described as shaping their ongoing development and reinforcing their belief in the importance of meaningful service-user involvement in future work contexts. EbE felt strongly their contributions were meaningful, and could significantly impact learning and understanding in training. Furthermore, the majority reported their involvement contributed significantly to their personal growth, aligning with prior research on EbE educators in mental health education (Happell et al., 2014).

However, satisfaction with current practices was mixed, and both participant groups reported a 'moderate' need for improvements. Quantitative findings were reflected in the qualitative data; although trainees described numerous positive impacts of EbE involvement, they also identified barriers that prevented them from fully benefiting from these experiences. Participants highlighted concerns about tokenism and limited diversity. Trainees felt that programmes did not adequately represent a full range of lived experiences, including different mental health presentations, different trajectories through services, and diverse demographic characteristics. Similarly, EbE reported obstacles that restricted the extent to which they could participate in the ways they wished, limiting their satisfaction and the degree of benefit they derived from their involvement. These findings are consistent with earlier research identifying limited representation (Howarth, 2018; Smith et al., 2020) and tokenism as commonly cited barriers (Clarke & Holttum, 2013). The present study adds to this evidence by showing how these barriers can restrict trainee learning and engagement.

Furthermore, trainees frequently described feeling surprised by the limited opportunities to engage with EbE and expressed a desire for greater, more consistent involvement. EbE similarly wished to contribute more extensively and across a broader

range of programme activities. These findings align with previous research, where trainees expressed disappointment about the extent and quality of service-user involvement within training, reporting that it occurred less than they believed it should (Smith et al., 2020). Likewise, in an earlier study, service users and carers perceived their involvement as falling below their expectations (Holtum et al., 2011). Finally, the study built on existing research, highlighting the potential emotional impact of involvement. While earlier research has highlighted that EbE participation can elicit distress for EbE and TCP (Kerry et al., 2023), the current study identified that negative effects to trainees were predominantly associated with participants own lived-experience identities. Within Kolb's (1984) experiential learning theory reflection is a critical stage for transforming experience into learning; where opportunities for reflection were limited, this appeared to be associated with distress rather than integration. Although exposure to emotionally challenging material is a recognised aspect of clinical psychology practice and routinely encountered within placements, the distress reported in relation to EbE involvement suggests a need for greater alignment between academic training and the support mechanisms commonly embedded in professional contexts, such as clinical supervision, peer supervision and structured reflective practices. Collectively, these findings suggest a shared recognition across both groups that current approaches to EbE involvement require further development to more effectively support trainee learning and enhance the quality of EbE experiences.

Strengths and Limitations

To the researcher's knowledge, this is the first investigation into the value, impact, and quality of current EbE involvement in DClinPsy programmes combining survey and interview methods and including participants from three key stakeholder groups. The study recruited 78% of courses across the three participant groups, exceeding the response rate of 45.5% reported in a similar study (Howarth, 2018). The study highlighted key benefits for trainees, including deeper clinical understanding, enhanced empathy, and increased confidence, as well as personal growth for EbE. Findings reinforce EbE involvement as a valuable resource and to an extent; mutually beneficial. By capturing both the positive impacts and difficulties associated with involvement, the study offers a balanced and comprehensive understanding of current practices. Collectively, these insights can inform DClinPsy programmes and the BPS by sharing

understanding, guiding improvements, and drawing greater attention to the need for meaningful and well-supported EbE involvement.

Furthermore, the study highlighted the extent of LE within the trainee sample, with 84.2% of trainees reporting some form of LE. Although this finding cannot be generalised beyond the sample, it may be suggestive of a high prevalence of LE within the wider TCP cohort. Bringing attention to this may help to normalise discussions of LE within training contexts and promote the value of trainees' own lived-experience perspectives; an issue reflected in participants' expressed hope that universities would recognise and value their LE to a greater extent. The study may be criticised due to overrepresentation of LE in the sample compared to the national trainee population, however research has highlighted psychologists fears of stigma, leading to non-disclosure of their LE identity (Svoboda, 2025), which suggests UK statistics may not accurately reflect trainee lived experience.

