A Social Identity Approach to Facilitating Therapy Groups

Thesis submitted for the degree of Doctor of Philosophy (Psychology),

Australian National University

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Declaration

I declare this thesis reports original work and has not been submitted, in whole or in part, in any previous application for a degree at any University or Institution. The research reported in this thesis is my own work conducted during my candidature at the Australian National University under the supervision of Professor Tegan Cruwys, Dr Mark Stevens, and Professor Michael Platow. In the case of multi-author publications incorporated in this thesis, I have specified my contributions in the Author Contributions sections of the relevant chapters.

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Abstract

Increasing demand for mental health services, coupled with a lack of therapists and funding to deliver them, underscores the need for effective and cost-efficient mental health interventions. Group therapy offers a potential solution because it is as effective as individual therapy, with the cost-saving advantage that multiple clients can be treated simultaneously by the same clinician. A problem with existing group therapy research and practice, however, is that facilitators are often (mis)conceptualised as relatively uninfluential and passive providers of treatment. This has led to a lack of theoretically driven research on effective facilitation. In this thesis, I propose that group facilitators should be reconceptualised as *leaders* who play an important role in determining the success of therapy. In line with this proposition, this thesis uses identity leadership theory as a framework to develop and test strategies for improving therapist effectiveness. This aim is achieved through a conceptual paper and four empirical papers. First, the conceptual paper outlines the theoretical basis for group therapy identity leadership and its hypothesised benefits. Second, a large corpus of data drawn from a group therapy trial (client end-of-session questionnaires, interviews, and video-recorded sessions) is used to catalogue and provide initial validation for a set of behaviours that constitute identity leadership in group therapy. Third, a longitudinal study with participants drawn from body acceptance groups demonstrates that when facilitators are perceived as aspirationally prototypical (embodying "who we want to be") by clients, positive changes occur in group norms around dieting and therapeutic outcomes. Fourth, in line with a growing movement advocating for the voices of people with lived experience of mental ill-health in health care provision, two experimental

studies demonstrate that therapist self-disclosure of *recovered and relevant* mental health conditions enhances perceptions of aspirational prototypicality, which improves perceptions of the therapist and expectations for prognosis. Finally, a qualitative study examining real-world experiences of therapist lived experience disclosures highlights the nuances and complexity in clients' and therapists' experiences of these disclosures, triangulating the finding that effective disclosures should be recovered and relevant. This thesis extends identity leadership theory into a group therapy context. It also contributes to clinical theory and practice by documenting diverse group therapy identity leadership behaviours and providing evidence for their positive impact. Overall, this thesis provides a strong case for the necessity and value of conceptualising facilitators as identity leaders.

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General Introduction and Thesis Overview

"*It's possible for [clinical] students to graduate without knowing anything about group dynamics or group therapy and take a job where they're running groups. But without training, these students don't know how to intervene when problems arise among members of the group, and they may not have adequate supervision. They're just expected to go in and do it based on their individual psychotherapy training*"
– Professor Cheri Marmarosh, recent president of the *Society of Group Psychology and Group Psychotherapy* (Novotney, 2019)

In this thesis, I present, for the first time, a social identity approach to facilitating therapy groups. The goal of this introductory chapter is to provide a broad introduction to the thesis topic and structure. To do this, I first provide some background information and outline the gap in the literature that this thesis seeks to fill: a lack of research and guidance on how to effectively facilitate therapy groups (as highlighted by Marmarosh above). I then provide a brief summary of the theoretical approach taken in this thesis. Following this, I outline the aims and research questions of this thesis and provide an overview of the thesis structure.

Background

Mental ill-health is highly prevalent, with recent research indicating that half of the global population will experience a mental health condition at some point in their life (McGrath et al., 2023). At any given time, the number of people worldwide experiencing a mental health condition is theorised to be over one billion (e.g., as it was in 2019; The Lancet Global Health, 2020). Despite the high prevalence of mental ill-health, there is a lack of funding for mental health services and a lack of trained mental health professionals available to provide these services (Wainberg et al., 2017). For

example, the global median of government health expenditure assigned to mental health services is <2% of the total health expenditure (World Health Organisation, 2021) despite mental health conditions comprising ~7% of the global burden of disease (Rehm & Shield, 2019). During the COVID-19 pandemic, the shortage of mental health services became increasingly evident to public health authorities, such that stark increases in mental ill-health (e.g., a 27% increase in depression) completely overwhelmed mental health systems across the world (e.g., American Psychological Association, 2021b; World Health Organisation, 2022).

It is possible that greater access to **group therapy** (see Box 1 for a definition), and a better understanding of how to deliver group therapy effectively, may represent one possible solution to the growing demand for mental health care (Clay, 2022). Indeed, during the pandemic, group therapy delivered in online formats provided a crucial means for therapists to continue supporting their clients (Margherita et al., 2022). Notably, a recent analysis by Whittingham et al. (2023) also indicated that increasing group therapy services by 10% in the United States would (a) improve treatment access for over 3.5 million people, (b) reduce the need for over 34,000 additional therapists, and (c) save over 5.6 billion dollars. In addition to being cost-effective, group therapy is also effective for treating a range of the most common mental health issues (e.g., Burlingame, 2023). Due to its strong evidence base, group therapy has been deemed a “triple E” treatment: it is Effective, Equivalent, and Efficient when compared to individual therapy (Burlingame et al., 2016; Burlingame & Strauss, 2021).

Box 1: What is group therapy?

A typical group therapy (also sometimes called 'group psychotherapy') session lasts one to two hours and involves a small group of people (usually between five and eight) coming together to discuss and explore their thoughts, emotions, behaviours, experiences, or relationships under the guidance of one or more group therapists (MacKenzie, 2002). Group therapy is similar to individual therapy (i.e., a single client working one on one with a therapist to explore and address their concerns) in many ways. For example, both treatment modalities: (a) focus on building a strong therapeutic relationship between therapists and clients, (b) direct therapists to use sessions to work on clients' goals, and (c) involve therapists providing various forms of support to clients (e.g., emotional support, informational support through psychoeducation). As stated above, the effectiveness of both modalities for achieving positive therapeutic outcomes are also equivalent. However, the *process* of achieving these outcomes is different (Holmes & Kivlighan, 2000). Unlike individual therapy, group therapy typically makes use of the group context – allowing clients the opportunity to interact with other clients, collaborate on group goals, share their perspectives, provide support, and hear other people's feedback, in addition to gaining perspectives and feedback from the therapist (Yalom & Leszcz, 2020).

Different types of group therapy have been developed, which differ in the way they are run and the content that is explored. As some examples: in a cognitive behavioural group, the therapist may explore the interrelationships of the thoughts, feelings, and behaviours of group members (e.g., Wolgensinger, 2015); in a compassion-focused group, the therapist may focus on the adaptive nature of emotions and encourage group members to practice self-compassion and foster inner safety (e.g., Griner et al., 2022); and in an interpersonal psychotherapy group, the therapist might focus on exploring how people can improve their interpersonal relationships and how relationships affect mental health (e.g., MacKenzie & Grabovac, 2001). Surprisingly, research has shown that neither the exact content explored, nor the type of the therapy matter as much as the quality of the relationship between clients and their therapist (Burlingame et al., 2018; Norcross & Wampold, 2018).

Considering the historical context in which group therapy was developed helps to further contextualise its suitability for solving the global mental health crisis. Health professionals inadvertently stumbled upon the benefits of group treatments in a bid to solve another global health crisis: the spread of "consumption" (i.e., tuberculosis). In 1905, a Boston physician ran educational classes for his tuberculosis patients in groups and found that the emotional support that attendees provided each other during and after classes led to better outcomes than when the education was delivered individually (Barlow et al., 2000; Litwick et al., 2022).

Group therapy continued to gain popularity during the Second World War, when the number of soldiers returning from war presenting with trauma-related mental health symptoms (so-called "battle fatigue" or "shell shock") overwhelmed the number of available health professionals (Jones, 2004). Group treatments were used to provide care to multiple people at once. However, beyond offering more efficiency, treating health professionals quickly noticed that veterans treated in groups were more likely to experience positive recovery outcomes than those treated individually (Grotjahn, 1947; Rutan, 2021; Scheidlinger, 1994). This led to the formation of two organisations for group therapists in 1942: the *Society for Group Psychotherapy and Psychodrama* (an interest group for social psychologists and clinicians) and the *American Group Psychotherapy Association* (primarily for clinicians; Scheidlinger, 2004). Since then, interest in and use of group therapy has continued to grow.

A problem with much of the early work on group therapy is that it lacked robust theoretical and empirical bases. A particularly disturbing example of this was the trend of nude psychotherapy groups in the 1960s and 1970s, which – based on very questionable theory and research – invited group attendees and facilitators to disrobe

during sessions to (supposedly) experience additional therapeutic benefits compared to participating in clothed therapy sessions (Nicholson, 2007). Facilitators of these groups also encouraged acts that would be considered highly unethical today, such as asking nude attendees to bathe together and stay awake for up to 36 hours. Group therapy research and practice have since moved away from nudity (and a similarly bare evidence base) and toward a requirement for more substantial empirical evidence. However, there are still some key issues in the literature. In particular, there has been limited focus on the role of **group therapy facilitators** (Burlingame & Jensen, 2017). The typical role of a group therapy facilitator is defined in Box 2.

Instead, most group therapy research focuses on factors such as differential effectiveness across types of group intervention (e.g., Cognitive Behavioural Therapy versus a mindfulness group; Arch et al., 2013) or the mode of delivery (e.g., online or face-to-face; King et al., 2009). As will be discussed in Chapter 1, one of the primary reasons for the lack of research on group facilitation is that clinicians are arguably reluctant to conceptualise themselves as “leaders”. This may lead clinicians and researchers alike to underestimate the impact of effective group facilitators on therapeutic outcomes.

Box 2: What is the role of a group facilitator?

Group therapists, often referred to as 'facilitators', are clinicians (e.g., psychologists, counsellors, social workers, etc.) who are tasked with leading therapy groups. Their role involves managing multiple priorities: guiding the overall therapeutic process and building a sense of connectedness within the group, delivering content to the group, and attending to the needs of individual group members (Corey, 2022). The specific content provided and leadership techniques or strategies used by the group therapist tend to depend on their theoretical background or the type of therapy group they are running. Indeed, instructions are often drawn from a facilitator manual or workbook associated with a particular treatment (e.g., Groups 4 Health manual; Haslam et al., 2025). However, surprisingly, no specific leadership technique or strategy has emerged as clearly superior for supporting client change (Forsyth, 2019).

Perhaps the most important task for the group therapist is to create and manage a positive therapeutic culture in which group members feel safe and supported to share their feelings and experiences (Rutan et al., 2019; Yalom & Leszcz, 2020). This involves keeping an eye on what is typically called "process". While definitions vary considerably, process generally refers to the dynamics of interaction between therapists and clients, with a particular focus on the development and progression of the relationship between therapists and clients, in addition to the relationships between clients (e.g., Beck & Lewis, 2000). The concept of process in group therapy relates closely the idea of the therapeutic relationship mentioned in Box 1. Process encompasses this alliance as well as the relationships between group members, and the overall group dynamics. Like the therapeutic relationship, process has been positioned as just as important, if not more important, as the specific content explored in groups (e.g., Yalom & Leszcz, 2020).

The work that does exist on group facilitators primarily provides general recommendations for how to effectively lead groups (most notably the seminal text of Yalom & Leszcz, 2020, which had its first edition published in 1970). However, this work

has not tended to provide theoretical or empirical reasons for *why* the strategies that are recommended will work. For example, a common recommendation is to outline group goals and rules at the start of therapy (e.g., Jacobs et al., 2012; Kaklauskas & Greene, 2019; Sobell & Sobell, 2011; Yalom & Leszcz, 2020). The empirical basis for this claim, however, is largely unclear and there is a lack of detail regarding the mechanisms through which setting goals and rules might lead to improved outcomes (i.e., there is a lack of both evidence and theory).

Aligned with this, several decades ago, Strong (1991) harshly branded counselling psychology as a field with an "aversion to theory-driven science". The lack of theory underpinning clinical and counselling psychology research and practice (both for group facilitation and more broadly) is problematic for several reasons. Regarding clinical practice, solid theory is necessary to adequately understand the underlying mechanisms of change in psychological interventions, allowing researchers and practitioners to design treatments and prepare practice guidelines that effectively target what is most important for driving change. As Corey et al. (2009) state, "Group leaders without any theory behind their interventions will probably find that their groups never reach a productive stage" (p.7). Regarding research, studies with a strong theoretical basis arguably allows for more theory-driven and meaningful hypotheses to be formulated, which can then be tested with more robust methodology (Burghardt & Bodansky, 2021). As the common saying (often attributed to Immanuel Kant) goes, "Practice without theory is blind".

Herein lies the gap that this thesis sought to fill. I aimed to examine group therapy facilitation using robust empirical methodology and, more importantly, from

the perspective of a well-established theory: the social identity approach to leadership (Haslam, Reicher, et al., 2020).

Theoretical Approach: The Social Identity Approach to Leadership

The social identity approach seeks to explain the process through which people come to view themselves as members of a group (i.e., as "we" and "us") rather than as individuals (i.e., as "I" and "me") and how this influences the way they act, think, and feel (Tajfel & Turner, 1979; Turner et al., 1987). Using this theoretical basis, the social identity approach to leadership (also known as "identity leadership theory") seeks to describe how leaders facilitate a shared sense of identity (i.e., of "who we are") within a group (Haslam, Reicher, et al., 2020). This shared sense of identity is proposed to influence the attitudes, thoughts, feelings, and behaviours of group members so that they align with the norms, values, and goals of the group. This approach to leadership is clearly relevant in a group therapy context, especially considering that a central goal of group therapy is to positively influence the attitudes, thoughts, feelings, and behaviours of group members to enhance their mental health.

Social identification is posited in identity leadership theory as the key mechanism through which identity leadership improves leadership outcomes. Social identification describes the process through which a person experiences their membership in a particular group as a meaningful part of who they are and the connection they feel with other group members (e.g., Tajfel & Turner, 1979). To build social identification, identity leadership theory directs leaders to engage in four key processes (Haslam, Reicher, et al., 2020). First, they must create a clear sense of what it means to be a member of that group (i.e., engage in identity entrepreneurship). Second, they must work to demonstrate that they represent important aspects of group

members' identity (i.e., be identity prototypical). Third, they must take actions that show they are a strong advocate for the group's best interests (i.e., engage in identity advancement). Finally, they must create structures that are meaningful to the group and allow group members to 'live out' meaningful aspects of their identity (i.e., engage in identity impresarioship). In this way, leadership is viewed as an active process contingent on building the group's connection to a shared identity and working to define what that identity entails.

Drawing from a social identity approach for this investigation was particularly beneficial because a substantial body of evidence suggests that increased social identification with meaningful groups (such as therapy groups) serves as a 'social cure', leading to improvements in both mental and physical health outcomes (refer to Haslam et al., 2018; Jetten et al., 2017 for comprehensive reviews and Steffens, LaRue, et al., 2021 for a meta-analysis). Notably, even in interventions not expressly targeted at fostering social identification, stronger social identification with a therapy group has been associated with better mental health outcomes (e.g., Cruwys, Stewart, et al., 2020; Meuret et al., 2016). This research on the social cure supports the idea that social identification is a key mechanism of change in group therapy contexts, and by extension, that facilitator engagement in identity leadership—which seeks to foster greater social identification among group members—may lead to enhanced treatment outcomes.

Something important to note, however, is that social identification with groups is not automatically beneficial for health. An emerging body of research demonstrates that groups can sometimes confer a 'social curse' rather than a 'social cure' (Kellezi & Reicher, 2012; Muldoon et al., 2019; Wakefield et al., 2019). The specifics of the social

curse are outside of the scope of this thesis; however, it is worth considering that leaders may play an important role in determining whether a group confers positive or negative effects on health outcomes. Indeed, the potential for negative outcomes to arise in therapy groups is also something carefully considered in clinical literature (e.g., Roback, 2000).

The Aim and Research Questions of this Thesis

The broad aim of this thesis was to apply identity leadership theory to group therapy facilitation. To achieve this aim, I examined three key research questions. Each is presented below with a brief rationale.

Research Question 1: What identity leadership behaviours are observed in group therapy?

A primary goal of this thesis was to outline practical strategies for improving group therapy facilitation. As Platow et al. (2015) stated, “Leadership…is about more than just ‘being’, it is about ‘doing’ as well” (p. 30). For the research and theoretical advancement in this thesis to make a real impact, it was critical to translate findings into practical recommendations for what group therapists should “do” if they want to be identity leaders. Indeed, Kant went on from saying “Practice without theory is blind" to state that “Theory without practice is empty”.

In addition, outlining tangible leadership strategies was intended to develop identity leadership theory more broadly. A common critique of identity leadership research has been the lack of understanding regarding the exact behaviours that constitute it (e.g., Stevens et al., 2021). Application in a group therapy setting provided an excellent opportunity to remedy this, because, unlike the sports, political, or organisational contexts in which identity leadership is usually studied, there tends to be

a good record of what occurred in group therapy. For example, it is common practice for clinicians to film group therapy sessions to improve their practice. Additionally, group therapists arguably already engage in identity leadership, given the similarities between important therapy principles (the need for respect and strong relationships) and the goals of identity leadership (an argument I make several times throughout this thesis). Examining group therapy behaviours therefore provided a good source of potential identity leadership behaviours that I also expected to be generalisable to other contexts (discussed in more detail in Chapter 3).

This research question was primarily explored in:

- Chapter 1 (where existing theory and research were used to outline possible identity leadership behaviours);
- Chapter 3 (where the first identity leadership behaviour framework was developed);
- And Chapters 5 and 6 (where the effect of a theorised identity leadership behaviour, therapists' disclosure of their own lived experience of mental ill-health to clients, was examined).

Research Question 2: What are some of the specific *benefits* of engaging in group therapy identity leadership?

Another goal of this project was to demonstrate the benefits that might follow from group therapists engaging in identity leadership. As observed in identity leadership research conducted in other contexts, such as sports and organisations (e.g., Fransen, McEwan, et al., 2020; Steffens, Haslam, Kerschreiter, et al., 2014; van Dick et al., 2018), it was expected that group therapy identity leadership would result in tangible benefits for facilitators and clients. Research highlighting the benefits of identity leadership in a

therapeutic context was also expected to yield generalisable findings that would prove useful for researchers and practitioners in other leadership contexts. For example, this could include managers seeking to understand how to reduce employee burnout (estimated to have affected 49% of health care employees during the COVID-19 pandemic; Prasad et al., 2021) or coaches who want to improve athlete wellbeing (e.g., see Stevens et al., 2024). Given that therapists tend to place respect and alliance at the heart of their work, I anticipated that leaders in other contexts might learn a lot from the way that identity leadership is implemented in therapeutic contexts.

This research question was explored in:

- Chapter 3 (where group therapist identity leadership was demonstrated to result in increased group member social identification with the therapy group)
- Chapter 4 (where identity leadership, specifically identity prototypicality, was demonstrated to improve body satisfaction and reduce dieting intentions in therapy groups for body acceptance)
- Chapter 5 (where therapists' identity prototypicality was demonstrated to lead to more positive perceptions of the therapist, higher ratings of the therapist's expertness, and a more positive expected prognosis for therapy).

Research Question 3: What are some of the *mechanisms* through which group therapy identity leadership might enhance group therapy effectiveness?

This thesis aimed to not only provide information about the behaviours that might constitute identity leadership (RQ1) or the benefits that identity leadership might have on therapy (RQ2), but also to explain how and why these potential benefits might arise (i.e., explore some of the potential mechanisms). In doing so, this thesis aimed to

address a key gap in the group therapy literature: a lot of evidence shows that group therapy works, but limited evidence explains *why* (i.e., mediators, process, or mechanisms of change; Aafjes-van Doorn & Horne, 2022; Greene et al., 2019). Where there is research on mechanisms of change, a lack of consistency exists in the conclusions that can be drawn, especially regarding mechanisms that transcend specific therapy types or diagnoses. Indeed, a summary of the past 30 years of group therapy research concluded that

> "an increasing number of studies have implemented rigorous study designs to test moderators of treatment efficacy in the various meta-analyses. However, no clear trends have emerged" (Rosendahl et al., 2021).

This research question was explored in:

- Chapter 1 (where some possible pathways through which identity leadership may confer benefits were outlined; e.g., by facilitating group members' greater attendance at, and engagement in, group therapy)
- Chapter 4 (where positive change in group norms over time was demonstrated to be a key mechanism through which identity leadership improves mental health)
- Chapter 6 (where the conditions under which therapists' lived experience disclosures—a theorised identity leadership behaviour—are maximally beneficial for clients was explored).