The high rate of LE within the TCP sample may also be viewed as a limitation. Trainees with LE backgrounds may be more inclined to engage with research on this topic and may naturally hold more favourable or supportive views toward EbE involvement. This introduces the possibility of self-selection bias and raises the risk that the findings reflect a more positive stance than is representative of the wider trainee cohort. A further limitation concerns researcher positionality. Although reflexive practices were used throughout, the researcher's position as a TCP with prior EbE experience may have influenced data interpretation through insider knowledge and shared professional context. Consequently, caution is needed when generalising findings

A limitation of the present study concerns variation in programme representation across participant groups. Only 8 out of 34 courses were represented within the course director subsample, whereas trainee and EbE participants reflected a larger proportion of programmes. This imbalance limits the extent to which course director insights can be generalised to UK DClinPsy programmes as it may not present an accurate overview of involvement, partially inhibiting one of studies aims. The researcher acknowledges that aspects of the recruitment process may have contributed to this. Invitation emails for all participant groups were distributed at similar time points, which may have caused

confusion and inadvertently reduced engagement. The TCP sample was relatively small (n = 101) compared to the national trainee population. However, this remains the largest sample to date for a research study of this nature. Despite the modest sample, the study offers valuable insights and generates learnings that can be meaningfully applied beyond the current participant group.

Implications and Recommendations for training programmes

The findings offer practical implications for the design and delivery of clinical psychology training, highlighting specific needs and conditions for effective involvement for trainees and experts. Recommendations were developed using existing literature and the present findings (see appendix R for summary of feedback provided through the open-text survey responses), in collaboration with the University of Glasgow CUSP group. Following review of the findings, the CUSP group contributed suggestions for future action. However, additional work is needed to establish how these recommendations can be feasibly implemented and embedded within training programmes.

Please see Appendix U for the suggestion recommendations developed in collaboration with the CUSP group.

Future Research

EBE involvement in the DClinPsy remains under-examined; future research should further explore the experiences of trainees, EBE contributors, and course directors. Additionally, it would be valuable to compare the contribution of trainees' own lived experience with exposure to EbE on the programme for outcomes such as confidence, empathy, and attitudes, and to identify which forms of lived-experience engagement (self or expert) result in greatest benefit.

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Appendices

Appendix A: PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.7
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.8
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.9-10
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.10
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.11
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.11
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.86
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.12
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.12
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.12
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.12
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.12
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.14
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	p.12
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.15

	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.13
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	p.12
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	p.20
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.14
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.14
Study characteristics	17	Cite each included study and present its characteristics.	p.15
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.20
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	p.15
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.20
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	p.21
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	p.20
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.32
	23b	Discuss any limitations of the evidence included in the review.	p.33-35
	23c	Discuss any limitations of the review processes used.	p.33-35
	23d	Discuss implications of the results for practice, policy, and future research.	p.35

OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.11
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Not provided
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	p.97-98

Appendix B: Search Strategy

PSYCINFO

APA PsycInfo <1806 to September 2025 Week 1>

1 exp Lived Experience/ 8814
2 ((lived or personal) adj3 experience*).ti,ab,id. 53612
3 1 or 2 53844
4 exp Mental Health/ 116064
5 mental health.ti,ab,id. 293028
6 4 or 5 306784
7 3 and 66784
8 Impaired Professionals/ 701
9 "mental health difficult*".ti,ab,id. 2635
10 "wounded healer".ti,ab,id. 235
11 "psychological distress".ti,ab,id. 29354
12 "mental health problems".ti,ab,id. 22548
13 "service user*".ti,ab,id. 9214
14 8 or 9 or 10 or 11 or 12 or 13 62607
15 7 or 14 68431
16 Postgraduate Training/ 1565
17 (Psychology Clinical or Clinical Psychology Graduate Training).ti,ab,id. 659
18 Clinical Psychology/ 10172
19 (Clinical psychologist or Counseling psychologist).ti,ab,id. 2974
20 Counseling Psychology/ 3314
21 Clinical Psychologists/ 3468
22 Counseling Psychologists/ 981
23 "trainee psycholog*".ti,ab,id. 79
24 "trainee counsel?ing psycholog*".ti,ab,id. 36
25 "clinical psycholog*".ti,ab,id. 21884
26 "counsel?ing psycholog*".ti,ab,id. 6294
27 "doctoral psychology student*".ti,ab,id. 78
28 "doctoral program*".ti,ab,id. 2372
29 "doctoral training".ti,ab,id. 862
30 "doctoral education".ti,ab,id. 746
31 (train* adj2 psycholog*).ti,ab,id. 9029
32 (psycholog* adj2 (student* or trainee* or train*) adj2 doctoral).ti,ab,id. 786
33 (professional adj2 psycholog* adj2 train*).ti,ab,id. 514
34 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 43790
35 15 and 34 1058
36 limit 35 to (english language and yr="2005 -Current") 827

MEDLINE

Ovid MEDLINE(R) ALL <1946 to September 13, 2025>

1 ((lived or personal) adj3 experience*).ti,ab,kw. 42702
2 exp Mental Health/ 76917
3 mental health.ti,ab,kw. 295562
4 exp Psychological Distress/ 9930
5 2 or 3 or 4 320686
6 1 and 54804
7 Professional Impairment/ 1232
8 "mental health difficult*".ti,ab,kw. 2168
9 "wounded healer".ti,ab,kw. 76
10 "psychological distress".ti,ab,kw. 36796
11 "mental health problems".ti,ab,kw. 22817
12 "service user*".ti,ab,kw. 9161
13 or/7-12 70216
14 6 or 13 74203
15 (Psychology Clinical or Clinical Psychology Graduate Training).ti,ab,kw. 273
16 Psychology, Clinical/ 3361
17 (Clinical psychologist or Counseling psychologist).ti,ab,kw. 1012
18 Psychologists/ 74
19 "doctoral education".ti,ab,kw.476
20 "trainee psycholog*".ti,ab,kw. 35
21 "trainee counsel?ing psycholog*".ti,ab,kw. 2
22 "clinical psycholog*".ti,ab,kw. 6220
23 "counsel?ing psycholog*".ti,ab,kw. 520
24 "doctoral psychology student*".ti,ab,kw. 6
25 "doctoral program*".ti,ab,kw.792
26 "doctoral training".ti,ab,kw. 295
27 (train* adj2 psycholog*).ti,ab,kw. 2625
28 (psycholog* adj2 (student* or trainee* or train*) adj2 doctoral).ti,ab,kw. 85
29 (professional adj2 psycholog* adj2 train*).ti,ab,kw. 56
30 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 12371
31 14 and 30 525
32 limit 31 to (english language and yr="2005 -Current") 459