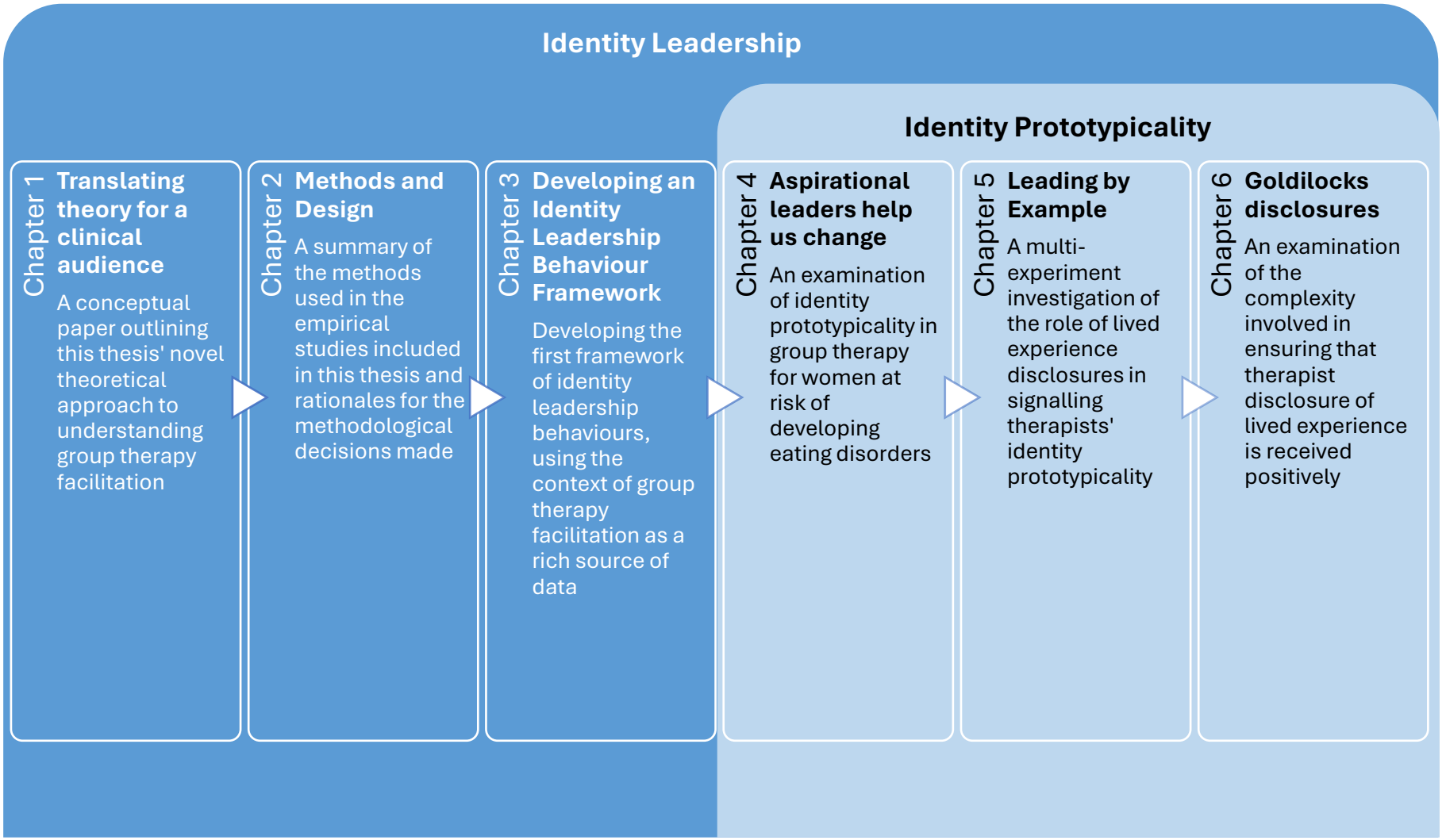
Chapter 3 arguably also addresses this research question by examining the effect of identity leadership behaviours on social identification. The well-established link between social identification and mental health—including social identification with therapy groups (Cruwys, Haslam, Dingle, Jetten, et al., 2014; Haslam et al., 2016)

and therapists (Cruwys et al., 2023; Lee et al., 2023, 2024) —can be used to hypothesise that identity leadership would improve mental health via its effect on group members' social identification.

Thesis Structure

Not including this introductory chapter, this thesis is comprised of seven chapters (see Figure 0.1 for a summary). Chapters 1, 3, 4, 5, and 6 are presented as a series of stand-alone academic papers, and Chapter 2 provides an overview of the methods and design of this thesis. Each stand-alone chapter contains a brief foreword describing the study's relevance to the thesis and has been prepared for publication; four are published, and one is in preparation. As such, there is some repetition within the introduction sections of these chapters (i.e., to outline the theoretical approach used and provide background for why more research into group therapy leadership is needed). The main body of the thesis ends with Chapter 7, which presents a general discussion regarding the findings of all studies. I will briefly discuss the purpose of each of these chapters in turn.

Figure 0.1 *Summary of the chapters contained in this thesis (excluding general discussion, which summarises all).*



Chapter Overview

Chapter 1. This chapter presents a published conceptual paper that introduces and outlines the social identity approach to understanding group therapy facilitation. The paper aims to provide a foundation for both clinicians and researchers to engage with this new approach, highlighting the potential benefits of group therapists adopting identity leadership practices. Additionally, it offers preliminary suggestions for clinical application and sets the agenda for future research in this field. The target audience for this paper is clinicians, and as such, it is published in a clinical psychology journal, *Clinical Psychology: Science and Practice*.

Chapter 2. This chapter provides a broad overview of the diverse methodology employed throughout the thesis. It includes brief rationales for each of the methodological and design decisions made, as well as information about my positionality as a researcher. Additionally, this chapter serves as a transition point, marking the shift from the theory-developing section of the thesis to the section detailing the empirical tests of the newly proposed approach.

Chapter 3. Continuing the broad examination of identity leadership in group therapy, this chapter presents an empirical paper that aims to identify specific behaviours constituting identity leadership. The investigation takes place in the context of a Groups 4 Health clinical trial (a social identity-based group therapy program; Haslam et al., 2025) for people with elevated social anxiety. In exploring and developing the first framework of tangible identity leadership behaviours, the chapter reports results from diverse data sources: quantitative surveys from five time points, qualitative interviews, and 45 hours of coded footage from group therapy sessions. The target audience for this chapter is social psychologists, particularly leadership researchers

interested in developments in identity leadership research. Consequently, this paper is in preparation for submission to a social psychology journal.

Chapter 4. This chapter marks a shift in research focus, examining *identity prototypicality* in more detail (see Chapter 2 for the rationale underpinning this research focus). It details a study aimed at determining whether the aspirational or average conceptualisation of prototypicality is more relevant and impactful in group therapy contexts. Within the context of body acceptance therapy groups for young women at risk of developing an eating disorder, this study examines how leader different prototypicality perceptions affect group norms around dieting, and consequently, dieting intentions and body satisfaction. The target audience for this paper is clinicians, and it has been published in the *British Journal of Clinical Psychology*.

Chapter 5. Building on the findings from Chapter 4, which established the importance of aspirational prototypicality for therapeutic outcomes, this chapter presents a multi-experiment paper exploring whether therapy leaders can demonstrate their identity prototypicality to clients through disclosures of their own lived experience with mental ill-health. The two experimental studies examine the impact of different therapist self-disclosures on aspirational and average prototypicality. They also examine how the two types of prototypicality affect several outcomes: (a) participants' positive perceptions of the therapist, (b) ratings of the therapist's expertness, and (c) expected prognosis for group therapy led by that therapist. Targeting both a social and a clinical audience, this chapter is published in the *British Journal of Psychology*.

Chapter 6. Building on the findings from Chapter 5, which indicated positive impacts of therapists' lived experience disclosures via aspirational prototypicality, this chapter explores the nuance and complexity in how clients and other therapists

perceive such disclosures. It presents a qualitative study examining perceptions and experiences of different kinds of therapist lived experience disclosures. The study asks clients and therapists to respond to therapist self-disclosure vignettes and recount their own experiences with therapist self-disclosure of lived experience during therapy. These are analysed using reflexive thematic analysis. This study takes a data-driven approach that allows for a broader consideration of the effects of lived experience disclosure beyond the bounds of the theoretical approach. This study is aimed at a clinical audience and is published in *Psychological Services*.

Chapter 7. This chapter presents a comprehensive discussion of the findings from all empirical studies conducted in this thesis. It synthesises the results across the various studies, providing an overarching perspective on the research program. The chapter also critically evaluates the strengths and limitations of the research conducted. Importantly, it sets the agenda for future research in this area, outlining key directions for continued investigation into identity leadership in group therapy and other health care contexts.

Chapter 1. Translating Theory for a Clinical Audience: A Social Identity Approach to Facilitating Therapy Groups

Paper Rationale and Introduction

My PhD research intersects two fields: social psychology (leadership research) and clinical psychology (group therapy research). As mentioned in the preceding chapter, a key focus of my PhD project was ensuring that theoretical advances were made in a practical direction, and directly translated into clinical recommendations for group therapists seeking to improve their leadership. To introduce this framework to clinicians and provide initial recommendations for practice, I decided to write a conceptual paper. This paper was written with a clinical audience in mind and intends to outline some of the potential benefits, behaviours, and mechanisms of group therapy identity leadership.

Publication Status

This paper was published in August 2023 in *Clinical Psychology: Science and Practice*. It is presented below as published with minor formatting changes. The citation is as follows:

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Author Contributions

I conceptualised the paper and wrote the original draft of the manuscript. All other authors (Tegan Cruwys, Mark Stevens, and Michael J. Platow) assisted with editing and providing feedback on the manuscript.

Abstract

Group therapy offers both an effective and cost-effective means to support mental health. Key to the benefits that clients derive from group therapy are its facilitators. However, minimal research has examined how their effectiveness can be maximised. To address this limitation, we propose that group facilitators should be conceptualised as *leaders*, and that identity leadership theory provides a valuable framework for efforts to understand and increase their effectiveness. We introduce and review identity leadership theory and its evidence base, then propose three key pathways through which identity leadership can enable therapy facilitators to support improved treatment outcomes. Specifically, we argue that by engaging in identity leadership, facilitators can: (a) improve clients' attendance at therapy sessions, (b) create new, health-promoting norms and identities, and (c) foster stronger therapeutic relationships with and among group members.

Key words

Therapeutic alliance; clinician effectiveness; identity leadership; group cohesion; group therapy.

Public Health Significance Statement

Group therapy facilitation is an understudied area of research, which means that the evidence base for how clinicians can lead groups most effectively is limited. We propose that identity leadership theory can help to address this by providing a

framework for research that yields practical guidance for group therapy facilitators. Drawing on empirical evidence from a range of contexts, we describe what identity leadership might look like in a group therapy context, and how it can help facilitators to promote better attendance, more positive group norms and identities, and stronger therapeutic relationships.

1.1. Introduction

Individual therapy is currently the treatment with the strongest evidence for addressing mental health concerns (American Psychological Association, 2013). However, cost and availability remain major barriers to access (Harvey & Gumport, 2015). Government support for mental health is also insufficient: the global median of government health expenditure assigned to mental health care is <2% of the total health expenditure (World Health Organisation, 2021). It is therefore imperative to identify interventions for mental health that are economical, accessible, and efficient.

Therapy delivered in *group* formats represents one possible solution because it allows multiple people to be treated simultaneously by the same health professional. Group therapy has been shown to be effective (and usually as effective as individual therapy) for a range of the most common mental health conditions, including anxiety disorders (Wolgensinger, 2015), eating disorders (Grenon et al., 2017), depression (Cuijpers et al., 2008), social anxiety (Colhoun et al., 2021), and substance use disorders (Lo Coco et al., 2019). Given the potential for group therapy to support mental health, understanding how to maximise its effectiveness is an important priority for research.

One particularly fruitful target for efforts to make group therapy more effective may be group therapy *facilitators,* who can and do have a direct impact on clients' therapy outcomes. Unfortunately, however, understanding of how facilitators can maximise their positive influence is limited. Indeed, in a review of 25 years of group therapy research, Burlingame and Jensen (2017) concluded that facilitators are "one of the least studied of all structural elements" (p. S197). These researchers' explanation for the lack of group facilitator research was that therapists' effectiveness has tended to be

considered as inextricably linked to the techniques they use (e.g., cognitive behavioural therapy), rather than being tied to general (or 'common') factors relevant across multiple therapy types. However, the notion that group therapists merely 'administer' treatments is not consistent with evidence on therapy process and common factors. Meta-analytic evidence has (controversially) found that the quality of the relationship between clients and their therapists has a greater bearing on treatment outcomes than the specific treatment technique they use (see Norcross & Wampold, 2018). It is therefore important to investigate predictors of facilitator effectiveness that extend beyond the treatment type they use.

We propose that another potential reason for the stalemate in research on group therapy facilitators is that they are rarely conceptualised as *leaders*. As a result, researchers have largely failed to draw on the insights provided by leadership theories and research, and clinicians have perhaps even been discouraged from conceptualising themselves in these terms. Clinicians may prefer the term 'group facilitator' or 'group therapist' to 'group leader', perhaps because these former terms imply a supportive process of helping. In contrast, a 'leader' is usually defined as a person seeking to exert social influence (e.g., Northouse, 2021). Power imbalances between clients and therapists are typically viewed as problematic in clinical settings (see Proctor, 2017 and Wilson, 2021 for detailed discussions), which may explain some of the aversion to terms seen to imply dominance or coercion. However, we argue that what clinicians seek to achieve in therapy – helping individuals change their thoughts, feelings, and behaviours in ways that improve their mental health – is indeed a form of social influence (see also Platow et al., 2020). In fact, leadership research is approaching a consensus that good

leadership rarely involves dominance at all but, rather, is supportive and reflects the needs of followers (e.g., Dambe & Moorad, 2009).

In line with this, we propose that leadership theories might offer valuable insights for maximising the effectiveness of group therapy facilitators. We propose that identity leadership theory (Haslam, Reicher, et al., 2020; Hogg, 2001) has particular potential in this regard, because it encourages a process of advocating for and representing group members' interests, rather than imposing top-down ideas on them. This bottom-up, supportive, and group-oriented approach to leadership is compatible with the group therapy context and values held by clinicians about their roles. For example, it emphasises power *through* (rather than over) the group (Turner, 2005).

Identity leadership theory also suggests that a key determinant of a leader's ability to influence people is whether the leader can foster a strong sense of connectedness (i.e., social identification) among members of the group they seek to lead (see Section 1.3 below for more details). This is particularly relevant in a group therapy context because extensive research has already established a link between social identification with meaningful groups (including therapy groups) and an array of positive mental health outcomes (see Haslam et al., 2018; Jetten et al., 2017; Steffens, LaRue, et al., 2021 for reviews). For example, greater social identification has been associated with reduced depression symptoms (Cruwys, Haslam, Dingle, Jetten, et al., 2014; Cruwys, South, et al., 2015), reduced substance misuse (Dingle et al., 2015; Frings & Albery, 2017), and reduced post-traumatic stress symptoms (Muldoon & Downes, 2007). A further benefit of applying an identity leadership theory lens to understanding group therapy contexts is, therefore, that it may help to explain why effective group facilitation yields improved treatment outcomes.

Below, we provide a brief synthesis of some existing approaches to understanding group therapists' effectiveness. We then introduce identity leadership theory and describe both the applicability of this framework to group therapy and the pathways through which identity leadership might give rise to positive outcomes for group members. Specifically, drawing on empirical evidence, we argue that identity leaders may be able to: (a) facilitate clients' greater attendance at, and engagement in, therapy, (b) create new, mental health promoting norms and social identities for clients, and (c) build stronger therapeutic relationships with clients. Throughout, we also signpost ways in which future research could inform effective group therapy facilitation.

1.2. Current Approaches to Understanding Group Therapy Facilitation

Recent research and theory concerning how facilitators can effectively lead therapy groups has tended to fall into one of two categories: (a) examining how facilitators can enhance group cohesion, and (b) examining how facilitators can best manage cultural diversity in the group. We briefly summarise these areas to conclude that, although this literature has many strengths, new research with a strong empirical and theoretical basis remains needed.

1.2.1. Group cohesion. Group cohesion is arguably the most well-studied construct in group therapy settings. Indeed, Burlingame et al. (2018) labelled it the "most popular of the relationship constructs in the group therapy literature" (p. 384). However, despite being widely studied, there has been considerable variation in the way the term itself has been operationalised. Descriptions range from broad notions of a general force that holds groups together (Dion, 2000) to more specific feelings of connectedness and emotional safety in therapy groups (Burlingame & Jensen, 2017).

Despite this diversity in conceptual definitions and operationalisations, robust evidence supports the link between cohesion and positive treatment outcomes (e.g., symptom reduction and goal attainment). A recent meta-analysis found that, overall, this relationship is moderate to large (*d* = .56; Burlingame et al., 2018). Importantly, this meta-analysis also examined the role that facilitators played in fostering group cohesion and found that when facilitators used strategies to build cohesion within the group, the relationship between group cohesion and treatment outcomes was stronger. For example, Lecomte et al. (2015) found that cohesion scores positively predicted symptom reduction in people attending a cognitive-behavioural therapy group for early psychosis. In these groups, facilitators were instructed to spend the first month developing cohesion, fostering trust, and building feelings of psychological safety in the group (which is also an emerging area of identity leadership research, e.g., Edmondson, 1999; Fransen, McEwan, et al., 2020 for a detailed description of psychological safety). These findings suggest that facilitators may play a key role in developing group cohesion and ensuring its positive effect on group member outcomes.

Some prior research has also aimed to provide practical guidance for clinicians on how to build group cohesion. For example, Burlingame et al. (2001) outlined several techniques that facilitators could use to foster group cohesion, including: setting treatment expectations, defining group rules and norms, designating people's roles in the group, providing interpersonal feedback, facilitating emotional expression, and exploring the shared meaning derived from emotional expression. Unfortunately, empirical research has not yet evaluated these specific techniques, so it remains unclear to what extent they are effective in fostering group cohesion.

Despite the potential positive outcomes of cohesion, it should be noted that some researchers have argued that group cohesion may not be universally positive in group therapy contexts. In particular, Hornsey et al. (2009) argued that, in cohesive groups, group members might feel reluctant to challenge each other or express unhappiness with group situations. This may be problematic in group therapy settings, where it is important for group members to feel safe and comfortable to express their thoughts and feelings.

In sum, although there are clear strengths in the cohesion literature, including a well-established link between cohesion and group therapy outcomes, more research is needed. This new research should explore which facilitator behaviours increase cohesion and how facilitators can ensure that cohesion has a positive effect.

1.2.2. Diversity considerations. Another body of research has explored how group therapy facilitators can best address diversity in therapy groups (i.e., consider the representation or composition of various social identity groups in the therapy group members). This arose from calls over the last few decades for group facilitators (and clinicians more generally) to adopt more inclusive practices (e.g., see Sue et al., 2009). Although diversity can refer to factors such as age, gender, sexuality, and more, most of this literature has explored *cultural* diversity within therapy groups, and how this may affect therapeutic processes (e.g., Burnes & Ross, 2010; D'Andrea, 2014; Debiak, 2007; Macnair-Semands, 2007; Okech et al., 2015; Sue & Sue, 2013; Taha et al., 2008). Some of this research explores facilitators' own cultural backgrounds, in line with the argument that group therapists bring their personal and cultural experiences to their role, and that this can affect their interactions with clients (Corey et al., 2015; Goh, 2005; Yalom & Leszcz, 2020).

Research about cultural considerations in therapy has tended to have an applied focus and not use experimental or quantitative methods. Instead, there has been a heavy reliance on qualitative (case study or interview) methods. One possible reason for this is the perspective of some researchers that quantitative methods "are not always the most respectful, effective, valid, or reliable ways to conduct multicultural counselling research" (D'Andrea & Heckman, 2008, p. 361). A benefit of research using qualitative methods is that research has captured varied experiences of group facilitators and attendees from a range of different cultural backgrounds.

A recent example is Terrazas-Carrillo et al.'s (2021) exploration of the experiences of Mexican American women participating in group therapy leadership training at university. The researchers found several common themes in the women's accounts, including (a) struggles to find a balance between being assertive in a leadership role and conflicting cultural values related to self-sacrifice, and (b) discomfort for young therapists when facilitating groups of older people due to the tendency in Latin culture to defer to elders. This research may help validate trainee therapists who feel that their cultural background influences their experiences facilitating groups, or even, at times, conflicts with Western assumptions embedded in training programs themselves.

This leadership diversity research has also generated several practical recommendations for clinical practice. Unfortunately, similar to research in the group cohesion domain, these recommendations have rarely been derived from empirical evidence or evaluated in terms of their effectiveness. For example, Okech et al. (2016) provided several guidelines for resolving group intercultural conflicts, including: (a) setting up group norms that emphasise cultural sensitivity, (b) ensuring that addressing cultural conflicts is a stated goal of the group, and (c) not avoiding topics such as race

and ethnicity during discussions. Similarly, the Multicultural and Social Justice Competence Principles for group therapists (Singh et al., 2012) provide useful suggestions, such as using storytelling or other more diverse methods of counselling, partnering with target populations to decide the time and setting of therapy, and actively endorsing multilingualism and sign language. However, these recommendations were based on inferences derived from a review of related literature, rather than targeted empirical investigations.

Cultural competence training programs have also become common for group therapy facilitators. However, they too have tended to lack empirical evidence to support their efficacy and have been implemented inconsistently (e.g., Bemak & Chung, 2004; Pernell-Arnold et al., 2012). As a recent example, Lefforge et al.'s (2020) training program aims to address microaggressions in group therapy. The program intuitively appears relevant for group therapists (e.g., they receive education on microaggressions and engage in role plays to experiment with strategies that could be used to address them). However, research has yet to assess whether the training leads to improved outcomes.

Overall, the diversity literature has made a valuable contribution to our understanding of effective group therapy facilitation. Key strengths include the focus on the real-world experiences of facilitators and attempts to derive practical strategies to help therapists. Nevertheless, as with the cohesion literature, research is needed to more rigorously test the strategies and guidance that have been proposed. More broadly, research to date has tended to lack a strong underpinning theoretical framework.

We contend that one framework with particular promise in the group therapy domain is the identity leadership approach (Haslam, Reicher, et al., 2020). In the

sections that follow, we describe how this theoretical framework might help to guide research and provide new insights. To this end, we draw on evidence from a diverse array of domains where the identity leadership approach is already influential for understanding leaders' effectiveness with a growing body of empirical support (e.g., organisations, politics, and sport).

1.3. Introducing a Social Identity Approach to Group Therapy Leadership

Comprising social identity theory (Tajfel & Turner, 1979) and self-categorisation theory (Turner et al., 1987), the social identity approach focuses on how people's psychology is structured by their group memberships. More specifically, according to this approach, people can, and do, define themselves both in terms of their personal identity (i.e., as 'I' and 'me') and in terms of their various social identities (e.g., as a member of a choir, sports team, or therapy group; Turner, 1982). Social identification refers to the degree to which people subjectively define themselves as a member of a group, come to view that group membership as an important part of who they are, and feel a strong affinity with other group members (e.g., Postmes et al., 2013). Social identities affect the way people think, feel, and behave, such that these become informed by the collective interests, goals, and aspirations of the psychological ingroup (i.e., they act in accordance with what is "normal" for the group; Turner, 1985). In this way, defining oneself in terms of a social identity that is shared with others (e.g., as 'we' and 'us' members of this therapy group) lays the foundation for a wide range of group processes to occur, including social influence and leadership (Turner, 1991) as well as other desirable processes such as empathy and helping (Cialdini et al., 1997; Levine et al., 2005).

The social identity approach to leadership (i.e., identity leadership) proposes that leadership is a process of social influence (Haslam, Reicher, et al., 2020; Hogg, 2001). However, contrary to traditional perspectives—which tend to emphasise the importance of leaders possessing specific traits or behaviours (e.g., see Bass & Riggio, 2006; Gardner et al., 2011; Liden et al., 2008)—the social identity approach asserts that any leader's capacity to exert influence (and lay the foundation for positive outcomes more generally), rests on the extent to which the leader helps group members to feel connected as a group (i.e., build a shared sense of social identity). In other words, effective leadership is seen as a process of "social identity management" (e.g., see (Steffens, Haslam, Reicher, et al., 2014). One reason that building this shared sense of identity is proposed to facilitate leaders' greater influence is because people often look to group members who best represent "us" (i.e., those who are *prototypical*) as a referent for how they should think, feel, and behave (Turner, 1991). This means that would-be leaders who can demonstrate that they are "one of us" are able to influence other group members' understanding of who "we" are and how "we" behave in a way that those outside "our group" could not. In addition, people trust prototypical leaders to have their group's best interests at heart and will, therefore, be more influenced by such a leader than by one that does not appear to represent or have a vested interest in the group (Hogg & van Knippenberg, 2003).