EMBASE

Embase 1947-Present, updated daily

1 ((lived or personal) adj3 experience*).ti,ab,kw. 60285
2 exp Mental Health/ 354076
3 mental health.ti,ab,kw. 378659
4 exp Psychological Distress/ 91903
5 2 or 3 or 4 599734
6 1 and 57720
7 Professional Impairment/ 14
8 "mental health difficult*".ti,ab,kw. 2646
9 "wounded healer".ti,ab,kw. 102
10 "psychological distress".ti,ab,kw. 47338
11 "mental health problems".ti,ab,kw. 28082
12 "service user*".ti,ab,kw. 12880
13 or/7-12 88613
14 6 or 13 95144
15 (Psychology Clinical or Clinical Psychology Graduate Training).ti,ab,kw. 141
16 Psychology, Clinical/ 8847
17 (Clinical psychologist or Counseling psychologist).ti,ab,kw. 2519
18 Psychologists/ 25316
19 "doctoral education".ti,ab,kw. 512
20 "trainee psycholog*".ti,ab,kw. 50
21 "trainee counsel?ing psycholog*".ti,ab,kw. 5
22 "clinical psycholog*".ti,ab,kw. 10399
23 "counsel?ing psycholog*".ti,ab,kw. 749
24 "doctoral psychology student*".ti,ab,kw. 9
25 "doctoral program*".ti,ab,kw. 923
26 "doctoral training".ti,ab,kw. 388
27 (train* adj2 psycholog*).ti,ab,kw. 3997
28 (psycholog* adj2 (student* or trainee* or train*) adj2 doctoral).ti,ab,kw. 124
29 (professional adj2 psycholog* adj2 train*).ti,ab,kw. 66
30 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 42933
31 14 and 30 1917
32 limit 31 to (english language and yr="2005 -Current") 1805

CINHAL

S34	S30 AND S31	Limiters - Publication Date: 20050101-20251231 Narrow by Language: - english Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S33	S30 AND S31	Narrow by Language: - english Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S32	S30 AND S31	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S31	S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S30	S28 OR S29	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database -	Display

			CINAHL	
S29	S7 OR S8 OR S9 OR S10 OR S11	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S28	S26 AND S27	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S27	S3 OR S4 OR S5 OR S6	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S26	S1 OR S2	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S25	OR TI (professional N2 psycholog* N2 train*) OR AB (professional N2 psycholog* N2 train*)	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display

S24	TI (psycholog* N2 (student* OR trainee* OR train*) N2 doctoral) OR AB (psycholog* N2 (student* OR trainee* OR train*) N2 doctoral)	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S23	TI (train* N2 psycholog*) OR AB (train* N2 psycholog*)	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S22	TI "doctoral training" OR AB "doctoral training"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S21	TI "doctoral program*" OR AB "doctoral program*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S20	TI "doctoral psychology student*" OR AB "doctoral psychology student*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S19	TI "doctoral education" OR AB	Search modes -	Interface -	Display

	"doctoral education"	Proximity	EBSCOhost Research Databases Search Screen - Advanced Search Database – CINAHL	
S18	TI "counsel?ing psycholog*" OR AB "clinical psycholog*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S17	TI "clinical psycholog*" OR AB "clinical psycholog*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S16	TI "trainee counsel?ing psycholog*" OR AB "trainee counsel?ing psycholog*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S15	TI "trainee psycholog*" OR AB "trainee psycholog*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S14	(MH "Psychologists")	Search modes - Proximity	Interface - EBSCOhost	Display

			Research Databases Search Screen - Advanced Search Database – CINAHL	
S13	(MH "Psychology, Clinical")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S12	(MH "Education, Doctoral+")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S11	TI "service user*" OR AB "service user*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S10	TI "mental health problems" OR AB "mental health problems"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S9	TI "wounded healer*" OR AB "wounded healer*"	Search modes - Proximity	Interface - EBSCOhost Research	Display

			Databases Search Screen - Advanced Search Database – CINAHL	
S8	TI "mental health difficult*" OR AB "mental health difficult*"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S7	(MH "Impairment, Health Professional")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S6	TI "psychological distress" OR AB "psychological distress"	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S5	(MH "Psychological Distress")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S4	TI "mental health" OR AB "mental health"	Search modes - Proximity	Interface - EBSCOhost Research Databases	Display

			Search Screen - Advanced Search Database – CINAHL	
S3	(MH "Mental Health")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S2	TI ((lived N2 experience*) OR (personal N2 experience*)) OR AB ((lived N2 experience*) OR (personal N2 experience*))	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display
S1	(MH "Life Experiences+")	Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	Display

Appendix C: CASP APPRAISAL TABLE
https://osf.io/sgec3/files/zxcpm

Appendix D: Development of thematic synthesis themes

https://osf.io/sgec3/files/tkq97

Appendix E: Theme frequency table

Theme	**Personal struggles carried into professional roles**			**Reframing distress through professional knowledge**		**Coping as a process of trial and error**				**Living in two worlds: negotiating service user and professional identity**		**Harnessing LE to enrich practice**			
	MH associated challenges	Work as a trigger	Stigma	Psychological literacy	Self-compassion	Personal therapy	Boundary managemen	Self-Care	Peer and Systemic	Integration	Conflict	Empathy	Therapeutic Alliance	LE as the foundation for therapeutic success	Career Pathways
Study															
Bamber et al. (2025)	×	✓	✓	×	×	✓	×	×	✓	✓	✓	✓	✓	✓	✓
Becker (2024)	×	✓		×	×	✓	✓	✓	✓	×	×	✓	✓	✓	✓
Burrows et al. (2023)	✓	×	✓	✓	×	×	✓	×	×	×	✓	✓	✓	×	✓
Charlemagne-Olde et al. (2012)	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	✓	×	✓	✓
Davidson (2013)	×	×	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Flanery (2023)	✓	✓	✓	✓	×	✓	✓	✓	✓	×	✓	✓	✓	✓	✓
Phyrdas (2014)	✓	✓		✓	×	×		×	✓	✓	✓	✓	✓	✓	✓
Reid (2023)	✓	✓	✓	×	×	✓	✓	×	✓	✓	✓	✓	×	✓	✓
Rhinehart (2023)	✓	×	✓	×	✓	×	×	×	×	✓	✓	×	×	×	✓
Svoboda (2025)	✓	×	✓	✓	✓	×	✓	×	✓	✓	×	✓	✓	×	✓

Appendix F: Sample of SR Reflexive Log

https://osf.io/sgec3/files/pxybk

Appendix G: Journal Article Reporting Standards (JARS) Checklist

JARS–Mixed Methods Reporting Checklist
Adapted from APA Style Journal Article Reporting Standards for Mixed Methods (JARS–Mixed, Table 1).

Source guidance: APA Style JARS–Mixed (Table 1). See https://apastyle.apa.org/jars/mixed-methods and https://apastyle.apa.org/jars/mixed-table-1.pdf

Section	Checklist item	Details	Location	Completed ✓x-
Title page	Identify study as mixed methods; name qualitative and quantitative methods used.	Title avoids qualitative wording e.g 'explore' and quantitative wording Mixed methods has been referenced, but individual methods have not been named due to lengthy title	p.43	✓
Abstract	Specify mixed methods design, participants/data sources, analytic strategy, main findings, and significance.	Abstract provides an overview of design, mixed methods data collection and analysis. Keywords identified	p.45	✓
Introduction	Description of research problems/questions Study objectives/aims	Summary of the limited evidence based provided Objectives of the research are clearly stated and discussed in the context of the research area	p.46 p.48	✓

Mixed methods design	Research design overview Participants or other data sources Researcher description/position	Mixed methods design consisting of quantitative electronic surveys and individual semi-structured interviews were thoroughly described. Justification of why the research topic is best addressed through the use of mixed-methods is clearly presented. Sources of data, and relevance to research question clearly described.	p.48 p.50 p.53	✓
Participant recruitment	Sampling framework, eligibility criteria, recruitment, sample size, and context	Participant inclusion/exclusion criteria clearly stated Recruitment method clear: volunteer sampling Sample size justified Representativeness of the sample discussed: sample demographics were compared to the UK population of Trainee Clinical Psychologists	p.49-50	✓
Data collection	Procedures, setting, researcher role/reflexivity), materials, and steps to enhance trustworthiness.	Overview of procedure detailed Materials: Interview topic guide and surveys included in	p.51-53	✓