Along these lines, the identity leadership approach proposes that there are four key principles leaders should seek to follow to maximise their influence and effectiveness (i.e., four key processes of social identity management). Specifically, leaders should strive to (a) create a strong sense of shared identity among group members (i.e., be an effective *identity entrepreneur*), (b) represent the shared identity of

the group (i.e., demonstrate their *identity prototypicality*, see above), (c) advocate for the needs and interests of the group *(identity advancement*), and (d) create structures, rituals, and activities that allow group members to live out the group's shared meaning and identity (*identity impresarioship*). For a visual representation of the process of influence according to identity leadership theory, see Figure 1.1.

Figure 1.1 *The process of influence in identity leadership*

Note. This figure depicts the process through which a group therapist can effectively lead (i.e., influence group members). First, they need to: (a) create a connected group that has a clear sense of "who we are" (identity entrepreneurship), (b) represent the group's unique identity (identity prototypicality), (c) advocate for the unique needs of the group (identity advancement), and (d) develop activities that are relevant to the group and that help it achieve its goals (identity impresarioship). Through these processes, leaders can foster a shared sense of identity within the group, or a sense of "us" as a therapy group. However, this emergent sense of social identity is *dynamic,* and so, as a member of the group, the leader is also influenced by the group. Finally, effective influence also requires that individual members of the therapy group connect with this shared sense of identity through social identification. Together, these processes allow a leader to effectively influence group members, in a way that flows *through* the group.

These terms (e.g., entrepreneurship) reflect the theory's origin in organisational contexts and might intuitively seem inconsistent with the values therapists hold about their roles. Indeed, as alluded to above, such terminology is perhaps one reason why the uptake of leadership theories has been minimal in clinical contexts to date. The word "entrepreneur", for example, might more readily call to mind the image of a businessperson than a clinician. However, identity entrepreneurship is similar to existing concepts in the group therapy facilitation literature. For example, Chen and Rybak (2004) state that effective facilitators must lead the group through a "norming" phase early in therapy where they establish the desired norms, culture, and rules of the group, and aim to foster a sense of "we-ness".

It is also important to note that identity leadership theory inherently acknowledges that the significance and relevance of specific principles (e.g., identity entrepreneurship) will differ across groups, such that it will depend on the specific identity and context of the group. For this reason, it is also possible that some principles will be more (or less) applicable depending on the type of group, and even the type of therapy group. For example, in a substance use recovery group, it might be particularly important for leaders to show that they understand the processes of recovery and act as model group members (i.e., demonstrate identity prototypicality). However, in a therapy group for managing stress, it may be more important for leaders to develop group activities (e.g., relaxation exercises) that are relevant to the goals of the group (i.e., demonstrate identity impresarioship).

To further illustrate how these principles might apply to group therapy, we use a hypothetical example of a therapy group led by Emily. From an identity leadership perspective, Emily might be a more effective group therapy facilitator if she (a) seeks to

create a cohesive group where everyone feels that they are included, (b) embodies the kind of person group members are striving to be (e.g., remains calm in the face of unexpected stressors), (c) advocates for group members in relevant ways – for example by appealing to a health insurer to cover group members' mental health expenses, and (d) organises specific, group-relevant activities for attendees to do before, during, and after therapy (e.g., coffee and snacks before therapy, relevant psychoeducation activities during therapy, and homework after therapy). Further examples of specific strategies that group therapy facilitators could use to demonstrate their identity leadership are provided in Table 1.1 (for a similar list in individual therapy sessions, see Lee et al., 2021). We refer to many of these in more detail in the following sections, noting that empirical studies to identify and validate a broader range of strategies are important avenues for future research.

Table 1.1 *Example strategies that identity leaders could use in group therapy.*

Identity leadership principle	Definition	Example strategies
Identity entrepreneurship	Creates a strong sense of shared identity among group members	• Establish group norms (e.g., through goals and rules) at the start of therapy that support the purpose of the group • Use language that creates a sense of shared identity (e.g., refer to group as "we" and "us") • Bring attention to group member similarities, including shared experiences and goals
Identity prototypicality	Represents the unique identity of the group	• Share personal stories of recovery • Disclose personal efforts made to work on group goals between sessions (e.g., during check in at start of therapy, briefly share a group-relevant strategy that was used that week) • Act as a role model for client therapy goals (e.g., use effective coping strategies in the face of unexpected challenges).
Identity advancement	Advocates for the needs and interests of the group	• Address difficult group member behaviours during sessions and frame in terms of group identity (e.g., explain that we shouldn't interrupt each other because we agreed as a group to listen respectfully to each other) • Advocate for resources needed for group members to achieve goals (e.g., better parking for people with disabilities) • Create an inclusive group environment
Identity impresarioship	Creates structures, rituals, and activities that allow group members to live out the group's shared meaning and identity	• Develop and promote group relevant activities and rituals (e.g., providing tea before session) • Create opportunities for people to provide social support to other group members • Set relevant homework activities that allow group members to 'live out' their identity in the outside world

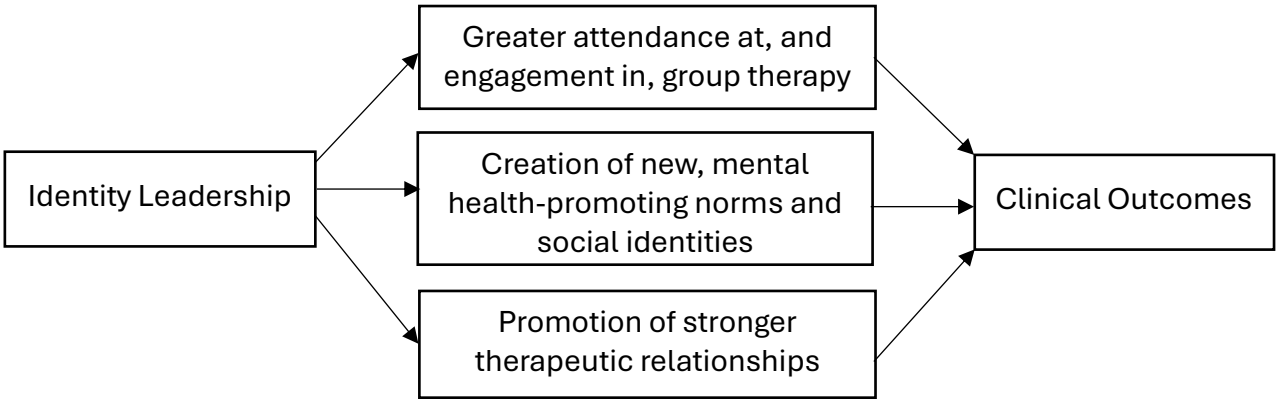
Over the last decade in particular, a considerable body of evidence across various contexts has highlighted a wide range of benefits associated with identity leadership, including greater group member performance (e.g., Fladerer et al., 2021), engagement (e.g., Stevens et al., 2022b), and endorsement of leaders (e.g., Haslam, 2004; Steffens, Munt, et al., 2021; Steffens & Haslam, 2013; Stevens et al., 2021). Notably, some studies have also indicated that identity leadership lays the foundation for group members to experience mental health benefits. For example, in a large international study, van Dick et al. (2018) found that each of the four identity leadership facets were independently associated with positive outcomes in organisational contexts (better relationships between employees and their team, greater trust in the leader, and greater job satisfaction) and that identity advancement in particular was linked to reduced burnout. Other studies have also demonstrated links between identity entrepreneurship and reduced burnout at work (Steffens et al., 2018; Steffens, Haslam, Kerschreiter, et al., 2014).

1.4. Proposed Pathways through which Identity Leadership can Facilitate Positive Outcomes in Group Therapy

Although identity leadership theory has received substantial empirical support across several domains (e.g., sports, organisations, politics), it has only recently been applied to a group therapy context (see Robertson et al., 2022 [Chapter 4], described below). Drawing on evidence from research in diverse contexts, in the following sections we propose three pathways through which identity leadership might give rise to positive outcomes for group therapy clients (see Figure 1.2 for an overview). We do not propose that these pathways are exhaustive. Indeed, research (albeit outside the group therapy context) has found evidence for a range of mechanisms through which identity

leadership can facilitate positive outcomes, including greater self-efficacy (Miller et al., 2020), greater informational resources (Mavor et al., 2017), and increased social support (Haslam et al., 2012; Jetten et al., 2009; Miller et al., 2020). However, the three pathways that we focus on represent areas in which we believe identity leadership could make a particularly substantial contribution in the group therapy context (e.g., because inconsistent attendance at group therapy is an issue that currently has limited effective solutions).

Figure 1.2 *Pathways through which identity leadership might improve clinical outcomes*



1.4.1. Identity leaders can facilitate group members' greater attendance at, and engagement in, group therapy. A prevailing issue in group therapy, and a major barrier to its effectiveness, is client dropout. A recent systematic review estimated the average dropout rate in group therapy at 16% (Lewis et al., 2020), while some studies have reported rates as high as 45% (Jørgensen et al., 2021). Considerable efforts have been made to understand the reasons for these high dropout rates and to help address them, with these efforts often focusing on clinical populations for whom dropout rates are particularly high—for example, veterans with post-traumatic stress disorder (Berke et al., 2019) and adolescents with features of borderline personality disorder (Jørgensen

et al., 2021). Several predictors of dropout have been established, including younger age, having a history of traumatic brain injury, type of therapy (e.g., more dropout for trauma-focused therapy), and lower reflective capacity (Berke et al., 2019; Jørgensen et al., 2021). In response, researchers have trialled various strategies to reduce dropout with varying success, such as adjunct email support (Delsignore et al., 2016) and motivational interviewing (Malins et al., 2020). However, dropout and inconsistent attendance remain persistent issues, and major barriers to the wider implementation of group therapy.

Identity leadership may represent a novel solution to increasing and sustaining clients' attendance at group therapy sessions. A central way that identity leadership may achieve this outcome relates to group norms. Specifically, through identity leadership, therapy facilitators may be able to instil positive group norms (i.e., whereby consistently attending group sessions becomes seen as an embedded, typical behaviour; Paquin et al., 2021) and facilitate group members' adherence to these norms by building their social identification as a group member.

This prediction is supported by a robust body of research. Recent research in physical activity contexts—where attrition and dropout are similarly pervasive issues (e.g., see Rand et al., 2020)—has provided promising evidence that facilitators who engage in identity leadership facilitate group members' more frequent attendance at group sessions (e.g., Steffens et al., 2019; Stevens et al., 2018, 2020, 2022b). This research has built on a key proposition of the social identity approach: to the extent that people define themselves in terms of a particular social identity, they become motivated to seek opportunities to 'live out' that identity and align their personal behaviours with the normative behaviours of representative group members (Turner et

al., 1987; see also Cruwys, Platow, et al., 2016). In doing so, the behaviour in question becomes a valued reflection of one's identity, rather than a chore to be adhered to. In face-to-face physical activity groups, research has found that greater social identification is associated with, and predicts, greater attendance at group sessions (e.g., Stevens, Rees, & Polman, 2019; Stevens et al., 2022a; Strachan et al., 2012). Building on this, identity leadership research has consistently found evidence for a mediation pathway such that, to the extent that sports team and exercise group leaders engage in identity leadership, group members tend to identify more strongly as members of that group and, in turn, participate in group sessions more often (Steffens et al., 2019; Stevens et al., 2018, 2020).

Also relevant is evidence from both sporting and organisational contexts that, to the extent that leaders engage in identity leadership, group members' desire to leave the group is lower. This has been demonstrated in cross-sectional studies of recreational soccer players (Krug et al., 2021) and American workers (Steffens, Haslam, Kerschreiter, et al., 2014). In a rigorous longitudinal study, workgroup leaders' perceived identity entrepreneurship predicted reduced turnover intentions in their employees 10 months later (Steffens et al., 2018). Notably, identity entrepreneurship also predicted workers' greater work engagement – that is, workers were more energetic at, enthusiastic about, and immersed in their work to the extent that they perceived that their leaders created a strong sense of shared identity among the workers. Applied to the group therapy setting, these findings suggest that clients may be more likely to continue to attend group therapy (and thus continue to receive its benefits) if their facilitators are seen to engage in identity leadership, particularly identity entrepreneurship.

Evidence from these contexts also suggests that leaders' engagement in identity leadership has positive implications for group members' engagement and effort *during* group sessions. For example, in a sample of 395 exercise class attendees, Stevens et al. (2022b) found that, to the extent that class members perceived their leader to engage in identity entrepreneurship, they reported greater in-class effort, higher enjoyment, and more positive affective experiences (see also Steffens et al., 2019). There is also some causal evidence for this effect. Following an experimental manipulation of identity entrepreneurship, Stevens, Rees, Steffens, et al. (2019) found some evidence that participants' effort during a physically demanding cycling task increased. Applied to a group therapy setting, this may suggest that clients in groups led by strong identity leaders may not only attend more regularly, but also be more engaged and participate more fully in discussions or activities. This could have important implications for the effectiveness of therapy.

Further evidence suggests that behaviours congruent with other specific dimensions of identity leadership have positive outcomes in a group therapy context. For example, there is already some evidence from the group therapy literature that creating group-relevant activities—a hallmark of identity impresarioship—might promote better attendance. Specifically, Baumgartner and Williams (2014) found that when group members shared lunch together before group therapy sessions this became a meaningful 'ritual' that supported their session attendance: group members stated that there was an expectation that "if you come for food, [you] stay for group" (p. 6). This is the kind of activity that a group therapy facilitator could readily organise for group members but has rarely been seen as an important feature of group facilitation.

We have reviewed promising evidence that effective identity leaders can play a supportive role in encouraging group members to engage more frequently and more wholeheartedly in group activities. Most of this research has been conducted outside the group therapy context which is, of course, very different from organisational or sporting contexts. Empirical research is therefore needed to examine whether the findings that have been consistently observed elsewhere generalise to group therapy settings.

There are many forms such research could take. A simple starting point—that would mirror the approach used in other domains (e.g., organisational, sport, and exercise contexts)—would be to measure group therapy members' perceptions of their facilitators' identity leadership and assess relationships between these perceptions and their session attendance, engagement, and treatment outcomes (e.g., using the validated Identity Leadership Inventory; Steffens, Haslam, Reicher, et al., 2014). Another alternative, which would provide insights into the causal effects of identity leadership in this context, would be to attempt to develop the identity leadership skills of group therapy facilitators and examine the effect of this on the same outcomes. Along these lines, empirical evidence has already demonstrated that identity leadership training programs—specifically, the 5R Program (Haslam et al., 2017)—can have several benefits. For example, tests of the 5R program in sport, exercise, and organisational contexts have demonstrated benefits including increases in group members' team identification, number of practice hours, intrinsic motivation, and commitment to team goals (Fransen et al., 2022; Fransen, Haslam, et al., 2020; Haslam et al., 2017; Mertens et al., 2020; Slater & Barker, 2019). Of particular interest is the finding, in two of these studies, that group members spent more hours doing group-relevant tasks (i.e.,

practicing sports) when their leaders were trained in identity leadership (see Mertens et al., 2020; Slater & Barker, 2019). It is possible that, in a group therapy context, this finding could translate to improvements in members' engagement and participation in therapy sessions and homework tasks.

1.4.2. Identity leaders can create and represent new, mental health-promoting norms and social identities. A growing body of research suggests that *which* social identities people internalise can have a substantial impact on their therapy experience and outcomes. Specifically, there is evidence from several studies that positive therapeutic outcomes flow when individuals internalise new identities that emphasise recovery (i.e., being 'in recovery' from a mental health condition), rather than maintaining previous mental illness identities, or identities defined by unhealthy behaviours (Best et al., 2011, 2016; Cruwys, Stewart, et al., 2020; Cruwys & Gunaseelan, 2016; Dingle et al., 2015; McNamara & Parsons, 2016). For example, in a sample of people in a residential group therapy program for substance use, Dingle et al. (2015) found that the degree to which people shifted from a 'user identity' to a 'recovery identity' accounted for substantial variance (up to 49%) in positive behaviour change and wellbeing, up to six months after therapy sessions ended. Similarly, Cruwys and Gunaseelan (2016) highlighted the negative impacts of people retaining connection to a negative 'illness identity'. These researchers found that people with clinical depression experienced poorer wellbeing outcomes to the extent that they identified as a 'depressed person'.

However, mental illness identities are not always detrimental to mental health outcomes. Evidence suggests that these identities can be protective if the focus is on solidarity with other people who are experiencing the same condition as them. For

example, Meuret et al. (2016) found that, across the course of group therapy for social anxiety, people experienced more positive treatment outcomes to the extent that they identified with both other people experiencing social anxiety (i.e., increased solidarity) *and* people in the general population (i.e., increased connection to a less stigmatised identity). In short, the social identities that people internalise during therapy and how these identities shift over time appear to be key to the effectiveness of therapy.

By attending to and fostering these social identities (e.g., recovery identities), facilitators may be able to improve outcomes in their therapy groups. Although none of the aforementioned studies investigated the role of group facilitators, evidence from other contexts suggests that, by engaging in identity leadership, group therapy facilitators may be able to effectively guide group members in transitioning between different identities during group therapy (e.g., from a user to a recovery identity). Specifically, evidence from political and organisational contexts suggests that leaders can actively shape the content of group identities through their language, and that this, in turn, can influence group members' thoughts and behaviours. For example, qualitative analyses of Barack Obama's speeches before his election as the president of the United States observed that he tended to position America as a hopeful and change-oriented nation that is widely inclusive of various kinds of people (e.g., Augoustinos & De Garis, 2012; Bligh & Kohles, 2009). Bligh and Kohles (2009) proposed that this framing of the American identity contributed to his election in 2008 because it aligned with what American people valued and the direction that they wanted their leader to guide them (i.e., identity advancement; see also Haslam, Reicher, et al., 2020; Hogg, 2020; Reicher et al., 2005). Evidence from organisational contexts also suggests that identity leaders can foster a sense of solidarity and pride. In a sample of 81 work

teams, Hou et al. (2021) found that identity leadership predicted greater team performance by increasing employees' feelings of pride in their group. Group therapy facilitators may similarly be able to use identity leadership to both (a) construct a hopeful, recovery-oriented group identity that resonates with the reasons that group members decided to attend therapy, and (b) increase members' feelings of solidarity with, and pride in, the group.

Being an effective identity leader—specifically, an effective identity entrepreneur—also means playing a role in shaping group norms. In a group therapy context, research suggests that the norms that people perceive to exist in their therapy group can directly predict the trajectory of their mental health improvement over time. For example, in a sample of young women who were at risk of developing eating disorders and receiving group therapy to promote body acceptance, Cruwys, Haslam, et al. (2015) found that change in participants' perceptions that their fellow group members endorsed positive norms about dieting preceded and predicted positive treatment outcomes. This suggests that efforts by facilitators to instil supportive group norms (e.g., through establishing group goals and rules) may help facilitate positive clinical outcomes. Along these lines, and speaking to the benefits of identity entrepreneurship in these settings, setting up group rules and norms is already considered good practice in the early stages of group therapy (e.g., see Chen & Rybak, 2004; Yalom & Leszcz, 2020).

A final point relates to the potential benefits of group therapy facilitators "leading by example" – that is, providing an explicit role model that embodies the norms and values of the new identities that clients are striving toward. As noted above, one of the four facets of identity leadership—identity prototypicality—refers to the extent to which

the leaders are representative of the group they wish to lead. However, there are at least two ways in which prototypicality can be conceptualised: for leaders to represent 'who we are' (i.e., the group's current identity) or 'who we want to be' (i.e., the group's aspired identity). Some debate remains regarding which is most advantageous to achieve specific leadership or group goals. However, a recent meta-analysis indicated that leaders who represent 'who we want to be' can be particularly effective (Steffens, Munt, et al., 2021). This is consistent with Abrams et al.'s (2008) proposition that prototypical leaders are granted 'innovation credits' that allow them to direct the group identity and norms toward their vision of the future because they are viewed as working toward the group's best interests. It is also highly relevant in a group therapy setting, where a facilitator may not represent all the aspects that currently define what it means to be a group member (e.g., they may not currently be experiencing symptoms of poor mental health) but may be able to validate and normalise clients' experiences and represent some of the qualities that group members desire to have.

The positive impact of facilitators representing the aspirational qualities of the group was recently demonstrated in the first empirical study of identity leadership in the group therapy context. Robertson et al. (2022; Chapter 4) found that, in a sample of 112 young women attending a body acceptance group therapy program, facilitators who were perceived to be more aspirational on group-relevant dimensions at the start of therapy (i.e., less frequently dieting and thinking negatively about their body compared to group members) achieved a greater reduction in group member approval of dieting across therapy. Importantly, these changes in group approval of dieting in turn predicted key therapeutic outcomes (body satisfaction and intentions to diet). This suggests that

group therapy facilitators may be more effective when they embody the distinctive aspirational identity of the groups that they lead (i.e., are aspirationally prototypical).

One way that facilitators could demonstrate this type of prototypicality would be to share their personal stories of recovery. Indeed, this aligns with evidence that (a) connecting with other people who are also in recovery can be highly beneficial in therapy and mutual support groups (Moos, 2007; Rowlands et al., 2021), and (b) consumer-led mental health interventions are effective (e.g., Doughty & Tse, 2011; Grey & O'Hagan, 2015). Speaking to these points in some specific contexts, research suggests that positive outcomes arise when people recovering from a traumatic experience connect with others who have had a shared or similar experience (e.g., Bradshaw & Muldoon, 2020; Naughton et al., 2019; see also Haslam et al., 2018 for a review). Additionally, research has found that Hearing Voices Network consumer-led support groups (which focus on recovery, coping, and shared identity) are beneficial for people experiencing psychosis, at least in part because they are led by people who understand what it means to experience psychosis (e.g., Longden et al., 2018). On the other hand, researchers and clinicians have highlighted the potential risks of disclosing lived experience (e.g., Faulkner & Basset, 2012; Henretty & Levitt, 2010; Johnsen & Ding, 2021; Lee, 2014), and so further research is needed to unpack the conditions under which such disclosure is likely to be helpful versus harmful for supporting client wellbeing.