		appendix Researcher reflexivity discussed, use of reflexive journaling and research supervision to enhance trustworthiness discussed.		
Data analysis	Collection and identification procedures	Description of statistical software used to analyse quantitative and qualitative data, and brief description of analysis procedure described. Example of coding process provided via annotated transcript in study appendix	p.52	✓
Validity, reliability and methodological integrity	Indicate methodological integrity, quantitative validity and reliability, and mixed methods validity or legitimacy	Reliability and validity partially addressed in discussion	p.74	✓
Findings/ results	Report qualitative findings/themes with illustrative evidence (e.g., excerpts). Report quantitative findings	Qualitative findings are clearly presented with quotes to illustrate themes, and theme diagram. Transcript excerpt is provided in study appendix Quantitative descriptive findings are clearly presented in tabular form and graphs are clearly labelled	p.61-74 p.54-61	✓
Discussion	Reflect on the implications of the integrated findings from	Findings of both surveys and interviews are	p.75-79	✓

	across the two methods	discussed separately and together. Implications are discussed and recommendations linked to research aims are presented.		

Appendix H: Final approved MRP proposal

***REMOVED FOR ENLIGHTEN REPOSITORY UPLOAD**

Appendix I: Ethics Approval Letter

College Ethics Committee

Prof Andrew Gumley

Project Title: Evaluating expert by experience contributions in UK Doctorate in Clinical Psychology education

Application No: 200240387

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to this project.

We are happy therefore to approve the project, subject to the following conditions

- Project end date as stipulated in original application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research: (http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or groups or datasets as defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report within 3 months of completion.

Terry Quinn
FWSO, FESO, MD, FRCP, BSc (hons), MBChB (hons)

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Tel – 0141 201 8519

Yours sincerely

Dr Terry Quinn

Appendix J: Participant Information Sheet

TCP survey
https://osf.io/mhd9q/files/62mjh

EbE survey
https://osf.io/mhd9q/files/e23tu

CD survey
https://osf.io/9fd54

TCP interview
https://osf.io/mhd9q/files/3d86w

Appendix K: Consent Form

TCP survey consent
https://osf.io/mc5j4

EbE survey consent
https://osf.io/x4njz

CD survey consent
https://osf.io/nx7p8

TCP interview consent
https://osf.io/qwe4b

Appendix L: Participant Debrief Sheet

https://osf.io/mhd9q/files/znh2w

Appendix M: Participant Surveys

https://osf.io/mhd9q/files/6hc3f

Appendix N: Interview Topic Guide

https://osf.io/mhd9q/files/gfvjs

Appendix O: Detailed Analysis Plan

https://osf.io/qr3sm

Appendix P: Data Availability Statement

Data Availability Statement
The raw study data cannot be shared due to important ethical and privacy considerations. The dataset contains highly personal information, including participants' geographic locations, affiliated universities, and demographic characteristics (such as; age, gender, ethnicity, and lived experience status). To protect participant confidentiality, these data cannot be made publicly available. Recordings and transcriptions will be destroyed following the appropriate waiting period as set out in the University of Glasgow data protection guidelines. The study will aim to be published online in the University of Glasgow thesis publication website via Enlighten and further publication will also be considered in the Frontiers of Psychology journal. A summary of findings will be disseminated to all DClinPsy programmes. The paper and the summary paper will include anonymised findings. Interested researchers may contact the corresponding author for further information regarding the study data.

Appendix Q: Annotated Transcript

***REMOVED FOR ENLIGHTEN REPOSITORY UPLOAD**

Appendix R: Open-text survey response summary table

Challenges to Expert by Experience Involvement

Experts by Experience	**Trainee Clinical Psychologists**
• Need to feel safe and valued before sharing • Distance for meetings • Inaccessible • Uncomfortable • Not always financially rewarded • Terminology and jargon is a barrier • Not employed • Lonely • Carer strain • Research obsession • University bureaucracy • Unequal allocation • No authority or responsibility • Not enough involvement • Distressing • Retraumatising • Emotional triggers • Neurodiversity needs not met • Not as involved as I would like	• Barriers the course puts in place • 'Elephant in the room' trainee lived experience not acknowledged • Course is very disorganised • Not enough opportunity to hear from EBEs • Informal sessions lack clarity and purpose • Not enough voices from the global majority • Same individuals involved repeatedly • Finding people from varied ethnic and cultural backgrounds is challenging • Hybrid teaching challenges and tech issues • Accessibility issues (stairs, physical barriers) • Wanting to ask questions without offending but not knowing how • Concerns about wellbeing and fair payment • EBEs expressing prejudiced views unchallenged • Placement barriers (few EBE structures) • Tokenistic involvement and lack of depth • Not all teaching streams include EBEs • Need for diverse range of EBEs (not just highly educated or high SES) • Little opportunity to speak directly to EBEs • EBE experiences cannot be generalise to practice • Concern for expert wellbeing • Systemic or organisational issues dominate involvement • Lack of continuity into placements and clinical careers

Suggestions for change and other feedback

Trainee Clinical Psychologists	**Experts by Experience**	**Course Directors**
• EBE to be paid fairly in line with the NIHR guidance • EBE involvement in teaching is enjoyable and valuable, but we need more • More representation of neurodiversity • More involvement in clinical skills training sessions • Role play of clinical skills and discussion with experts was incredibly helpful • EBE teaching aligning with placement time line (i.e. right before beginning CAMHS placement) • Regular involvement • Diversity in the expert group • Increased involvement in candidate selection • More structure • More time to hear from, and talk to experts • Experts to be core part of the course not an add on • More teaching involvement • Further input in assessments and research • What did experts find helpful in their experiences with services? • Coproduction from the ground up • Support for EBE leading sessions • Wider integration into the programme • Teaching and training on	• I would like to be involved in the course more • Involvement should begin at the start of the curriculum design • The EBE profession is not currently diverse enough • Greater engagement with trainees • More support for carers to be involved flexibly • Concerns that EBE can be tokenistic • Involvement with assessments • Physical health and disabilities represented more • More involvement with research • Regular structured feedback from EBE and Trainees to help courses improve involvement • Many EBEs have valuable skills beyond their personal experiences. Offering roles in co-facilitation, research collaboration, curriculum review panels, and trainee assessment can help move EBE involvement from tokenistic to truly transformative • More funding to enable experts to	• Hopes to expand EBE involvement in research design and coproduction • EBE involvement should be tailored to the individual as not everyone desires to be involved in the same way • EBE should be paid fairly, and provided with practical administration support to facilitate this • Diversity of EBE is something the course is working towards improving • Terminology needs to change: 'expert by experience' is patronising • Increasing efforts to enhance EBE involvement with trainee research projects from inception to dissemination • Plans to recruit further EBE to support delivery of EBE initiatives • EBE should be involved in summative outcomes for trainees (i.e. selection and assessments) • Need for support for experts within teams and regular supervision to help

any good practices/models of using personal lived experience and how to manage the dual roles when doing this. • Recognition of EBE identity within cohort • Increased accessibility to experts • More joint expert/lecture/clinician sessions	become involved in the way they wish to • EBEs should be treated as valued members of the training team, with appropriate payment, preparation time, debriefing opportunities, and ongoing support • Wider representation of mental health • EBE should be woven throughout training rather than involved in isolated sessions • EBE perspectives should feel integral, not peripheral	develop their skills in involvement • Broader range of lived experience would be beneficial • Involvement must be of mutual benefit, experts should not be expected to serve altruistically - they need to benefit from it too e.g. in building skills and confidence, accessing training/teaching experiences