This research could seek to investigate what facilitator behaviours and narratives influence the social identities that people internalise during group therapy. For example, considering the evidence for enhanced treatment outcomes when people identify more strongly with a recovery identity, researchers could investigate whether people identify

as being in recovery to a greater extent when their group facilitator also identifies as being in recovery and discloses this. A context where this could be particularly important is in group therapy for eating disorders, where clinicians need to carefully consider how they can best shape group norms to support positive trajectories. Particularly in inpatient settings (where clients live, receive therapy, and eat together), attempts to restrict eating appear to quickly become "contagious", which can create unhealthy competition to become "the best anorexic" (Vandereycken, 2011, p. 291). Inpatient group members are also reported to frequently discuss ways to stay thin during treatment and influence other group members to do so (Wu & Harrison, 2019). Interestingly, these behaviours have been shown to lead to stronger identification with the eating disorder illness identity, rather than new social identities prioritising recovery from the disorder (Ison & Kent, 2010). Given the high possibility of negative influence from other group members, it is important for researchers to determine how identity leaders can support the development of norms and identities which promote recovery. Interestingly, peer-led group-based treatments have been shown to be just as effective as clinician-led treatments for eating disorder prevention (Stice et al., 2017). One promising avenue for future research could therefore be to investigate whether more positive group norms, and thus improved individual outcomes, are observed when facilitators disclose personal stories of eating disorder recovery.

1.4.3. Identity leaders can promote stronger therapeutic relationships.

Clinicians are acutely aware of the importance of building strong relationships with clients. The value of this is well-supported by empirical evidence; the relationship between clinicians and clients has been shown to substantially and meaningfully influence both clinical outcomes (see Burlingame et al., 2018; Flückiger et al., 2018 for

recent meta-analyses in group and individual therapy) and attrition rates in group therapy (e.g., Gulamani et al., 2020). Strong therapeutic relationships are fundamental for promoting positive therapeutic change (e.g., Ardito & Rabellino, 2011).

There are various ways to conceptualise and measure the relationship between clinicians and clients. In individual therapy, it is commonly referred to as the therapeutic alliance (Horvath et al., 2011). In group therapy, this relationship is similarly important but, because multiple people are involved, it is more commonly conceptualised as group cohesion. As noted earlier, group cohesion incorporates various aspects of how group members feel about a group (i.e., group facilitators *and* other group members, e.g., Burlingame et al., 2001) and has been shown to predict positive treatment outcomes (Burlingame et al., 2018). It is also arguably related to social identification. Specifically, in detailed theoretical analyses of the relationship, several researchers have suggested that greater group cohesion may be an outcome of strong social identification (Hogg, 1992; Hornsey et al., 2007, 2009)—a perspective that has been supported by empirical research in sports contexts (e.g., Fransen et al., 2016; Worley et al., 2020). In the group therapy context, group features and characteristics that have been linked to greater cohesion (e.g., having a group comprised of people with similar diagnoses; Burlingame et al., 2018) have also been shown to predict greater social identification (Cruwys, Stewart, et al., 2020). Given these findings, we argue that social identification is key to building effective therapeutic relationships and that efforts to enhance it (e.g., through facilitators engaging in identity leadership) may lead to improved therapeutic relationships in group therapy (see also Hornsey et al., 2007; 2009).

There is already some evidence that speaks to this in individual therapy. In a recent study, Lee et al. (2023) recruited 251 individual therapy clients and asked them to recall their therapy experiences and rate the strength of their therapeutic alliance with their therapist. The researchers found that the extent to which participants felt a strong sense of shared identification with their therapist positively predicted their ratings of the therapeutic alliance. Importantly, Lee et al. (2023) also found that the extent to which participants perceived that their therapist engaged in identity leadership also positively predicted greater therapeutic alliance. Another recent study by Cruwys et al. (2023) obtained similar findings: both social identification and identity leadership ratings positively predicted substantial variance in client ratings of the therapeutic alliance. These studies provide evidence that (a) identity leadership can improve the therapeutic alliance, but also that (b) social identification and therapeutic relationship constructs (e.g., the therapeutic alliance) are related. This may suggest that efforts to build social identification could also improve the therapeutic relationship (and vice versa), such that identity leadership could enhance therapeutic relationships even though it is primarily aimed at increasing social identification.

Extending these findings to the group therapy context, we would predict that efforts to increase social identification through identity leadership may also increase group cohesion. Indeed, along these lines, many of the strategies Burlingame et al. (2001) recommended that facilitators use to increase group cohesion mentioned earlier are consistent with the strategies of identity leadership, particularly the dimension of identity entrepreneurship. For example, facilitators seeking to demonstrate their identity entrepreneurship might aim to set clear treatment expectations, collaboratively define group rules and norms, and designate people to group roles. They might also encourage

emotional expression and explore the shared meaning derived from this to build connectedness and solidarity among group members. Research mentioned earlier by Meuret et al. (2016) speaks to the power of solidarity in group therapy; these researchers found that better treatment outcomes were observed by clients who identified more strongly with people experiencing the same symptoms as them over the course of therapy.

Another specific way group therapy facilitators might demonstrate their identity entrepreneurship and thus build stronger therapeutic relationships is by using inclusive and collective language. Research has already suggested that when group therapy members speak about goals inclusively and collectively (e.g., “we are in this together”) this has positive effects on treatment. Specifically, in a qualitative study of online support sessions for people with eating disorders, McNamara and Parsons (2016) found that inclusive language by group members was integral to building a shared sense of identity in the support groups and to improved therapeutic experiences. Research applying the identity leadership framework to political contexts has highlighted the value of leaders using collective language. Using archival data spanning 112 years and 43 elections, Steffens and Haslam (2013) found that the extent to which Australian Prime Minister candidates used the words “we” and “us” predicted their likelihood of election victory, such that victors used these words 61% more frequently than unsuccessful candidates. The researchers proposed that this was because collective language helped to promote a shared sense of Australian identity among voters (see also Fladerer et al., 2021).

Importantly, there is also compelling evidence that efforts to increase social identification (e.g., through identity entrepreneurship) facilitate improved clinical

outcomes. Specifically, and as mentioned briefly above, a large body of research has indicated that increased social identification with meaningful groups (e.g., therapy groups) can act as a 'social cure' that improves mental and physical health (see Haslam et al., 2018; Jetten et al., 2017 for reviews). Indeed, in a recent meta-analysis of interventions aiming to increase social identification, Steffens, LaRue, et al. (2021) found that social identification with therapy groups strongly predicted positive health outcomes (Hedges *g* = 1.02). Moreover, even in treatments not specifically aimed at increasing social identification, greater identification with a therapy group has been linked to improved health and treatment outcomes (e.g., Cameron et al., 2018; Cruwys, Haslam, Dingle, Jetten, et al., 2014; Meuret et al., 2016; Postmes et al., 2019). This supports the idea that social identification can be a key mechanism of change in group therapy contexts. Furthermore, specifically targeting social identification may be a fruitful avenue through which improved group therapy outcomes can be achieved.

In sum, we contend that by engaging in identity leadership (particularly identity entrepreneurship), group therapy facilitators may be able to improve the therapeutic relationship and, through this, facilitate improved outcomes for group therapy clients. Part of the reason for our assertion relates to the relationship between social identification and group cohesion – a widely used measure of the therapeutic relationship in group therapy. Although further empirical research examining the relationship and overlap between these concepts in group therapy settings is needed, evidence to date suggests (a) that social identification can give rise to greater perceptions of group cohesion, and (b) that efforts to increase either within a group are likely to simultaneously increase the other. This is evidenced by prior research conducted in individual therapy settings (e.g., Cruwys et al., 2023; Lee et al., 2023)

demonstrating that social identification and therapeutic alliance are strongly related, and that identity leadership positively predicts therapeutic alliance ratings.

Given the positive outcomes that have been shown to flow from both in group therapy contexts, research is needed to test whether identity leadership promotes positive outcomes specifically via their effect on these constructs. Here, one option would be to experimentally manipulate identity leadership and assess the effects of this on participants' ratings of the therapeutic relationship (i.e., group cohesion, traditional measures of therapeutic alliance, and social identification) and downstream outcomes. Such research could draw on Stevens, Rees, Steffens, et al.'s (2019) study, which experimentally manipulated a facet of identity leadership and found that confederate leaders engaging in identity entrepreneurship resulted in improvements in indicators of participants' effort and performance during an exercise task. In this study, confederate leaders were provided with scripts to demonstrate either high or low levels of identity entrepreneurship (e.g., they were asked to repeatedly use either collective language or individual language). Such scripts could similarly be developed for experimental studies of (simulated) group therapy sessions. Participants could then be asked to watch recordings and rate facilitators on various dimensions, such as how connected they feel to the facilitators and their overall effectiveness (for other manipulations of identity leadership see Haslam & Platow, 2001; Platow et al., 1995, 1997, 2006; Platow & van Knippenberg, 2001). Alternatively, facilitators could be trained in identity leadership (as described above) and the benefits of being part of a therapy group led by a facilitator who has received this training could be assessed (e.g., through comparison to a randomised control group whose facilitator has received no leadership training). In addition to the outcomes proposed above (i.e., therapy session attendance and

treatment outcomes), participants' perceptions of the strength of the therapeutic relationship could be assessed and examined as a potential mediator.

1.5. Conclusion

Facilitators are often central to the success of therapy groups but are rarely conceptualised as *leaders* of them. This has led to a tendency for the insights offered by leadership science to be overlooked in these settings. Given its emphasis on power *through* (rather than power over) the group, identity leadership theory appears particularly well-suited to guiding group therapy facilitators' efforts to enhance their effectiveness and foster improved treatment outcomes for group members. Indeed, empirical evidence from various contexts points to multiple pathways through which adopting this style of leadership may give rise to positive outcomes. These include by (a) promoting people's greater attendance at, and engagement in, group therapy, (b) helping create new, mental health-promoting norms and social identities, and (c) strengthening therapeutic relationships. We hope that the present article acts as a stimulus for group facilitators to consider alternative ways enhance their effectiveness, and as a guide for researchers seeking to conduct empirical research focused on understanding the factors that shape the effectiveness of group therapy.

Chapter 2. Methods and Design

This chapter provides information about my positionality as a researcher and the choice of methods used in this thesis. Given that each empirical chapter is written as a standalone paper with its own methods section, I aim here to provide a cohesive overview of the methods chosen across the project. The strengths and limitations of these decisions are returned to in more detail in the General Discussion (Chapter 7).

2.1. Reflexivity Statement (Researcher Positionality)

This section briefly discusses how my prior assumptions and experiences shaped this project. First, I have primarily approached the study of group therapy leadership through the lens of Western science and empirical research. This perspective is informed by my background as a White Australian, as well as my educational background in Australian schools and universities. It is crucial to recognise that group-based healing modalities have existed for thousands of years in Indigenous and religious communities (e.g., Burke et al., 2022; Dylan, 2003; Sargant, 1949). As some examples: in Australia, Aboriginal and Torres Strait Islander peoples have a long history of “yarning circles”, which can function much like a therapy group and provide a platform for people to communicate, learn, and heal together (Burke et al., 2022; Kennedy et al., 2022). In the United States and Canada, First Nations peoples similarly have a long history of using “talking circles” and “healing circles” (Dylan, 2003; Mehl-Madrona & Mainguy, 2014). Interestingly, healing circles have also successfully been implemented into mainstream health care; for example, as an effective alternative to Alcoholics Anonymous (i.e., a mutual support group aimed at encouraging sobriety from alcohol use) for people who do not align with the standard spiritual beliefs promoted in

Alcoholics Anonymous (Vick et al., 1998). Although beyond the scope of my thesis, I want to acknowledge that there is likely a wealth of knowledge about how to effectively lead group healing modalities held by Indigenous and spiritual communities across the world.

Second, residing in Australia informed the legal and political lens through which I viewed certain aspects of this project. In Australia, the health professional regulatory body (Australian Health Practitioner Regulatory Agency; AHPRA) mandates that health professionals (e.g., psychologists), report other professionals who they believe are "impaired" (AHPRA, 2023). The regulations around this could be interpreted such that "impairment" includes a professional who is experiencing mental ill-health. Having these regulations in mind during my research made salient the contradiction between the potential benefits of therapist disclosure and the potential consequences for therapists who disclose information about their mental health (see Chapters 5 and 6). For instance, this directed added emphasis toward the possibility that a therapist who discloses information about their mental health to client may put their registration as a health professional at risk. This topic is discussed further in the General Discussion.

Third, I am not a registered psychologist and have not trained in or practiced psychology in a clinical or therapeutic context. My knowledge about therapy is primarily drawn from my academic study of clinical psychology throughout my undergraduate and doctoral degrees. Throughout my research, I have been cognisant that my lack of clinical experience means that I do not have the same level of intuitive or experiential understanding of group therapy as a researcher who also works as a clinician. To this end, I sought formal feedback on my methods, interpretation of results, and writing throughout this PhD project from clinical psychologists (in particular, my primary

supervisor Professor Tegan Cruwys), as well as informal feedback in discussions with colleagues and friends who work as general practitioners, counsellors, and social workers. I also attended all group therapy supervision sessions for facilitators and acted as a trial manager for the study detailed in Chapter 3, which allowed me to better understand the clinical processes of group therapy and what occurs during clinical supervision. However, it is worth noting that my position as a researcher rather than a clinician may also have some benefits. For example, it means that I am less personally invested in findings that relate to the effectiveness of therapists or therapy.

2.2. Choice of Methods

In this section, I will discuss the rationale behind my choice of methods. As this was the first investigation of identity leadership in a group therapy context, I wanted to use a mixed-methods approach to gain a broad understanding of what identity leadership might look like in group therapy and what its effects might be. The methods I chose were intended to be appropriate for both the clinical context and the social psychological theory used to investigate it. An important consideration here was the balance between ethical constraints of working in clinical contexts and the need for experimental rigour (especially when drawing from and testing social psychology theory, which has traditionally been dominated by experimental methods). For instance, ethical concerns arising from the clinical context of our research meant that we could not manipulate the behaviours of identity leadership in real therapy sessions (especially given that we had limited data on the effects that they might have on clients). So, to accommodate this ethical constraint, strategies were used such as (a) examining behaviours that occurred naturally in therapy sessions but that I believed were

theoretically linked to identity leadership and (b) developing vignettes to present to participants and elicit relevant responses.

2.2.1. Quantitative methods. Broadly, quantitative research methods were used to quantify the prevalence of identity leadership behaviours, assess their impact on shaping group dynamics, and explore their empirical relationship with mediators and therapeutic outcomes of interest. Quantitative analysis aimed to identify patterns, trends, and relationships that might illuminate how identity leadership operates in group therapy settings. I primarily used quantitative methods where the variables were known, commonly studied, and had validated measures available. For example, I studied perceptions of therapists' identity leadership using the Identity Leadership Inventory (Steffens, Haslam, Reicher, et al., 2014) and studied social identification using the four-item scale from Postmes et al. (2013).

For the quantitative statistical analysis methods, I aimed to select suitable tests for each study design, sample size, and resulting statistical power. In Chapters 3 and 4, I used mixed-effects modelling to account for the variance in outcomes attributable to the participant (i.e., because repeated measures were obtained from each participant) and the therapy group (i.e., because participants were clustered in therapy groups). I could have also accounted for variance attributable to the specific therapists running the groups in these studies, however, this was infeasible due to therapists facilitating multiple groups with a different co-facilitator each time and having insufficient observations. In Chapter 4, I also used mixed-effects mediation analysis to examine the effect that the identity prototypicality of the therapist had on the outcomes via normative change. I had hoped to run similar analyses for Chapter 3, but was not adequately powered to do so, given the small sample size (N = 33). These chapters thus

primarily focus on examining key outcomes over time, for which there were more observations of the dependent variable.

2.2.2. Qualitative methods. Qualitative research methods were used to provide a richer and deeper exploration of the experiences and perceptions of identity leadership in group therapy from both the client and therapist perspectives. I primarily used qualitative methodology when the variables were unknown, such as the specific behaviours of group therapy identity leadership. I also used qualitative methods to explore the perspectives and experiences of clients and therapists more broadly, such as conducting qualitative interviews with clients about the impact of identity leadership behaviours in the group therapy study detailed in Chapter 3 and asking clients and therapists to recount and respond to instances of therapist self-disclosure in Chapter 6.

Qualitative methods were also chosen because they can better capture the perspectives and stories of people from marginalised communities (e.g., people experiencing mental ill-health; Campbell et al., 2021; Moree, 2018). Similar to what was said about multicultural counselling research in Chapter 1, using qualitative methods in health research allows researchers to discover and uncover people's thoughts and actions in a person-centred way (Renjith et al., 2021). Speaking to the need for this, a critique that has been levelled at group therapy research is that there is not enough focus on holistic measures of wellbeing and human experience, coupled with an overemphasis on simplistic investigations of whether particular treatments work (e.g., by examining only symptom reduction; Marmarosh et al., 2022). Demonstrating the value of qualitative measures for capturing these more holistic elements, interviewing clients in the Chapter 3 allowed me to capture things like clients' realisation that it was normal to feel anxious when they saw that their facilitators were sometimes anxious

about running the therapy group. For this reason, qualitative methods have been positioned as an excellent complement to clinical trials (e.g., to provide information about the meaning and impact of quantified change in participants' symptoms; Gibson et al., 2004).

2.3. Choice of Chapter Composition

In this section, I will discuss the rationale behind the allocation of my studies into their respective chapters. First, Chapter 5 (Study 1) and Chapter 6 both have the same sample of clients and therapists but are presented in separate chapters. This is because this study was planned with multiple research questions in mind. The choice to do this was intentional, to make the best use of the cost and effort (both my own and the participants') required to screen, and recruit samples of current or recent clients and therapists. Highlighting the distinct research questions, Chapter 6 does not use the same theoretical framework as the rest of the thesis chapters and instead explores the topic of self-disclosure using a data-driven approach. Additionally, Chapter 6 discusses experiences of therapist self-disclosure in both individual and group therapy settings, whereas Chapter 5 (and the rest of the thesis) only considers group therapy. I could not reasonably limit the sample recruited to people who have *only* delivered or attended group therapy because most therapists who run groups also are or have been individual therapists and most group therapy clients have also received individual therapy. I also do not have any specific reason to believe that self-disclosure of lived experience would function differently in a group versus an individual setting.

Second, Chapter 3 details a clinical trial study with a large corpus of data, including survey, interview, and video data. Although only one chapter is presented on this study in this thesis, I would like to prepare other related outputs due to the

complexity of the findings and the large amount of data. For example, I found that facilitator and client ratings of the facilitators' identity leadership (both measured using the Identity Leadership Inventory) were unrelated to each other. The disconnect between leader and follower ratings of identity leadership is of interest to me and something that I will pursue further studies on; however, it is tangential to the clinical focus of this thesis.

Finally, I decided to combine the reporting of my second study on therapist self-disclosure with the first study detailed in Chapter 5, rather than writing it up as a separate chapter. This is because the second study directly replicates and extends the first study.

2.4. Choice of Samples

This program of research includes an exploration of group therapy identity leadership in two clinical samples[1]: people with social anxiety (Chapter 3) and women at risk of developing eating disorders (Chapter 4). Samples of therapists and clients were also recruited for the studies detailed in Chapters 5 and 6.

2.4.1. Social anxiety. The choice to recruit people with social anxiety (Chapter 3) stemmed primarily from collaborative and practical considerations. The key reason is that I collaborated on this study with another PhD candidate, Jessica L. Donaldson, who studies a social identity approach to understanding social anxiety. Collaborating on this research project allowed us to conduct a more time- and resource-intensive study than we would have managed individually. Additionally, we were able to combine our strength sets. Jessica is a clinical psychologist and was able to lead clinical and risk

[1] In both instances, it was not determined whether participants had a diagnosed condition, however, they were screened for clinically elevated levels of the primary symptom of interest before participating in the studies.

aspects of the trial. I had more time available to lead day-to-day administration and experience coordinating multi-component studies. This means that, in addition to the study on identity leadership presented in Chapter 3, Jessica has led a further research output presenting our finding that the treatment effectively reduced social anxiety, loneliness, and depression symptoms for people with social anxiety (Donaldson et al., 2025).

Another reason to investigate identity leadership for the first time in the context of social anxiety relates to practicality and impact: social anxiety disorder is common and disabling. The global prevalence of social anxiety disorder is estimated to be around 3.1% of the population in a given 12-month period (Stein et al., 2017). Our study was also conducted in Australia, where the prevalence of social anxiety disorder is even higher, such that between 2020 and 2022, the 12-month prevalence of social anxiety disorder was 7.3% of the population (Australian Bureau of Statistics, 2023). This provides a larger population to recruit from, generalise to, and advance understandings of.

Studying group therapy identity leadership in this population is beneficial because the findings can speak to how therapists can better engage people with social anxiety in group treatments. People with social anxiety benefit greatly from group therapy (e.g., Barkowski et al., 2016). However, they are often reluctant to attend and remain in group-based treatments, with a key reason being fear of negative judgement from other group members (Book et al., 2009; Shay, 2021). This is perhaps unsurprising; a key feature of social anxiety is an extreme fear of situations in which one could be negatively evaluated by other people (American Psychiatric Association, 2013). In considering the factors that might help to engage people with social anxiety in group

treatments, one study found that there were no differences in group therapy outcomes (e.g., in symptom severity or demographic factors) for clients who dropped out versus completed the program (Hofmann & Suvak, 2006). This suggests that other factors determine the willingness to sign up for and stay in group therapy treatments for people with social anxiety, some of which may be targets for intervention by therapists. I anticipate that some of these targets can be addressed by group therapists adopting an identity leadership approach to their facilitation.

Regarding this sample, it should be noted that the population features (anxiety about social situations) presented a barrier to recruiting our intended sample size. We hoped, based on a power analysis, to recruit a sample of around 80 participants to commence the therapy sessions. However, after recruiting across various sources for over one year, only 33 participants commenced the program.

2.4.2. Eating disorders. The decision to examine group therapy identity leadership in a sample of women at risk of developing eating disorders (Chapter 4) also involved practical considerations. During the first year of my PhD (2021), COVID-related lockdowns and restrictions prevented face-to-face data collection. To maintain productivity during this time, I conducted a secondary data analysis of body acceptance group therapy data that my primary supervisor had available. Facilitator data from this study had not yet been examined, so my project had limited overlap with prior outputs employing the same sample (Cruwys, Haslam, et al., 2015; Cruwys, Steffens, et al., 2020).

Regardless of these practical considerations, I was also interested in researching group therapy identity leadership in a population of people with (or at risk of developing) eating disorders for theoretical reasons. Group therapy for people with eating disorders

is notoriously challenging, due to the possibility for harmful norms to emerge. As some examples, symptoms of disorders such as anorexia nervosa have been reported to become "contagious" among group members (Vandereycken, 2011) and group members can negatively influence each other away from recovery (e.g., Babb et al., 2022; Webb et al., 2022; Wu & Harrison, 2019).

There is also a fair bit of research examining the impacts of a therapist's own lived experience of an eating disorder, which is a research interest of mine (and one that I focus closely on in Chapters 5 and 6). Considerations about lived experience in this space are important because hearing about eating disorder pathology can be triggering, but also because it can be difficult for people who have not experienced eating disorders to truly understand what it is like (Barbarich, 2002; Bloomgarden et al., 2003; de Vos et al., 2016; Johnston et al., 2005; Warren et al., 2013).

2.4.3. Clients and therapists. The target samples for the studies in Chapters 5 and 6 were intentional. In Study 1 (detailed in both Chapters 5 and 6), I specifically recruited therapists and clients for several reasons. First, I anticipated that real clients and therapists would have more insights into the effects of the therapist self-disclosures detailed in our vignettes compared to undergraduate students or general population adults (i.e., the populations recruited in previous studies on this topic). Second, it allowed me to collect data for my qualitative study (Chapter 6) in the same survey because I could ask participants about their experiences with therapist self-disclosure of lived experience (either as a client or a therapist). Finally, the recruitment of both clients and therapists allowed for comparisons between how therapists and clients viewed therapist self-disclosure of lived experience.

In Study 2 of Chapter 5, I also recruited purposive samples of clients and general population adults. These samples were recruited so that I could determine whether the sample choice of real clients and therapists in the first study explained why my findings did not replicate those obtained in some prior research. The most relevant previous study (i.e., Moody et al., 2021) had recruited general population adults, so I recruited this same population to see if I would replicate their findings. I was also interested in whether general population adults' ratings of the vignettes would be different from clients' ratings.

2.5. Engagement with Open Science Practices

In conducting this program of research, where possible, I adhered to open science practices. The study detailed in Chapter 3 was preregistered as a clinical trial with the Australia and New Zealand Clinical Trials Registry. This is most relevant to the output led by Jessica L. Donaldson mentioned earlier, however, it also allowed me to preregister some of the methods used to investigate identity leadership. I also preregistered the quantitative component of Study 1 in Chapter 5. The choice to preregister these studies was to ensure transparency and accountability. The study detailed in Chapter 4 was not preregistered because it was secondary data; however, I did obtain ethical approval to use this secondary data and generated hypotheses prior to data analysis (albeit not registered). I also did not preregister the second study detailed in Chapter 5. The reason for this was that it was a replication of the first study, which was already pre-registered. I did not preregister the qualitative study in Chapter 6 because I took an exploratory, data-driven approach and was unsure whether to preregister this. The method used—reflexive thematic analysis—also encourages transparent reporting of the process after it has been completed, allowing the

researchers to report on how the analysis developed over time. In hindsight, I should have preregistered my research questions and plans to use reflexive thematic analysis, which I will do for future qualitative studies.

I would like to note here that when preregistering Study 1 presented in Chapter 5, I did not include a focal hypothesis (i.e., that aspirational prototypicality would have a positive effect on the outcomes measured). This was an oversight that I realised once data analysis had begun. The process of developing this hypothesis post hoc, rather than a priori, reflects my increasing knowledge about hypothesis generation, statistical analysis, and research design gathered as I continued throughout my doctoral studies. This hypothesis logically draws from the literature, theory, and my other hypotheses, which I would argue (in line with Rubin, 2017) means that it does not represent a problematic form of Hypothesising After Results Known (HARKing). However, in the interest of transparency and honesty, this analysis is framed as exploratory when presented in Chapter 5.

2.6. Choice of Prototypicality Focus for Chapters 4 to 6

In this last section, I will describe the rationale behind my strong focus on identity prototypicality (henceforth "prototypicality") throughout my thesis. My interest in prototypicality was inspired by two key debates occurring in the literature as I conducted my PhD research. Namely, the aspirational vs. average prototypicality debate in identity leadership literature and the lived experience debate in clinical literature.

Regarding the first debate, as mentioned in the previous chapters, there has been contention in identity leadership literature about whether it is more important that a leader represents an average member of the group ("who we are now") or an

aspirational member of the group ("who we want to be"). At the start of my thesis, a meta-analysis was published demonstrating that the aspirational conceptualisation of prototypicality better predicts leadership effectiveness compared to the average conceptualisation (i.e., Steffens, Munt, et al., 2021). The studies in this meta-analysis were largely drawn from organisational contexts but I hypothesised that similar findings would be observed in clinical contexts. At face value, it makes much more sense for a therapist to represent an aspired identity (e.g., recovery from mental ill-health) for clients than an average or current identity (e.g., experiencing mental ill-health). This hypothesis led to the conceptualisation of the study detailed in Chapter 4.

Regarding the second debate, there is contention in clinical literature surrounding whether it is useful and appropriate for therapists to have "lived experience" of mental ill-health in addition to their discipline-based qualifications (e.g., Sunkel & Sartor, 2022; see Chapters 5 and 6 for more details). Speaking to this debate, I hypothesised that self-disclosure of lived experience may be beneficial because it signals to clients that the therapist is "one of us" (i.e., prototypicality). In particular, I hypothesised that self-disclosure of lived experience may be more impactful when it is of a recovered condition because this type of disclosure may uniquely signal the therapist's *aspirational* prototypicality. This hypothesis led to the conceptualisation of the studies in Chapters 5 and 6).

Although I focused most closely on prototypicality throughout this thesis, it is worth considering the merits of taking a more holistic approach and examining the four identity leadership facets across all studies. Indeed, as this thesis represents the first test of identity leadership theory in the group therapy context, examining all four facets in each study may have provided a more comprehensive overview of the applicability of

identity leadership in this context. However, taking such an approach may have led me to draw less specific, actionable conclusions about identity leadership in group therapy facilitators. One advantage of the approach I took—focusing only one study on testing the entire identity leadership model (Chapter 3) and the rest on prototypicality (Chapters 4 – 6)—was that it allowed me to draw more in-depth conclusions about the role of prototypicality in group therapy, such as the specific circumstances in which self-disclosure of lived experience (a prototypicality behaviour) had maximally positive effects.

I reasoned that, if any identity leadership facet warranted isolated examination, prototypicality was the best choice. This was because, firstly, it allowed me to contribute to two key debates in the literature (as described above), meaning that insights gained were more readily applied to theory developments and practice. Additionally, prototypicality plays a central role in underpinning the other facets of identity leadership. As outlined in Chapter 1, one of the core determinants of whether someone is viewed as an identity leader is the extent to which group members perceive them to be “one of us”. Without group members perceiving the leader as one of us, it is possible that efforts they make to engage in entrepreneurship, advancement, or impresarioship will not be accepted by group members or effective. For instance, group-relevant activities or rituals proposed by the leader (an example of impresarioship, see Chapter 3) may not be well-received or engaged with by group members if the leader is perceived to be an outsider. Having established the role of prototypicality throughout this thesis, the logical next step would be to examine the other facets in more detail. I return to this point in the general discussion (Chapter 7),

where I particularly emphasise the value of examining impresarioship in future research.

In summary, I chose to focus on prototypicality so that my research would be able to weigh in on two popular debates in the literature: the average vs. aspirational prototypicality debate (in particular, in Chapter 4 and 5) and the lived experience debate (in particular, in Chapters 5 and 6). Indeed, I hope this whole thesis speaks to relevant debates in the clinical sphere and brings a fresh theoretical perspective that can yield useful insights for clinicians and researchers alike.

Chapter 3. Developing an Identity Leadership Behaviour Framework: Application in the Context of Group Therapy

Paper Rationale and Introduction

Having established a theoretical foundation for identity leadership behaviours in Chapter 1, I sought to further develop my framework of behaviours in an empirical study. In doing so, I aimed to address a key critique of identity leadership theory: the lack of concrete, observable behaviours (e.g., Stevens et al., 2021). My PhD's applied focus on group therapy facilitation provided an ideal setting for observing and analysing identity leadership behaviours. Group therapists, in my view, already engage in practices that align with identity leadership principles, such as fostering cohesive groups and building strong relationships based on trust and respect. To develop this framework, I employed a theory-driven, three-stage process that involved: an initial generation and client (follower) consultation stage, a refinement stage, and a quantitative testing stage.

One limitation of my study was that I was unable to recruit as many participants as I had hoped and was underpowered to conduct mediation analyses examining whether identity leadership predicted social identification and, subsequently, better clinical outcomes. As such, this chapter focuses more on how I developed the framework of behaviours. Despite some limitations, I hope that this study provides a foundation for future investigations of concrete identity leadership behaviours across various fields.

Publication Status

This study is in preparation for publication. The target audience is social psychologists interested in new developments in identity leadership theory, so it will be submitted to a social psychology journal.

Author Contributions

I formed the identity leadership-related research questions explored in the present study, with support from my PhD supervisors (Tegan Cruwys, Mark Stevens, and Michael J. Platow). This clinical trial project was a collaboration between Jessica L. Donaldson and I. Jessica L. Donaldson formed separate research questions about the efficacy of Groups 4 Health for people with social anxiety and produced an output on this topic. I was the trial manager for this study, overseeing most aspects of data collection and administration. Jessica L. Donaldson oversaw the clinical and risk aspects of the project, responsible for screening, contacting, and following up with clients, with supervision from Tegan Cruwys. Throughout each stage of the trial, Tegan Cruwys and Joanne Rathbone provided guidance and supervision. I conducted all quantitative data analysis and wrote the original draft of this manuscript. Jessica L. Donaldson conducted all quantitative data analysis and wrote the original draft for her output (Donaldson et al., 2025). We collaborated on the analysis of the client interview data for each of our outputs. The manuscript continues to be edited in collaboration with all coauthors (Tegan Cruwys, Jessica L. Donaldson, Mark Stevens, Michael J. Platow, Joanne Rathbone). Our collaborative process is also described in more detail in the Methods section of this chapter.

Abstract

A growing body of research demonstrates the positive effects of identity leadership on leadership effectiveness. However, there is limited information about *the specific behaviours* that constitute identity leadership. To address this gap, we developed the first framework of concrete identity leadership behaviours. The context of study chosen was group therapy facilitation, where we reasoned that the core principles of identity leadership are highly compatible with the goals of therapy. However, we aimed to focus on behaviours that would be applicable across varied leadership contexts. The identity leadership behaviour framework was developed using an iterative, collaborative, and theory-driven three-stage process: (1) an initial generation and client (follower) consultation stage, (2) a refinement stage, and (3) a quantitative testing stage. Data included a corpus of 30 recorded therapy sessions (~45 hours) from 9 facilitators of 6 distinct therapy groups, self-report data from clients (123 surveys from 33 therapy clients across 5 sessions), and interviews with six clients post-therapy about their experiences. The first two stages led to the identification of twelve behaviours theoretically aligned with identity leadership (e.g., self-disclosure of relevant experiences). Unexpectedly, in the third stage, the frequency of these behaviours was not related to client ratings of facilitators' identity leadership across therapy. In several cases, however, the rate of these behaviours in the first therapy session predicted change in clients' social identification across therapy. Our study provides the first practical guidance for identity leaders and offers a framework for further investigation.

3.1. Introduction

Effective leadership is crucial across various domains, from workplaces to health care. A large body of research has explored leadership effectiveness through the lens of the social identity approach to leadership (i.e., identity leadership theory; Haslam, Reicher, et al., 2020). This research has spanned various contexts, such as health, clinical psychology, sport and exercise, organisations, politics, and education (e.g., empirical studies from the last two years include Brown & Slater, 2023; Cárdenas et al., 2024; Cruwys et al., 2023; Haslam, Reicher, et al., 2023; Haslam, Reutas, et al., 2023; Lee et al., 2023, 2024; Schei et al., 2023; Smith & Templeton, 2024; van Knippenberg et al., 2024). This theory argues that a leader's effectiveness hinges on their ability to represent, craft, advance, and embed a sense of shared identity among their followers. Despite growing research in this area, a gap in understanding exists regarding the *specific behaviours* that constitute identity leadership.

To address this gap, our study aimed to create the first identity leadership behaviour framework. We chose to do this in the context of group therapy facilitation, specifically focusing on the Groups 4 Health (G4H) program (Haslam et al., 2025). This setting provided an ideal environment for observing and developing identity leadership behaviours due to its natural alignment with identity leadership principles. Specifically, G4H places therapeutic emphasis on fostering a sense of connectedness and cohesion among group members. By examining the interactions between group facilitators and clients, we sought to identify concrete behaviours that exemplify identity leadership, with the goal that these behaviours would apply to and inform practice both in the therapy context and across various leadership domains.

3.1.1. Identity Leadership in Group Therapy

Yalom and Leszcz (2020) stated that group therapy facilitation is challenging because the facilitator must operate simultaneously as a group member and a leader. Identity leadership theory (Haslam, Reicher, et al., 2020) directly addresses this tension, suggesting that leaders are effective to the extent that they are viewed as "one of us" (i.e., a member of the group). The foundation for identity leadership theory is the social identity approach, comprised of social identity theory (Tajfel & Turner, 1979) and self-categorisation theory (Turner et al., 1987). This approach recognises that individuals define themselves in terms of both personal identity (as 'I' and 'me') and their various group memberships (e.g., 'we' and 'us'; Turner, 1982). The extent to which people feel connected to these groups is referred to as their level of *social identification*. This term is formally defined as the affinity that people feel with other members of a group, and the extent to which being a member of that group is an important part of their self-concept (Tajfel & Turner, 1979).

Particularly relevant to the context of leadership, to the extent that people socially identify with a group, they align their thoughts, feelings, and behaviours with the collective interests, identity, and norms of the psychological ingroup (Turner, 1991, 2010). The extent to which leaders can promote followers' social identification with the group is therefore an important determinant of their influence and effectiveness. Empirically supporting this, research drawn from a variety of contexts has found that follower social identification increases as a result of leaders' identity leadership and that this underpins a range of positive outcomes, such as reduced burnout, improved team functioning, and better health and treatment outcomes (e.g., Fransen et al., 2022;

Krug et al., 2021; Lee et al., 2023; Mertens et al., 2020; Steffens et al., 2019, 2024; van Dick et al., 2018, 2021).

Having established the critical role of social identification in leadership effectiveness, it is important to understand how leaders can actively foster it. Identity leadership theory outlines four key processes that foster a shared sense of identification: identity prototypicality, entrepreneurship, advancement, and impresarioship (Haslam, Reicher, et al., 2020). To illustrate how these processes might manifest in practice, we provide examples of their application in the context of group therapy facilitation (drawing from Robertson et al., 2023 [Chapter 1]). To demonstrate identity prototypicality, group therapy identity leaders might seek to embody the kind of person group members are striving to be (e.g. by sharing personal stories of recovery). To demonstrate identity entrepreneurship, group therapy identity leaders might seek to create a cohesive group where everyone feels included (e.g., by establishing group norms at the start of therapy that support the group's purpose). To demonstrate identity advancement, group therapy identity leaders might advocate for group members in relevant ways (e.g., by addressing difficult group member behaviours and framing in terms of group identity). Finally, to demonstrate identity impresarioship, group therapy identity leaders might create structures that allow clients to live out the group identity (e.g., by developing and promoting group-relevant activities and rituals).

These four processes provide a good framework for understanding how leaders can effectively foster social identification and, consequently, positively influence group outcomes. However, while these and similar examples have been proposed in the literature (e.g., Lee et al., 2021; Robertson et al., 2023 [Chapter 1]), the specific behaviours associated with identity leadership have not yet been empirically tested.

This gap in the literature points to the need for further research to empirically tie identity leadership to specific behaviours.

3.1.2. The Need for Concrete Identity Leadership Behaviours

Despite the large (and growing) body of research supporting identity leadership theory, there remains a gap in understanding the *specific* actions or behaviours that might enhance follower social identification. For example, although training for identity leadership (the 5R Leadership Training Program) exists and has proven efficacious (Fransen et al., 2022; Haslam, Reutas, et al., 2023; Mertens et al., 2020), it primarily directs leaders to build their identity leadership capacity by reflecting on the identity and needs of their group of followers, including through consultation with followers (Haslam et al., 2017). That is, the behaviours of identity leadership tend to be idiosyncratically developed by the leader, rather than drawn from a set of recommended context-independent strategies.

This close consideration of followers' specific needs, rather than focusing on generic leadership strategies, is considered one of the key strengths of the identity leadership approach compared to other leadership approaches (Haslam et al., 2024). However, to further strengthen the theory and provide practical guidance for leaders, researchers have advocated for the development of some context-independent strategies that constitute identity leadership. For example, in their discussion of the status and future directions of identity leadership in sport and exercise, Stevens et al. (2021) highlighted the "need for the identity leadership approach to be falsifiable" and encouraged researchers:

> "to tackle the challenge of identifying concrete forms of identity leadership, rather than 'hiding behind' notions that (a) effective identity leadership

behaviours vary across groups, and (b) what constitutes identity leadership is, to some extent, in the 'eye of the beholder'. Although these points may both be true, they do not preclude attempts to identify some behaviours or strategies that are consistent with identity leadership in most (if not all) instances." (p. 7).

Previous efforts to identify context-independent identity leadership behaviours have focused on the use of collective language ('we' and 'us'), perhaps due to the ease with which this behaviour can be identified and manipulated experimentally (Fladerer et al., 2021; Steffens & Haslam, 2013; Stevens et al., 2019). As one example, Stevens et al. (2019) found that people doing an exercise task led by a leader who repeatedly used collective language ('we' and 'us'; theorised to display a high level of identity entrepreneurship) put in more effort and had better performance outcomes than those led by a leader who repeatedly used individual language ('me' and 'you'; displaying low identity entrepreneurship). Beyond collective language, however, there are likely other behaviours that are useful across multiple leadership contexts. The present study aimed to identify such behaviours in the context of group therapy facilitation, thus rising to the challenge set by Stevens et al. (2021).

3.1.3. The Present Study

This study aimed to develop the first framework of identity leadership behaviours. We chose to conduct this research in the context of G4H (Haslam et al., 2025) therapy groups among clients with elevated social anxiety. G4H is an evidence-based, five-session, structured therapeutic group program designed to enhance clients' group-based belonging. Particularly relevant to our investigation, it was also developed using social identity principles. The study was conducted as part of a larger clinical trial, which also examined whether G4H was effective for people with social anxiety,

prospectively registered with the Australian New Zealand Clinical Trials Registry (ACTRN12622000077763). The clinical efficacy is reported elsewhere (Donaldson et al., 2025).

We anticipated that the facilitators of G4H groups for people with social anxiety would elicit identity leadership behaviours for several reasons. First, although the principles of group therapy facilitation and identity leadership were developed in distinct literatures and with different theoretical bases, they are highly congruent. For instance, both group therapy facilitation and identity leadership practice emphasise respect, strong relationships, and building connectedness and cohesion among group members (Haslam, Reicher, et al., 2020; Kaklauskas & Greene, 2019). Second, as mentioned, G4H is informed by social identity principles. This means that, although G4H group facilitators are not trained in identity leadership, they are cognisant of the importance of social identities. Third, we anticipated that clients' social anxiety symptoms (i.e., fear of social situations and being judged negatively by others; American Psychiatric Association, 2013) may necessitate more explicit identity leadership behaviours as facilitators try to create a safe and inclusive environment that enables clients to feel comfortable participating in group activities and connecting with others.

We developed the behavioural framework through a three-stage process using multiple data sources. These data included: over 45 hours of group therapy footage, questionnaires completed by clients at the end of each of the five group therapy sessions, and interviews with clients about their perceptions of their facilitators' identity leadership. The three stages are described in detail below, but, briefly, they involved (1) a generation and follower consultation stage to develop an initial list of behaviours; (2) a

refinement stage, and (3) a quantitative testing and initial validation stage. This comprehensive approach allowed us to triangulate findings from multiple perspectives and refine our understanding of identity leadership behaviours. In this third stage, we had two key hypotheses: that the behaviours would be related to follower perceptions of their leaders' identity leadership (H1) and that the behaviours would predict social identification (i.e., the key theorised outcome of identity leadership; H2).

3.2. Methods

3.2.1. Participants

Clients were adults with elevated social anxiety, recruited through advertisements posted at local health clinics, on the Australian National University campus, and online. Interested participants were directed to complete an online screener, which 137 adults completed. After a risk and eligibility assessment process (see clinical trial registration for details), 90 respondents were deemed eligible and invited to participate. Thirty-three clients signed up, provided informed consent, and attended at least one therapy session. Two clients chose not to answer end-of-session questionnaires, resulting in a client sample of 31 for these analyses. The sample included 22 women (66.67%), 9 men (27.27%), and 2 non-binary adults (6.06%), aged between 18 and 67 years (M = 25.66, SD = 10.90). Most clients self-identified as White (n = 21, 63.64%), with other ethnicities including Asian, Middle Eastern, and Mixed (n = 12, 36.36%; collapsed to reduce identifiability). Clients recruited via the research participation system received course credit. All clients received compensation with gift vouchers if they completed the end-of-program survey ($10) and interview ($20).

Therapy group facilitators were nine women: eight trainee clinical psychologists studying at the Australian National University and one member of the research team[2]. Trainee psychologists were invited via email to sign up for G4H training and to obtain clinical experience running group therapy. Facilitators were aged between 23 and 29 years (M = 24.78; SD = 1.86). Most facilitators self-identified as White (n = 5; 55.56%), other ethnicities included Asian and Pacific Islander (n = 4; 44.44%; collapsed to reduce identifiability). They co-facilitated six groups in unique pairs. In addition to their intensive clinical training, all facilitators received a half-day training in G4H facilitation run by TC or JR (experts in G4H delivery), and received support and weekly supervision from a registered clinical psychologist (TC).

3.2.2. Materials

The G4H therapy program (Haslam et al., 2025) is a manualised treatment aimed at bolstering group-based connectedness. It has demonstrated efficacy in reducing loneliness and depression in Phase I, II, and III trials (Cruwys et al., 2022; Haslam et al., 2016, 2019). It comprises five sessions: four weekly sessions followed by a booster session 3-4 weeks later. Sessions typically last up to 90 minutes (average of 90.23 minutes in this study). The first session provides psychoeducation on the importance of groups for health and wellbeing. In the second session, clients complete a social identity map, which visually represents their group memberships (see Cruwys et al., 2016). The third and fourth sessions explore how clients can reconnect with existing groups and expand their social networks. The final session allows clients to

[2] Note that due to scheduling issues, one member of the research team (JR) co-facilitated one of the groups with a trainee psychologist. She is not a trainee psychologist but is a social identity researcher with extensive experience in facilitating G4H groups and a PhD in Psychology.

troubleshoot any challenges that may have arisen and re-complete their social identity maps.