Appendix S: Sample MRP Reflexive Journal Entry

https://osf.io/mhd9q/files/69nft

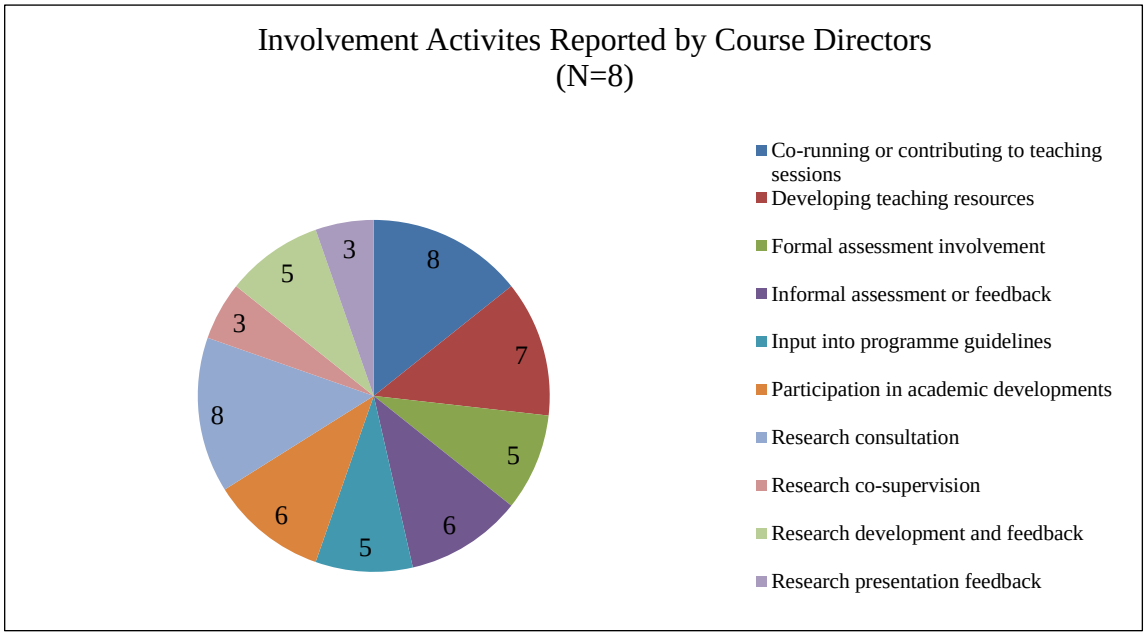
Appendix T: Course Director Insights

Survey Data:

- 8 course directors responded to the survey
- Course directors most commonly reported EbE involvement in adult, health-related presentation, or learning disabilities teaching

Figure 3

Areas of Doctoral Clinical Psychology Programme Engagement Reported by Course Directors'



Appendix U: Proposed Recommendations to Enhance Expert by Experience Involvement on Doctorate in Clinical Psychology Programmes

1. Greater diversity across gender, ethnicity, mental health presentations, recency of experiences, and varied experiences of treatment
2. More support to manage emotional triggers experienced by experts and trainees
3. Wider opportunities for trainees to directly engage with EBE
4. EBE involvement across all teaching streams, not just a select few areas
5. Opportunity to get to know experts before they contribute; helping experts to feel safer when being vulnerable and helps trainees feel more comfortable to ask questions
6. Programmes should consider access barriers to experts contributing (e.g., caring needs, location) and must consider the needs of experts (e.g., neurodiversity)
7. Programmes to recognise EBE identity within cohorts
8. EBE teaching to align with placement timeline
9. Further integration into different areas of the programme to combat tokenism and increase meaning
10. Practical support for EBE (e.g., technology, support in the lecture room)
11. Increased involvement in summative and formative assessments
12. Opportunities for EbE to receive direct feedback from trainees
13. Involvement to be tailored to the expert, as not everyone wishes to be involved in the same way
14. More social engagement at the end of EbE led sessions to foster connection and alignment, reducing 'them and us' divides