3.2.3. Measures

In Stage 3 of the behaviour framework development, we examined the relationship of the identity leadership behaviours with measures of social identification and identity leadership. Both measures were completed by clients at the end of each session. The Four-Item measure of Social Identification (Leach et al., 2008; Postmes et al., 2013) was used to assess identification with the G4H group. Items (e.g., "I identify with my G4H group") were rated on a five-point scale (1 *Strongly Disagree* – 5 *Strongly Agree*). Client perceptions of their facilitators' identity leadership were measured using the Identity Leadership Inventory (ILI; Steffens et al., 2014), administered at the end of each session. Items (e.g., "The leaders embody what G4H stands for") are rated on a seven-point scale (1 *Strongly Disagree* – 7 *Strongly Agree*). We used the longer, 15-item version of the scale at Time 1 (after session 1) and Time 5 (after session 5) and the shorter, four-item version after all other sessions (due to the need to keep the end-of-session surveys extremely brief). Both the social identification and identity leadership measures are valid and reliable (Postmes et al., 2013; Steffens et al., 2014; van Dick et al., 2018). For example, the ILI demonstrates robust predictive validity and can accurately predict relevant outcomes, such as team identification and job satisfaction (e.g., Steffens et al., 2014; van Dick et al., 2018). Internal consistency ranged from acceptable to excellent for the social identification measure, $\alpha_{T1} = .89$; $\alpha_{T2} = .67$; $\alpha_{T3} = .78$; $\alpha_{T4} = .87$; and $\alpha_{T5} = .92$ and was good or excellent for the identity leadership measure, $\alpha_{T1} = .95$; $\alpha_{T2} = .93$; $\alpha_{T3} = .87$; $\alpha_{T4} = .83$; and $\alpha_{T5} = .95$.

3.2.4. Procedure

After screening clients and training facilitators (described above), six in-person therapy groups were run, each with five or six clients and co-facilitated by the same facilitators each session. If a facilitator was unwell, the remaining facilitator ran the group alone. If clients missed a session, they were offered a catch-up session with the facilitators. All sessions were video recorded. After each session, clients completed end-of-session surveys. Post-program, six clients participated in semi-structured interviews, conducted via Zoom or in person with AR or JD. The study received ethical approval from the Australian National University Human Research Ethics Committee (#2021/794). Informed consent was obtained from all participants for each part of the project (therapy sessions, video recording, surveys, interview). After data collection, development of the identity leadership framework occurred in three stages, described below.

3.2.4.1. Stage 1: Initial behaviour generation and follower consultation. To generate an initial list of potential identity leadership behaviours, AR watched all 30 therapy session videos (45 hours), starting with the first session of all six therapy groups (to capture a range of behaviours across different facilitators) and then watching all other sessions in sequence. Guided by definitions of each facet of identity leadership (see Table 3.1) and drawing from identity leadership theory and research AR coded each instance of a behaviour theoretically aligned with identity leadership. As some examples of prior research which guided this process, AR drew from the list of hypothesised group therapy identity leadership behaviours outlined by Robertson et al. (2023; Chapter 1) and the specific identity leadership behaviours mentioned in research on the 5R identity leadership training program (e.g., directing leaders to engage in

activities to explore shared values among the group and develop group goals; Fransen, Haslam, et al., 2020). AR also included collective language as a code from the outset, as it is the most extensively studied identity leadership behaviour (e.g., Fladerer et al., 2021; Steffens & Haslam, 2013; Stevens et al., 2019). To balance precision and practicality, all sessions were broken into 30-second increments, and each coded behaviour was listed in order under the corresponding increment (such that we could determine when the behaviour occurred to the nearest 30-second interval, rather than recording the exact second). If a behaviour extended into the next 30-second interval, it was not coded again in that interval, to clearly distinguish between repeat behaviours and extended behaviours.

Alongside the coding process, we also invited all clients to participate in semi-structured interviews, of which, six chose to participate. In these interviews, the interviewer explored the client's perceptions of what behaviours their facilitators did (or could have done) that aligned with the principles of identity leadership, and/or enhanced their experience. These data allowed us to generate a greater number of initial behaviours and provided an additional data source for triangulating findings from the quantitative surveys and coded videos. Interviews started with a general question "What was it like interacting with your therapy facilitators?", followed by questions about the facets of identity leadership (see Table 3.1 for details). To elicit specific behaviours, follow-up prompts were asked as needed, e.g., "Can you give some examples of things they did or said to make you feel this way?". The interviews also contained questions about social anxiety and experiences in G4H, which were beyond the scope of this paper (see Donaldson et al., 2025).

Table 3.1 *Identity leadership facet definitions and interview questions.*

Identity leadership facet	Definition	Interview Question
Identity Prototypicality	Demonstrates that they represent the unique identity of the therapy group.	"Were your leaders similar to you or your group? In what ways?
Identity Entrepreneurship	Creates a strong sense of shared identity among group members and facilitates group bonding and cohesion.	"Did the facilitators bring you all together as a group?"
Identity Advancement	Demonstrates that they have the needs and interests of the group at heart. In this context, the needs and interests primarily relate to improving clients' mental health.	"Did you feel like the facilitators had your best interests at heart?"
Identity Impresarioship	Creates structures, rituals, and activities that allow group members to live out the therapy group's shared meaning and identity.	"Did the facilitators initiate any activities or ask you to do any tasks that you felt helped bring the group together?"

Notes. Definitions adapted from Haslam, Reicher, et al. (2020).

To more holistically guide the development of the behaviour framework and capture the meanings and impact of behaviours in context, we analysed the interview data using Braun and Clarke's (2019) six-step reflexive thematic analysis process (i.e., rather than simply generating a list of client-mentioned behaviours). The primary goal of this analysis was to identify clusters of behaviours, explore their impact, and link the clusters to the four facets of identity leadership (where possible). This proceeded as follows: in the data familiarisation stage, AR and JD transcribed and read all interviews and discussed overall impressions. In the generating initial codes stage, AR coded all

responses, clustering related content and focusing on mentioned behaviours (e.g., clustering answers to entrepreneurship questions; clustering statements about 'safety'). In the generating themes stage, AR consulted JD and TC separately for guidance, leveraging their knowledge of G4H and identity leadership. In the reviewing themes stage, AR reduced theme overlap and ensured alignment with identity leadership theory. Lastly, the defining and naming themes and producing the report stages were done collaboratively among all coauthors when writing and editing the manuscript. The team's combined expertise in identity leadership, social anxiety, and group therapy facilitation informed the final themes included. Considering our expertise and the theoretical framework we were using explicitly during theme generation aligns with the reflexive thematic analysis approach (Braun & Clarke, 2019). This approach emphasises the active role of researchers in knowledge and theme production. As an example, knowledge about common group therapy facilitation strategies and therapist training allowed us to infer potential motivations behind certain facilitator behaviours (e.g., that facilitators might have mentioned what happened in other therapy groups to normalise client experiences and emphasise group uniqueness).

3.4.2.2. Stage 2: Collaborative refinement of the identity leadership behaviour framework. This stage aimed to refine the framework to reduce overlap between the behaviours and critically analyse each behaviour's relevance to identity leadership theory. The refinement process was primarily guided by how clearly each potential behaviour uniquely corresponded to an aspect of identity leadership using theory, research, and insights gained from the follower consultation in Stage 1. We sought to develop a concise framework of identity leadership behaviours with minimal

overlap with other models of 'good' leadership or therapy practice and which would likely be applicable across different contexts (not just therapy).

This process occurred collaboratively and iteratively with all coauthors. The authorship team have expertise in identity leadership theory and have applied it to various contexts (e.g., sports, therapy, politics, organisations). The behaviour list was refined iteratively through discussions and written feedback on drafts of the behaviour framework. Key factors considered in this stage are reported in the results.

3.4.2.3. Stage 3: Examination of the relationship between the final behaviour framework and quantitative measures. Stage 3 involved conducting quantitative analysis to examine the relevance of the behaviours to identity leadership and social identification measures. We hypothesised: (1) that the behaviours would be related to follower perceptions of their leaders' identity leadership and (2) that the behaviours would predict social identification over time (i.e., a key theorised outcome of identity leadership).

We tested the first hypothesis by examining the contemporaneous relationship between the rate at which each behaviour occurred within a therapy session and client ratings on the ILI (i.e., both were measured at all time points, which allowed us to examine their overall relationship over time). We examined each behaviour in a separate mixed-effects repeated measures model. Observations (N = 123 for all models except the group rituals behaviour, N = 99, and co-leadership behaviours, N = 92) were nested within clients (N = 31), who were nested in therapy groups (N = 6). Including random intercepts for therapy group or random slopes led to model convergence issues, likely due to no variance in identity leadership scores being attributable to differences between therapy groups and large correlations between the slopes and intercepts (see

Bates et al., 2018; Matuschek et al., 2017). We therefore only specified random intercepts for participants. Fixed effects in each model included the main effects for time and behaviour, as well as their interaction. The key outputs of interest were the main effect of each behaviour and its interaction with time. If significant, the behaviour main effect indicated that, at the start of therapy (i.e., when Time = 0), the rate at which a behaviour occurred predicted ratings on the ILI. If the interaction was significant, this indicated that the relationship between a behaviour and identity leadership changed over time. Specifying separate models for each behaviour was intended to conserve power which, for modelling the effect of leader behaviours (measured at Level 3: the therapy group), we expected to be negatively impacted by the small number of therapy groups (Snijders, 2005).

To test the second hypothesis, we examined whether the rate at which facilitators engaged in each behaviour in Session 1 predicted clients' social identification with their therapy group across therapy. The model specification was similar to the models predicting the ILI described above with the following key differences: (a) the outcome (social identification) was measured at all five time points but the predictor (the rate of a behaviour) was only included from the first session to model its longitudinal effects more accurately, (b) we added Session 1 social identification as a covariate to control for the effect of initial social identification levels on change over time and (c) we did not have a model for co-leadership (behaviour 12) as there were no instances observed in Session 1.

To minimise the likelihood of making a Type I error when running multiple models to test each hypothesis (see Rubin, 2024), we used the Benjamini-Hochberg method to control the false discovery rate (FDR; Benjamini & Hochberg, 1995, see also Glickman

et al., 2014 for a non-mathematical explanation). Put simply, the FDR is the proportion of all confirmed hypotheses that are spurious (i.e., Type I errors or 'false discoveries'). We chose to control the FDR rather than the experiment-wise or family-wise error rate as the latter methods are considered too conservative for exploratory research of this nature (i.e., we did not want to inflate the Type II error rate; Verhoeven et al., 2005). See Appendix A for more detailed information about how this method was implemented.

In both the identity leadership and social identification analyses, all variables except time (coded 0 – 4; Sessions 1 – 5) were standardised before analysis. This includes the behaviours, which were converted to a rate for each session (i.e., dividing the raw frequency of behaviours by the session duration in minutes) and then standardised (converted to a z-score) for ease of comparison across behaviours in each session and time. The main effect of the behaviour on the outcome (identity leadership or social identification) is therefore a standardised coefficient (β), but the main effect of time and interaction are semi-standardised (*b,* a raw one-unit change in time corresponding to a standard deviation increase in the dependent variable; Stavig, 1977). All analyses were conducted in *R* (Version 4.4.1) using the *RStudio* interface. Mixed-effects models were calculated using *lme4* (Bates et al., 2015) and *lmerTest* (Kuznetsova et al., 2017), which estimates model degrees of freedom and *p*-values using Satterthwaite approximation (see Luke, 2017). Variance explained by each model (R^2 values) was estimated using the *r2glmm* package (Nakagawa & Schielzeth, 2013).

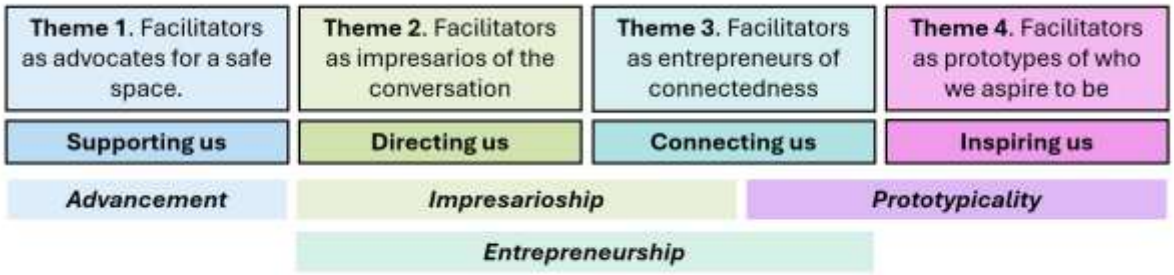
3.3. Results

3.3.1. Stage 1: Initial behaviour generation and follower consultation

Stage 1 led to the development of an initial list of 47 behaviours (see Appendix B). The follower consultation process led to the generation of four themes. The themes,

including the facets of identity leadership that they best capture, are summarised in Figure 3.1. The age and gender of each interviewee are listed the first time they appear, and names are pseudonyms (most of which were chosen by the interviewee).

Figure 3.1 *Interview themes and their relation to the four facets of identity leadership.*



3.3.1.1. Theme 1. Supporting us: Facilitators as advocates for a safe space.

Interviewees indicated that facilitators primarily demonstrated identity advancement by creating a safe space, especially through their considerate responses to clients. Interestingly, interviewees often struggled to generate specific behaviours related to advancement, inherently assuming that the facilitators wanted the best for the group. For example, Nick (man, 19 years) said, "*They're therapists after all! And they were going through this booklet to help us*."

Interviewees cited both verbal and non-verbal (e.g., "*nodding*", "*welcoming eye contact*") elements as crucial to setting up this safe space. As some examples,

> "*I think it's the way that they react. When I, when anyone share any kind of experience. Um, they're very positive. Non-judgemental, that people feel safe when they have to disclose something that is a little bit more like private*" (Cerys, woman, 23 years).

> "*The feedback that they gave us really reinforced that…sense, that familiarity, that we could talk about these sensitive topics to them*" (Nick).

> "[it was] *not what they said, but the way they said it, like the tone and delivery just seemed very calm and caring and approachable"* (Hilary, woman, 38 years).

This suggests facilitators demonstrated advancement by cultivating a safe space and responding appropriately to client disclosures. The practice of providing supportive feedback is common in therapy, but also has broader applications. Indeed, identity leadership has been found to improve group functioning and wellbeing in part because it fosters a sense of psychological safety in other research contexts (Fransen et al., 2020; Haslam, Reutas, et al., 2023). Drawing inspiration from therapy practice, leaders in varied contexts could be directed to use minimal encouragers (e.g., nodding) and respond thoughtfully to follower concerns to enhance psychological safety.

3.3.1.2. Theme 2. Directing us: Facilitators as impresarios of the conversation. Interviewees perceived their facilitators to demonstrate impresarioship primarily through the skilful management of the therapy conversation. That is, their ability to "*drive the conversation*" and keep it "*flowing*". This comprised several components. First, facilitators showed mindfulness of practical structures that supported conversation and flexibility in their delivery, such as setting up a circle of chairs rather than desks or adapting activities (e.g., from pairs to whole group) to reduce awkwardness. Second, they clearly set expectations, also aligning with identity entrepreneurship. Multiple interviewees highlighted the benefits of facilitators setting clear group rules and expectations. As Georgia (woman, 19 years) explained: "*going back to that culture of openness. I'm not sure how it came about, but we definitely…create[d] some rules. Maybe that opened up the discussion*".

Third, facilitators carefully managed shifts between tangential conversations and manualised content: "*know[ing] when to talk, but…also know[ing] when to stay silent"*

(Nick). In particular, facilitators helped to continue tangential conversations when they were meaningful to the group identity (e.g., how to deal with exam stress). For example,

> "[the facilitators] *were good at listening, but also knew when to interject and, sort of, yeah move on to other things…they followed the program, but they also allowed for like if people went off on tangents a bit*" (Hilary).
>
> *"when we went off on that tangent, [the facilitators] were like facilitating that and…continuing to ask the question around to the rest of the group…I think that was really nice that we could share that*" (Georgia).

Thinking of conversation management as a form of identity impresarioship may apply to other leadership contexts, particularly in ensuring that group tasks and norms foster genuine and warm connections (which is also highly relevant to Theme 3). For example, in a workplace setting, a leader might manage meetings to allow time for both task-focused discussions and personal sharing (i.e., side conversations). By skilfully managing side conversations and weaving moments of connection into group tasks, leaders might cultivate an environment where warm relationships develop naturally alongside work processes, which may ultimately enhance productivity and wellbeing. Initial support for this proposition in a workplace context can be drawn from studies demonstrating that genuine friendships at work enhance meaning, productivity, wellbeing, and job satisfaction (Klinghoffer et al., 2019; Mao et al., 2012; Patel & Plowman, 2022; Xiao et al., 2020).

3.3.1.3. Theme 3. Connecting us: Facilitators as entrepreneurs of connectedness. Interviewees highlighted specific facilitator behaviours that fostered a cohesive sense of "us" and the feeling of "*doing it [therapy] together*". This theme intersected most of the facets of identity leadership, reflecting the overarching goal of

identity leaders: to create a shared sense of us. Facilitators employed several strategies to build connectedness. First, they prompted people to share similar stories and experiences, enhancing relatability. For example, Dale (man, 31 years) noted that "*the facilitators, they asked us one by one, the same question. And after hearing the stories of other participants I could relate to them more."* Second, all interviewees mentioned the effectiveness of the social identity mapping activity (therefore reflecting impresarioship in addition to entrepreneurship) in Sessions 2 and 5 (Cruwys et al., 2016) for highlighting connections between clients' life experiences and social worlds. For example,

> "*Just discussing life experiences really brought us together…it was interesting to realise that you're not alone out there. That fostered our connections with one another…doing that activity [the social identity maps] with the support groups kind of helped as well*" (Nick).

Interviewees also mentioned that they liked it when facilitators compared the maps of their G4H members to other therapy groups they had facilitated. For example, Georgia said she liked it when her facilitators *"were able to compare other groups with our group, for like past experiences and stuff like that."* This helped to normalise diversity in social worlds (e.g., a small number of connections). It also highlighted unique positive aspects of their group (i.e., positive group distinctiveness), which prior research has positioned as key to effective group communication (Sullivan & Short, 2011) and able to be fostered by identity leadership (Schei et al., 2023).

Third, facilitators joining in on the activities was reported to foster a sense that everyone (including the facilitators) was connected as part of the same group. This aligns closely with prototypicality ("being one of us"). For example,

> "*It probably helped a lot that [the facilitators] shared when they went around… that was really good because it didn't feel like we were being made to do things for them to observe, like, we were all doing it together"* (Felix, non-binary, 23 years).
>
> "*it wasn't where they were coming across as like teacher and student, where the teacher would be up the front, they would give out the homework, the student completes the homework. No, the teacher was like, 'I'm doing it with you'. All the leaders were like, 'Let's do this together.' So I think that helped with the group*" (Georgia).

These behaviours can easily be applied to other leadership contexts to foster a greater sense of connectedness among followers. For example, managers could join in on team-building activities with their staff (rather than facilitating or observing them) or teachers could join in on learning activities with their students. Interestingly, a version of social identity mapping is already part of the 5R identity leadership training (Haslam et al., 2017), further evidencing its connection to identity leadership and usefulness in leadership contexts.

3.3.1.4. Theme 4. Inspiring us: Facilitators as prototypes of who we aspire to be. To demonstrate that they were prototypical, interviewees highlighted the importance of facilitators disclosing experiences or identities that demonstrated their similarity to members on group-relevant dimensions. This helped to make the facilitators and content more "*relatable*". Specifically, interviewees felt that their facilitators were "*part of the in-group*" (Felix) when they disclosed or demonstrated: (a) that they also experience social anxiety or troubles with their social worlds (i.e., directly

tied to the group purpose) and (b) that they were postgraduate students at the university where the groups were held (at which all interviewees were students).

Regarding social anxiety, Cerys explained that she did not want her facilitator to be a "*perfect human being*", and that facilitators showing *"a little bit level of anxiety, made me feel like, 'okay, it's normal to feel anxious'".* Regarding student identity, Nick said that the facilitators being students,

> "*helped with being able to discuss these topics, because we knew what the shared experiences were like. We all have experiences coming to uni. We all have experiences of academic pressures. So we can all relate to one another. It helps with the familiarity. That's probably the reason why we were able to connect so quickly after just 2, 3 sessions*."

Connecting over these shared identities and experiences appeared to give interviewees a feeling that their leaders understood their experiences (see Du et al., 2024). Another key consideration here was that facilitators only showed "*a little bit*" of anxiety (rather than experiencing clinical anxiety levels like group members) and were postgraduates ("*it would probably be weird if they were undergrads*", Felix). This aligns with the idea that it is more important for identity leaders to represent a group's *aspirational* prototypicality (who we want to be), rather than be exactly like the group in the present moment (i.e., who we are now; Robertson et al., 2022; Steffens, Munt, et al., 2021; van Knippenberg et al., 2024). While self-disclosure is common in therapy (Johnsen & Ding, 2021), the strategic use of self-disclosure to highlight relevant aspirational identities (i.e., demonstrate prototypicality) could be valuable in many leadership contexts.

3.3.2. Stage 2: Collaborative Refinement of Identity Leadership Behaviour Framework

After several rounds of refinement and feedback, we arrived at a final framework consisting of 12 identity leadership behaviours (presented in Table 3.2 with some therapy-related examples and a rationale for each behaviour). The most frequent behaviour was the use of collective language, occurring an average of 116.7 times per session (approximately 1.3 times per minute; see Appendix C for all behaviour frequencies). The least frequent behaviour was developing rituals, which occurred less than once per session on average (about once every 2 hours). The refinement process broadly included consideration of (1) parsimony of the framework, (2) theoretical justification of each behaviour as an example of identity leadership, (3) alignment of each behaviour with the identity leadership facets, and (4) the perspective of followers.

3.3.2.1. Parsimony of the Framework. To reduce the number and overlap of behaviours, we combined similar behaviours under broader categories. For example, we created a new category called “co-leadership,” which encompassed actions such as facilitators leading group brainstorming sessions and providing opportunities for group members to share their knowledge. We also removed two infrequently observed behaviours—creating physical items such as rules sheets for the group (impresarioship) and demonstrating personal investment in the group (e.g., working on goals outside sessions; prototypicality). These occurred in less than half of the sessions (i.e., less than 15 times across the 30 recorded sessions), so it was difficult to calculate their relationship with the ILI and social identification as we planned in Stage 3. However, it is likely that these infrequent behaviours are still examples of identity leadership and should be considered for future research.

3.3.2.2. Theoretical Justification. Most refinements occurred through collaborative consideration of whether the behaviour (uniquely) aligned with the definition of identity leadership and could be clearly argued as such using evidence from prior literature, theory, and the follower consultation process. Definitions of specific facets were used (see Table 3.1), as well as the key guiding principle that behaviours were identity leadership when they sought to create a shared sense of identity within the group. This led to the removal of several behaviours that, although good leadership or good therapy practice, were not necessarily identity leadership. As an illustrative example of this process, we originally coded nonspecific small talk as an entrepreneurship behaviour on the basis that it helped the group to bond over topics such as what happened on the weekend or their feelings about the weather. However, as part of our consolidation process it was agreed that making small talk, while likely good for easing participants into sessions and facilitating bonding, was not specifically identity leadership. By contrast, a related entrepreneurship behaviour (discussing ingroup topics) was retained, which captured small talk specifically about topics that highlighted shared identity and interests outside of therapy (being a student, being a churchgoer, etc.) and therefore was considered more closely linked to identity leadership.

Along similar lines, another group of behaviours that were excluded were those constituting good practice but that may have been individuating rather than group focused. For example, one of the removed behaviours was catering to particular participant needs, such as getting a table to accommodate a participant with a sore wrist. Although this is an inclusive leadership practice, we agreed that focusing on one participant's needs is likely individuating, whereas tailoring activities and structures *for*

the group was more reflective of identity leadership and this behaviour was retained. That is, changing the format of an activity or the room to support the needs of the group—for example, when participants expressed a preference for speaking in a group and hearing all members' perspectives rather than talking in pairs—was more reflective of identity leadership than adapting activities for one follower. This highlights a point for consideration, that small variations of inclusive leadership practices may make them more effective (e.g., saying that the group would benefit from an accessible change to a structure, rather than singling out a follower with additional needs).

3.3.2.3. Alignment with Identity Leadership Facets. We extensively discussed the correspondence between each behaviour and the facets of identity leadership. Even within each behaviour, different instances could align with a different facet. For example, at times talking about ingroup topics was best understood as an instance of entrepreneurship, creating a shared sense of identity and drawing attention to what makes the group unique (e.g., a shared interest in video gaming). Other times it served as a group-relevant icebreaker to build connection at the start of a session for group members who were reluctant to speak (an instance of advancement). Although the 12 behaviours are classified into a discrete facet in Table 2, this is a tentative classified and some may be better thought of as relating to the global construct of identity leadership.

3.3.2.4. Follower Perspectives. Finally, we aimed to incorporate follower (client) perspectives in our refinement and development of the rationale for each behaviour's alignment with identity leadership (see rationale column in Table 2). This required balancing the incorporation of their perspectives with the need for specific actions that were observable to an outside coder and able to be generalised to contexts outside of G4H groups. Some client suggestions were not included in the final list because they

were too nonspecific or not readily observable to an outside coder. For example, it was difficult to reliably determine whether clients perceived facilitator feedback as nonjudgmental and supportive. Instead, we included more specific, observable behaviours that might exemplify this (e.g., facilitators normalising client experiences). To ensure generalisability across various contexts, we also aimed to exclude client-listed behaviours that merely reflected standard G4H program content (e.g., social identity mapping), focusing on actions that demonstrated leadership beyond the prescribed intervention activities (not least because behaviours that occurred at set points during therapy provided no variability for analysis in Stage 3). This approach ensured that our final behaviours were observable, generalisable, and informed by both theoretical understanding and follower experiences.

Table 3.2 *Group therapy identity leadership facilitator behaviours.*

Identity Leadership Facet	Behaviour	Context-Independent Definition	Therapy-Relevant Examples	Rationale
Prototypicality	1. Self-disclosure	Discloses a relevant personal experience	• Talks about own issues dealing with incompatible groups (relevant to group discussion) • Discloses own challenges finding friends in local area	Sharing about oneself in ways that highlight similar experiences was theorised to demonstrate that the leader is "one of us", as mentioned by clients in Theme 4.
	2. Joins in activities	Joins in on a group activity as a regular group member would	• Fills in answers to activity in own copy of workbook • Does activity at the same time as group (e.g., social identity map) • Discusses own answers to question when sharing around the circle	Joining in activities with followers was theorised to demonstrate that leaders are prototypical group members. Followers mentioned leaders joining in as being key to bringing the group together in Theme 3.
Entrepreneurship	3. Collective language	Refers to the group using collective pronouns	• Refers to therapy group as "we" and "us" • Refers to a broader shared human experience, e.g. "sometimes when *we* feel stressed"	Collective language was theorised to represent entrepreneurship based on prior research (e.g., Stevens, Rees, Steffens, et al., 2019).
	4. Talks about ingroup topics	Brings attention to shared identity outside of specific group purpose (i.e., talks about what makes 'us' specifically unique)	• Small talk about "ingroup" non-therapy related topics, such as university or Church (when group members disclosed their shared faith) • Talks about unique challenges and opportunities specific to local area	Discussing ingroup topics that were unrelated to the specific purpose of the group was theorised to help the group to bond over broader shared identities. Followers reported that this was helpful in Themes 2 (i.e., tangential topics assisted with bonding) and 4 (that it was useful when facilitator could also

				participate in discussions about, for example, being a student).
	5. Brings attention to positive group dynamics	Comments on process or positive group dynamic (i.e., highlights shared way of *doing* and *being*)	• Comments that group have been talking a lot more this session • Comments on unique ways that group are doing an activity or think (compared to other therapy groups or ways the group did the activity or thought in prior sessions)	Commenting on positive group dynamics (often called 'process' in therapy; Beck & Lewis, 2000) was theorised to embed a positive sense of group identity. Comparing group to relevant (positive) out-groups (other therapy groups or our group in the past) was mentioned by followers as facilitating bonding and an understanding of how their group was unique (Theme 3).
	6. Discusses group purpose	Outlines or reiterates the purpose of the group	• Reassures client who finds it difficult to talk to new people/feeling lonely/etc. by saying "That's what G4H is about" or "That's why we're all here"	Discussing the purpose of the group was theorised to explicitly craft a sense of who we are by reiterating the roles of group members and the reason for the group's existence.
	7. Uses follower language	Uses followers' language, wording, examples when providing explanations or education	• Gives example for an activity or psychoeducation that is related to broader group identities (e.g., groups that students might have in their lives) • Uses a client's experience as an example case • Uses clients' wording and language when explaining concepts	Tailoring content to the group by incorporating their unique wording and examples into it was theorised to help leaders highlight the value of group member perspectives, ensure the relevance of group knowledge and activities, and highlight the unique ways the group views the world.
Advancement	8. Normalises experience	Helps group member understand that their thoughts, feelings, behaviours, or	• Makes normalising remarks, such as "These things happen to all of us", "That is a very normal/common experience", or "We all feel like that sometimes"	Normalising is primarily a therapy behaviour but its focus on highlighting shared connection to the experiences of the broader identity of "humanity" was theorised to connect it to identity leadership. It was placed in advancement as it advances the

		experiences are common and normal		psychological needs of the group. Normalising was likely part of the "positive feedback" that followers reported their leaders provided them in Theme 1, which was reported to foster a sense of psychological safety.
	9. Deals with difficult group member behaviours	Manages difficult, disruptive, or otherwise challenging group member behaviour to ensure that group environment is safe and productive	• Encourages clients not to interrupt group activities out of respect for their fellow group members • Encourages clients to abide by agreed-upon group rules	Managing the group environment by addressing difficult behaviour was theorised to advance the needs of the group by creating a safe environment. This is also related to entrepreneurship, as it was usually framed in terms of violating group rules, which reinforces the way "we" do things. Followers reported the benefits of rules in Theme 2.
Impresarioship	10. Tailors activities and structures in response to group needs	Tailors delivery of content and format of planned activities to the needs of the group	• Suggests that homework could be done at the start of sessions given that several clients are busy at the moment • Modifies discussion questions or format to accommodate clients (e.g., if they are confused or would like to share in pairs instead of with the whole group) • Changes instructions in manual to better align with the group (e.g., only need to set one goal because it is exam period and clients are working on study-related goals) • Adds discussion about social anxiety to session (i.e., not in manual but relevant to group)	Tailoring group activities and structures to align with the group identity and needs was theorised to demonstrate leaders' commitment to building structures that best supported the group. Followers reported that leaders being flexible in how discussions and activities operated was key to living out and discussing important aspects of their identity (Theme 2). It is worth noting that followers may not have noticed many of these facilitator adjustments as they were usually seamlessly integrated into the existing structure.

11. Develops group ritual	Develops or promotes an activity for the group to do regularly	• Offers tea and coffee before sessions • Suggests that people can stay back to discuss anything further or ask questions after sessions • Sets aside time for quiet writing and reflection at the end of each session • Begins group with a brief catch up on what happened that week (in response to clients saying they would like to do that each week)	Developing and promoting rituals for the group was theorised to add extra elements to sessions that aligned with what followers needed (e.g., coffees or quiet writing time) that was perhaps not part of planned activities. Doing so also may have helped to bring the group together in a shared, unique activity.
12. Leads collaboratively with followers	Leads collaboratively with followers, in ways that allow followers to support each other and live out identity	• Prompts group to provide advice and solution ideas to other group members • Leads group brainstorming sessions • Asks client to educate the group on a relevant topic • Encourages clients to provide feedback to each other	The value of shared or informal leadership has previously been linked to identity leadership in sports contexts (e.g., Fransen et al., 2014; Mertens et al., 2021). Leaders providing opportunities for followers to lead and provide social support to each other (e.g., Avanzi et al., 2015) was theorised to bring the group together and help them to live out their identity as group members (especially given that the group purpose was related to providing advice and support to others).

3.3.3. Stage 3: Examination of the relationship between the final behaviour framework and quantitative measures.

3.3.3.1. Preliminary analysis. Full Information Maximum Likelihood was used to handle missing data (17.8% of end-of-session survey data were missing), which allows all available observations to be included in the final model, widely considered to be an effective way to manage missing longitudinal data including in clinical trial data (e.g., Beunckens et al., 2005; Lane, 2008; Larsen, 2011; Molenberghs, 2004). Regarding assumptions, there were some issues with negative skew (due to most participants rating social identification and identity leadership high and a few participants rating it low); however, no transformations were applied to the data before analyses, given that mixed-effects models are robust to violations of distributional assumptions (Schielzeth et al., 2020). Means and standard deviations for key measures in each session are depicted in Table 3.3 and their correlations across all time points are depicted in Table 3.4. Intraclass correlations indicated that a mixed-effects approach was appropriate. For identity leadership scores (H1), 10% of the variance was explained by differences in time, and 57.3% was explained by individual differences. Differences between therapy groups explained near-zero variance (likely reflecting low power to detect effects at this level due to the small sample size of six therapy groups; Maas & Hox, 2005; Snijders, 2005). For social identification scores (H2), 5.0% of the variance was explained by differences across time points, 59.2% was explained by individual differences, and 5.4% was explained by differences between therapy groups.

Table 3.3 *Descriptive statistics for key measures*.

Variable	Session				
	1	2	3	4	5
	Mean (*SD*)	*Mean* (*SD*)	*Mean* (*SD*)	*Mean* (*SD*)	*Mean* (*SD*)
Social identification	3.84 (0.74)	3.96 (0.60)	4.15 (0.61)	4.38 (0.70)	4.13 (0.97)
Identity leadership	6.15 (0.72)	6.18 (0.75)	6.53 (0.60)	6.56 (0.70)	6.59 (0.47)
Identity prototypicality	6.00 (0.89)	6.00 (0.89)	6.61 (0.66)	6.48 (0.98)	6.55 (0.56)
Identity entrepreneurship	6.26 (0.77)	6.21 (0.83)	6.52 (0.79)	6.67 (0.73)	6.62 (0.51)
Identity advancement	6.19 (0.77)	6.17 (0.92)	6.52 (0.73)	6.57 (0.75)	6.76 (0.41)
Identity impresarioship	6.15 (0.85)	6.33 (0.64)	6.48 (0.67)	6.52 (0.98)	6.38 (0.72)

Notes. SD = Standard Deviation. Sample size varied at each time point, n_{T1} = 31; n_{T2} = 24; n_{T3} = 23; n_{T4} = 21; and n_{T5} = 24. Social identification had a maximum score of 5 and the identity leadership measures had a maximum score of 7.

Table 3.4 *Repeated measures correlations between key variables computed across all time points*.

Variable	1	2	3	4	5	6
1. Social identification	1					
2. Identity leadership	.26*	1				
3. Identity prototypicality	.23*	.87*	1			
4. Identity entrepreneurship	.24*	.84*	.62*	1		
5. Identity advancement	.26*	.82*	.66*	.57*	1	
6. Identity impresarioship	.10	.76*	.50*	.59*	.47*	1

Notes. * *p*-value significant after correcting for multiple tests using Benjamini-Hochberg method (grouping p-values of the 15 correlations). Repeated measures correlations calculated using *rmcorr* package (Bakdash & Marusich, 2017). *N* = 93.

3.3.3.2. H1. Results are displayed in Table 3.5. After FDR correction (grouping the 24 tests for both the main effect of each behaviour [*n* = 12] and the interactions with time [*n* = 12][3]), all behaviour-related main and interaction effects for the ILI were no

[3] We did not include p-values for the main effect of time in our correction as the general trend of identity leadership over time was not closely related to our hypothesis test of the relationship between identity leadership behaviours and identity leadership ratings.

longer significant. The significant, positive main effect of time (ranging between β = .20 – .23 depending on the behaviour in the model) indicated that identity leadership ratings significantly increased over time, at the mean rate of the identity leadership behaviour in that model. Given that we aligned each behaviour with a particular facet of identity leadership, we also examined the relationship of the behaviours with each identity leadership subscale (see Appendix D for this analysis). Similarly, although there were some significant effects before correction, after correcting for multiple tests using the Benjamini-Hochberg method, all effects were nonsignificant. Overall, this analysis suggests that the rates of identity leadership behaviours we coded were unrelated to ratings of identity leadership on the ILI.

Table 3.5 *Mixed-effect models of the contemporaneous relationship between ILI scores and the rate of identity leadership behaviours.*

	Time				Behaviour					Time*Behaviour					Model Fit		
Model	*b*	SE	*df*	*p*	β	SE	*df*	*p*	*Sig?*	*b*	SE	*df*	*p*	*Sig?*	R^2	$X^2(2)$	*p*
Self-disclosure	**.21**	.04	95.01	<.001	.12	.11	114.87	.279	N	-.03	.04	99.85	.408	N	.11	1.16	.560
Joins in activities	**.21**	.04	95.12	<.001	-.18	.10	100.71	.065	N	.07	.04	100.80	.088	N	.12	3.53	.171
Collective language	**.20**	.04	95.55	<.001	-.02	.10	108.64	.821	N	.04	.04	98.75	.261	N	.11	1.94	.379
Talks about ingroup topics	**.21**	.04	95.09	<.001	.23	.10	108.52	.020	N	-.07	.04	95.79	.064	N	.13	5.58	.061
Comments on positive group dynamics	**.21**	.04	95.36	<.001	.10	.10	109.99	.330	N	-.05	.04	97.89	.167	N	.11	1.91	.384
Discusses group purpose	**.21**	.04	95.47	<.001	-.06	.10	111.49	.564	N	.02	.04	100.88	.578	N	.10	0.37	.831
Uses follower language	**.20**	.04	94.98	<.001	-.18	.10	103.66	.070	N	.03	.04	104.57	.457	N	.12	5.14	.077
Normalises experience	**.20**	.04	94.71	<.001	.13	.09	102.47	.159	N	-.11	.04	99.40	.013	N	.13	6.62	.037
Deals with difficult behaviours	**.21**	.04	95.61	<.001	.12	.10	105.19	.248	N	-.04	.04	101.17	.308	N	.11	1.36	.508
Tailors activities or structures	**.21**	.04	95.13	<.001	.12	.10	105.81	.245	N	-.05	.04	106.71	.221	N	.11	1.54	.462
Develops group ritual	**.23**	.05	71.83	<.001	-.30	.11	78.95	.006	N	.13	.05	72.90	.015	N	.10	7.68	.021
Leads collaboratively	**.22**	.05	64.17	<.001	.17	.13	68.47	.201	N	-.08	.05	69.76	.123	N	.08	2.20	.333

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no). All models *N* = 123 except "Develops group ritual", *N* = 99 (due to no instance of the behaviour in session 5), and "Leads collaboratively", *N* = 92 (due to no instance of behaviour in session 1).

3.3.3.3. H2. Results are displayed in Table 3.6. After FDR correction (grouping the 22 tests for both the main effect of each behaviour [*n* = 11] and the interactions with time [*n* = 11]), significant increases in social identification over time were predicted by the rate at which facilitators normalised their experiences (see Figure 3.2 for the interaction plots for all behaviours). Unexpectedly, there were negative interaction effects for the rate that facilitators joined in on group activities, used collective language, and developed group rituals in Session 1. Given that social identification increased over time, this interaction is best conceptualised as the behaviours predicting less increase in social identification over time.

No main effects of behaviour were significant. The significant main effect of time observed in all models indicated that social identification scores increased over time, when the rate of the identity leadership behaviour was at its mean and controlling for initial levels of social identification (i.e., when they were at their mean level). Additionally, in all models, the Session 1 social identification covariate was significant. The purpose of its inclusion was primarily so that we could separate the effects of change over time from the initial levels of social identification (as was done in Cruwys, Haslam, Haslam, et al., 2022).

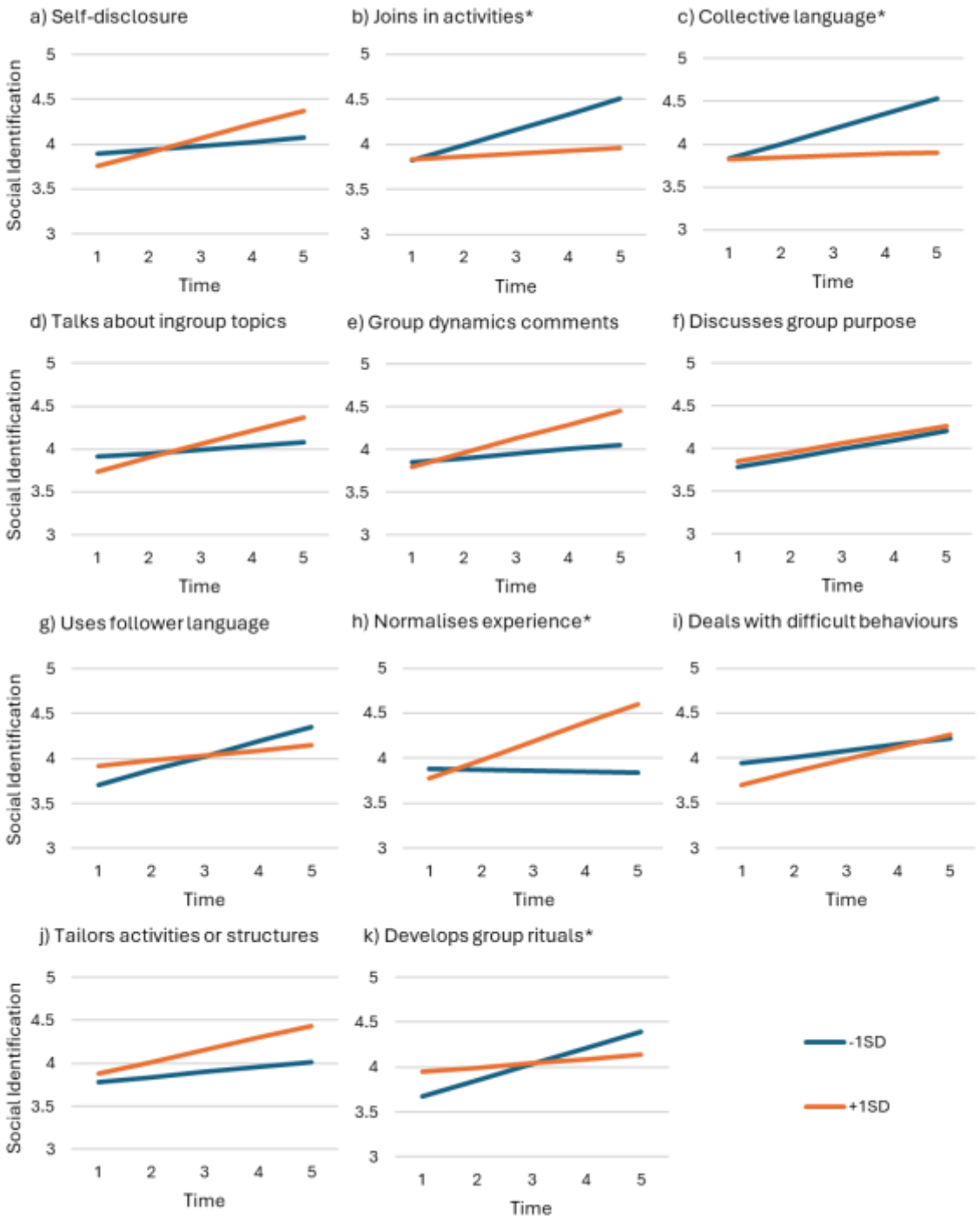
Before correction, there were also significant increases in social identification over time associated with the rate at which leaders self-disclosed, talked about ingroup topics, and commented on positive group dynamics. Significant decreases were observed for using clients' language. However, these effects were not robust following correction and so may be false positives.

Table 3.6 *Mixed-effect models of the longitudinal effect of Session 1 identity leadership behaviours on social identification.*

	Time				Session 1 Social id.				Behaviour					Time*Behaviour					Model Fit		
Behaviour	*b*	SE	df	p	β	SE	df	p	β	SE	df	p	Sig?	*b*	SE	df	p	Sig?	*R2*	$X^2(3)$	p
Self-disclosure	**.13**	.04	98.88	<.001	**.72**	.10	32.53	<.001	-.09	.11	62.33	.405	N	.07	.04	100.44	.036	N	.55	37.82	<.001
Joins in activities	**.14**	.03	99.40	<.001	**.69**	.09	32.47	<.001	.001	.11	63.64	.989	N	**-.09**	.03	96.39	.010	Y	.57	42.98	<.001
Collective language	**.13**	.04	99.58	<.001	**.69**	.09	32.90	<.001	-.002	.11	68.99	.986	N	**-.10**	.04	104.66	.009	Y	.58	43.05	<.001
Talks about ingroup topics	**.13**	.04	98.83	<.001	**.72**	.10	32.74	<.001	-.11	.11	61.40	.313	N	.08	.03	99.39	.027	N	.55	38.22	<.001
Comments on positive group dynamics	**.14**	.04	98.86	<.001	**.72**	.09	32.82	<.001	-.03	.12	63.64	.776	N	.07	.04	99.30	.046	N	.55	38.20	<.001
Discusses group purpose	**.14**	.04	99.10	<.001	**.71**	.10	33.18	<.001	.04	.12	65.99	.712	N	<.001	.04	103.20	.996	N	.54	33.43	<.001
Uses follower language	**.14**	.04	99.01	<.001	**.72**	.10	33.14	<.001	.14	.11	57.89	.219	N	-.07	.03	95.47	.039	N	.54	37.54	<.001
Normalises experience	**.13**	.03	99.24	<.001	**.69**	.09	32.70	<.001	-.07	.11	65.49	.528	N	**.15**	.04	104.55	<.001	Y	.59	50.22	<.001
Deals with difficult behaviours	**.14**	.04	99.25	<.001	**.70**	.10	33.40	<.001	-.16	.11	60.53	.167	N	.05	.03	98.49	.175	N	.54	35.67	<.001
Tailors activities or structures	**.13**	.04	99.41	<.001	**.69**	.09	32.25	<.001	.06	.12	64.51	.592	N	.05	.04	96.63	.141	N	.56	38.13	<.001
Develops group ritual	**.15**	.04	99.45	<.001	**.72**	.10	33.51	<.001	.18	.11	57.37	.121	N	**-.09**	.03	96.53	.009	Y	.55	40.11	<.001

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. Social id = social identification with G4H group. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no).

Figure 3.2 *Effect of identity leadership behaviours on social identification over time.*

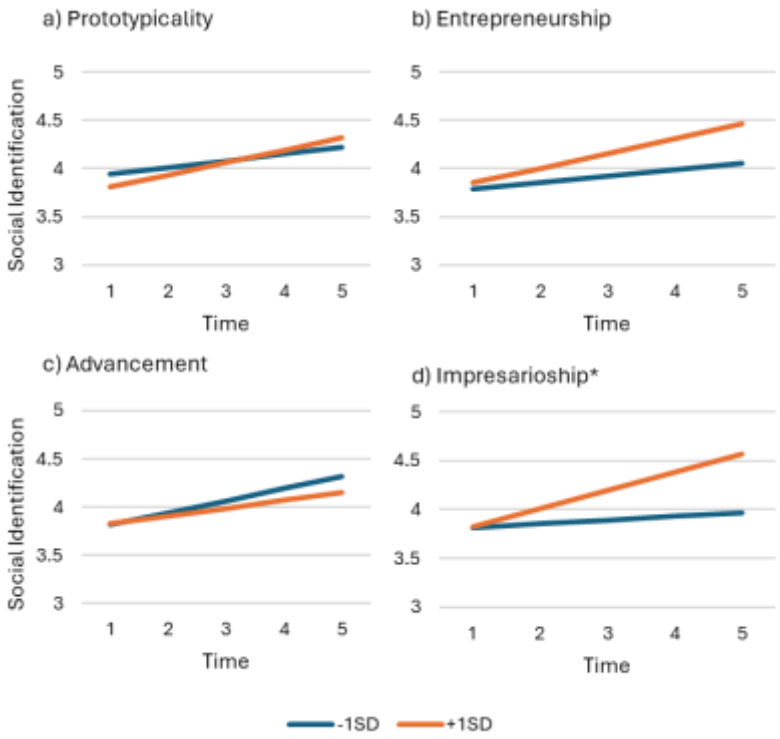


Notes. Stars indicate interactions that are significant after correction. Lines depict the trend of social identification scores (estimated marginal means) across therapy for leaders engaging in that behaviour at the rate of one standard deviation above (orange) or below (blue) the mean for all groups. These models adjust for initial social identification scores, allowing for examination of changes in social identification over time while controlling for baseline levels.

3.3.3.4. Additional analysis: Effect of ILI scores on social identification.

Given the unexpected lack of support for our hypotheses, we examined whether followers' ratings of their leaders using the ILI in Session 1 would predict increases in social identification over time, hypothesising that they would, based on prior literature mentioned in the introduction. Models were specified and corrected in the same way as those described above for H2. Results are displayed in Table 3.7 and interaction plots for each facet are in Figure 3.3. Interestingly, there were no main effects observed and only identity impresarioship ratings predicted increases in social identification over time.

Figure 3.3 *Effect of identity leadership on social identification over time*.



Notes. Stars indicate interactions that are significant after correction. Lines depict the trend of social identification scores (estimated marginal means) across therapy for leaders engaging in that behaviour at the rate of one standard deviation above (orange) or below (blue) the mean for all groups. These models adjust for initial social identification scores, allowing for examination of changes in social identification over time while controlling for baseline levels.

Table 3.7 *Mixed-effect models of the longitudinal effect of Session 1 ILI scores on social identification.*

	Time				**Session 1 Social id.**				**Identity Leadership**					**Time*Identity Leadership**					**Model Fit**		
Identity leadership facet	*b*	SE	df	p	β	SE	df	p	β	SE	df	p	Sig?	*b*	SE	df	p	Sig?	*R2*	X^2	p
Prototypicality	**.14**	.04	99.84	<.001	**.71**	.10	32.55	<.001	-.01	.12	62.62	.898	N	.03	.04	99.22	.466	N	.54	33.89	<.001
Entrepreneurship	**.14**	.04	99.53	<.001	**.71**	.09	32.60	<.001	.04	.11	66.65	.716	N	.06	.04	97.55	.104	N	.56	38.51	<.001
Advancement	**.14**	.04	99.02	<.001	**.73**	.10	32.93	<.001	.001	.12	59.73	.963	N	-.03	.04	96.59	.415	N	.54	34.15	<.001
Impresarioship	**.15**	.04	99.78	<.001	**.68**	.09	32.67	<.001	.01	.11	68.41	.967	N	**.10**	.03	97.99	.005	Y	.59	45.60	<.001
Global identity leadership score	**.14**	.04	99.57	<.001	**.70**	.10	32.69	<.001	.01	.12	63.29	.923	N	.04	.04	97.71	.259	N	.54	35.33	<.001

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. Social id = social identification with G4H group. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no).

3.4. Discussion

This study examined, for the first time, the specific behaviours that constitute identity leadership. We used an iterative, collaborative, and theory-driven process to develop the first framework of identity leadership behaviours. While the context of the study was group therapy facilitation, we aimed to develop behaviours that would be applicable across a range of contexts. This was intended to maximise our contribution to the field and address the limitation outlined by Stevens et al. (2021) regarding the lack of concrete, context-independent identity leadership strategies. In the first stage, we generated an initial list of possible behaviours by coding videos of group therapy sessions. In addition to video coding, we consulted with followers (i.e., clients) and thematically analysed their responses to provide unique insights into the impacts and processes of identity leadership in practice. Themes from the interviews highlighted the power of identity leadership to facilitate safe spaces, keep conversations flowing, foster a sense of connectedness, and enable leaders to be aspirational role models. The difficulty of grouping client-specified behaviours and impacts distinctly into the four theorised facets of identity leadership (prototypicality, entrepreneurship, advancement, impresarioship) also highlighted their interconnectedness in practice.

After generating the initial list of behaviours, we refined the list collaboratively through discussions focused on how relevant the behaviours were to identity leadership theory. Key considerations in our discussion included: (a) parsimony of the framework, (b) theoretical justification of each behaviour as an example of identity leadership, (c) alignment of each behaviour with the identity leadership facets, and (d) the perspective of followers. These considerations may serve as valuable points of reflection for researchers in the field seeking to develop additional identity leadership behaviours.

Finally, we conducted quantitative analyses to test two hypotheses. First, that the rate at which facilitators engaged in the behaviours would be associated with follower ILI ratings. Second, that the rate facilitators engaged in the behaviours in Session 1 would predict increases in follower social identification with the therapy group across therapy. Counter to the first hypothesis, the rate of the behaviours was unrelated to ILI ratings (after we corrected for multiple tests of the hypothesis). Partially supporting the second hypothesis, the rate at which facilitators normalised experiences predicted greater increases in social identification over time. Interestingly, and contradicting this hypothesis, most behaviours were unrelated to social identification and certain facilitator behaviours in the first session predicted less increase in follower social identification over time. These behaviours included joining in on group activities, using collective language, and developing group rituals. Before we corrected for multiple tests, there were also significant increases in social identification over time associated with the rate at which leaders self-disclosed relevant experiences to the group, talked about ingroup topics, and commented on positive group dynamics. Although these results may be false positives due to multiple testing, they suggest potential avenues for future research, particularly in studies with greater statistical power.

Based on these findings, we can conclude that the behaviour with the strongest evidence for being an instance of identity leadership is normalising follower experiences. Unexpectedly, we failed to find robust quantitative evidence supporting the other behaviours we tested (such as self-disclosure, discussing ingroup topics, and commenting on positive group dynamics) as examples of identity leadership. In particular, the behaviours we have the least evidence for are those that showed an

unexpected negative association with social identification over time: joining in activities, using collective language, and developing rituals.

Interpreting these negative interactions slightly differently, perhaps sometimes identity leadership is the *absence* of behaviours (e.g., stepping back and letting group members direct conversation tangents or activities, as discussed in Theme 2). If this is the case, measuring the absolute frequency of a behaviour (as was done in our study) may not be suitable for all identity leadership behaviours. For the joining in activities behaviour, several interviewees explicitly mentioned instances where this behaviour made everyone feel connected as a group, providing strong evidence that it is an identity leadership behaviour. However, quantitative analysis indicated that the extent facilitators joined in behaviours in the first session of therapy predicted *less* increase in social identification. Perhaps leaders joining in is most effective during a few meaningful activities rather than during all activities. This is easy to visualise in a workplace context, where it may be beneficial if a manager joins in on a team-building activity but not if they join in on all employee activities and tasks (which would likely be viewed as overbearing). Similarly, for collective language, the objective rate may matter less than how it compares to total words spoken[4] (e.g., Steffens & Haslam, 2013 controlled for total words spoken in their analysis). Indeed, interviewees highlighted the importance of facilitators *knowing when to speak* and when to let the conversation between group members flow. This highlights the importance of considering context when developing a framework of identity leadership behaviours, not just in identifying

[4] We are unable to test this because, due to the sensitive nature of therapy discussions, the university ethics committee did not approve the transcription of sessions.

the behaviour itself but in determining whether a specific instance will have a positive effect.

Additionally, an alternate explanation for the effect of developing rituals may be that it has an immediate positive effect on increasing ratings of social identification, potentially creating a ceiling effect. This idea is supported by our data: developing rituals had the largest difference in the marginal means for social identification in Session 1 (about 0.3 points on a 5-point scale) between clients whose leaders developed rituals at higher and lower than average rates. For most other behaviours, the difference between the Session 1 marginal means was very small (0.002 – 0.1; except for dealing with difficult behaviours and participant language, both 0.2; this can also be seen visually in Figure 3.2). This suggests that the impact of ritual development on social identification might be more immediate and that groups without extensive ritual development might more gradually build social identification.

3.4.1. Implications

Our findings have a range of theoretical, practical, and clinical implications. First, our framework of behaviours serves as an indicative guide for practitioners and researchers. Leaders might consider how some of these behaviours can be implemented into their practice. Researchers might draw from our methods to develop additional context-independent identity leadership strategies and test them across varied contexts (e.g., sports, organisations, other health care, education, etc.). Although the exploratory nature of our methods had several strengths, we recommend future researchers build on these to systematically refine and generate behaviours. For example, a Delphi study, which involves systematically gathering and consolidating expert opinions through multiple rounds of structured feedback, could further

triangulate our findings (Hasson et al., 2000; Linstone & Turoff, 1975; Okoli & Pawlowski, 2004).

Second, this project highlights the complex relationship between context and identity leadership behaviours. Although we aimed to develop context-independent behaviours, the behaviour we uncovered the strongest evidence for (normalising) was the most specifically related to the therapy context. This suggests that even among relatively context-independent behaviours, those most closely aligned with a particular context may be the most impactful. Additionally, the conflicting quantitative and qualitative results (e.g., for joining in activities) underscore the need for leaders to consider the timing and context of specific instances of behaviour, rather than simply maximising the frequency of these behaviours.

These findings bring us back to the initial challenge of identity leadership outlined in the introduction: the need for behaviours to be idiosyncratically developed and tailored to the leadership context. This continues to pose a challenge for identity leadership theory and practice: how can we systematically train leaders in identity leadership when the most effective behaviours are context-specific and open to interpretation? While answering this question fully will require future research, we propose an initial suggestion: identity leadership should incorporate a guiding set of theoretical principles *and* a catalogue of illustrative identity leadership behaviours (such as the one we present here). Moving forward, balancing generalisability and context-specificity is crucial for advancing both the theory and practice of identity leadership.

Third, our findings raise important questions about the validity of the ILI, at least in the context of group therapy, which is not its usual application (i.e., sports and

organisational settings). Several pieces of evidence support this. Firstly, except for the impresarioship subscale, the ILI did not predict social identification in our study, contrary to findings in sports and organisational contexts (e.g., Steffens et al., 2014; van Dick et al., 2018). Secondly, client endorsement of their facilitators was nearly at the maximum score on the scale from the start of therapy. This may suggest that the items are too easily endorsed for therapists, whose practice arguably already aligns closely with identity leadership principles. Lastly, some clients expressed confusion during the end-of-session survey completion time (when AR was packing up groups) about certain ILI items (e.g., what "events" were included in "This leader arranges events that help the G4H group function effectively"). This indicates that the development of context-specific adaptations of the ILI may be appropriate. Following recent efforts to adapt the identity leadership scale for youth sports (i.e., Butalia et al., 2024), we recommend that future research focus on adapting the ILI for clinical contexts. Adaptations might modify items to reflect higher levels of identity leadership or refer to therapy-specific behaviours that clients can more easily distinguish.

Fourth, our findings indicate that impresarioship may be a relatively overlooked but important process for identity leadership researchers and practitioners to consider. Despite its apparent importance in therapy, impresarioship is the least studied facet of identity leadership. Indeed, in van Dick et al.'s (2018) list of indicative references for each facet of identity leadership, the only reference for impresarioship provided is Haslam, Reicher, et al.'s (2020) identity leadership book. More recent research has examined impresarioship, finding it is a key component in mobilising collective action (Jurstakova et al., 2024) and underpins factors such as trust in the leader and inspiration (Evans et al., 2021; Figgins et al., 2024). This suggests that an increased

focus on impresarioship might significantly enhance our ability to develop effective identity leadership practices across various contexts.

Finally, given the group therapy context, our findings have important clinical implications. By finding that identity leadership has positive effects in therapy (e.g., those highlighted in our thematic analysis), our study builds on existing theoretical work by Robertson et al. (2023; [Chapter 1]), providing additional evidence for the suggestion that training therapists in identity leadership could improve practice. Such training would also address calls for more group therapy facilitation-specific training for therapists (e.g., Marmarosh, 2024; Whittingham et al., 2021). Our findings also challenge traditional ideas about therapy practice. For example, most facilitators would not consider their anxiety whilst facilitating groups as a positive therapeutic force. However, several clients mentioned that facilitators' anxiety demonstrated that it is possible to feel anxious *and* manage a social situation effectively – and described this as effective leadership.

3.4.2. Strengths, Limitations, and Directions for Future Research

Our study has several strengths. First, we used a unique data resource (real therapy footage), which provided a rare opportunity to obtain authentic insights into identity leadership in practice. Second, we triangulated data across multiple sources, enhancing the robustness of our findings. Third, we used a longitudinal design, which allowed examination of identity leadership effects over time. Perhaps most significantly, to the best of our knowledge, this study is the first to outline and investigate concrete behaviours of identity leadership beyond collective language, marking a substantial advancement in the field.

These strengths should be considered in light of some key limitations. First, the sample size was small due to recruitment challenges, a common issue in clinical trial research (Biggs et al., 2020). This may have limited our ability to detect small effects and generalise our findings. Second, although the list of identity leadership behaviours was developed collaboratively with followers and other researchers, only one author conducted the video coding to obtain the frequency of behaviours. Third, we did not interview facilitators to obtain their perspectives on their leadership. Finally, our behaviours were primarily limited to observable and verbal behaviours. We could not accurately code nonverbal elements due to facilitators moving around during sessions (often in and out of frame) and some issues with camera quality. To address some of these limitations, we propose that future research include leader interviews to provide another source of data for triangulation and capture identity leadership behaviours that occur outside of followers' awareness (e.g., a leader seamlessly adapting an activity) or outside of the immediate group context (e.g., reflecting before a team meeting). For example, a recent study found that asking coaches to engage in social identity-based reflective activities improved follower ratings of their identity leadership (Brown & Slater, 2023). Future research could also examine nonverbal behaviours using more sophisticated technology (e.g., see Blanch-Hartigan et al., 2018 for advice). Most importantly, we hope this study provides a foundation for future research seeking to investigate concrete identity leadership behaviours in other fields.

3.5. Conclusion

This study represents the first attempt to examine the specific behaviours that constitute identity leadership, seeking to address the lack of concrete, context-independent identity leadership strategies that have been previously specified. Through

an iterative, collaborative, and theory-driven process, we developed a novel framework of identity leadership behaviours in the context of group therapy facilitation, with potential applications across diverse leadership settings. The findings revealed both the potential and the challenges of defining the concrete behaviours of identity leadership. Normalising follower experiences emerged as the behaviour with the strongest evidence of being an instance of identity leadership, while unexpected results for other behaviours (e.g., joining in activities, using collective language) highlighted the complexity of identity leadership in practice. Interestingly, our findings underscored the importance of carefully considering the timing and circumstances under which behaviours will have a positive effect. This may indicate that identity leadership behaviours can never be truly context-independent; even when implementing recommended concrete identity leadership strategies, it remains critical that leaders consider the specific context and needs of their group. We hope this study provides a foundation for future investigations of concrete identity leadership behaviours across various fields.

Chapter 4. Aspirational Leaders Help Us Change: Ingroup Prototypicality Enables Effective Group Psychotherapy Leadership

Paper Rationale and Introduction

Following the development of a framework of identity leadership behaviours in Chapter 3, the rest of the thesis shifts toward closely examining one specific facet of identity leadership: identity prototypicality. As mentioned in Chapter 2, when I began my thesis, there was an ongoing debate among identity leadership researchers about the best way to conceptualise prototypicality. Specifically, the debate centred on which of two types of prototypicality was most impactful for leadership outcomes: aspirational prototypicality or average prototypicality. Meta-analytic evidence (Steffens, Munt, et al., 2021) from organisational contexts demonstrated that aspirational prototypicality was most beneficial for leadership effectiveness. In this study, I sought to investigate whether this finding also held true in group therapy contexts. I hypothesised that, as in organisational settings, aspirational prototypicality would be more relevant to group therapy settings. I reasoned that it made more sense for a therapist to represent an aspired ideal ("who we want to be") for the group rather than representing the current identity of the group ("who we are now").

Throughout this chapter, I use the term "exemplar" to refer to leaders representing average-type prototypicality. This term is not used in other chapters of my thesis. After the publication of this paper in 2022, my supervisor Professor Michael J. Platow alerted me that he and his colleagues were developing a new scale measuring the two types of prototypicality (i.e., van Knippenberg et al., 2024). To better align with

others in the literature, I decided to refer to *prototypicality types* (average-type or aspirational-type prototypicality) rather than *types of leaders* (exemplar leaders or aspirational leaders) in subsequent outputs and the rest of this thesis.

Publication Status

This study was published in the *British Journal of Clinical Psychology* in December 2022. It is presented here as published, except for minor changes to the formatting of figures and tables. The spelling has also been converted to Australian English to align with the rest of the thesis. The citation is as follows:

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Author Contributions

This study was conducted using secondary data. Tegan Cruwys collected the original data for this study as part of a larger project (Cruwys, Haslam, et al., 2015). I formed the research questions explored in the present study, with supervisory support from all other authors (Tegan Cruwys, Mark Stevens, and Michael J. Platow). I also conducted all data analysis and wrote the original manuscript draft. All other authors (Tegan Cruwys, Mark Stevens, and Michael J. Platow) assisted with editing and providing feedback on the manuscript.

Abstract

Objectives: Research suggests that leaders are effective to the extent that they are ingroup prototypical (i.e., represent the identity of the group they seek to lead).

However, it is unclear whether leaders are more effective when they represent the group's *current* identity (exemplify who we *are*) or the group's *aspired* identity (embody who we *want to be*). This study investigated which of these forms of prototypicality best predicted leadership effectiveness in a group psychotherapy context.

Design: Longitudinal study.

Methods: 519 questionnaire responses were obtained from 112 women attending a four-session body acceptance program. Focal measures included participant ratings of how often they thought their psychotherapy leaders and fellow group members would (a) engage in dieting thoughts and behaviours, and (b) approve of dieting. Given the body acceptance focus of the program, leader ingroup prototypicality was conceptualised as the difference between participants' perceptions of how often their leaders, versus group members, would diet at the start of therapy. Leadership effectiveness was conceptualised as reductions in perceived group approval of dieting across therapy. We also examined the effect of prototypicality on two therapeutic outcomes: body satisfaction and intentions to diet.

Results: A mixed-effects repeated measures analysis indicated that group approval of dieting decreased more rapidly when participants perceived their leaders as aspirational (thought that group leaders dieted *less frequently* than group members) than when they perceived them as exemplary (thought that group leaders dieted *as frequently* as group members). A mediation analysis indicated that changes in group approval of dieting also mediated the relationship between leader ingroup prototypicality and improved therapeutic outcomes.

Conclusions: Findings suggest that group psychotherapy leaders may increase their effectiveness by striving to embody their group's aspired identity.

Key words

Ingroup prototypicality; Group psychotherapy; Group psychotherapy leadership; Group norms; Normative change

Practitioner Points

- Clinicians may be more effective when they are perceived to represent the aspirational goals of a psychotherapy group, rather than to represent the group's current state.
- The way that participants of therapy groups view their therapists may influence how the norms of the group change over the course of therapy.
- Practical strategies for clinicians to demonstrate how they represent a group's aspirational identity could be integrated into clinician training to enhance psychotherapy effectiveness.

4.1. Introduction

Group psychotherapy has been increasingly recognised as an efficient and cost-effective alternative to individual psychotherapy (Cuijpers et al., 2008; Tucker & Oei, 2007). However, delivering effective group psychotherapy sessions can be challenging for therapists, not least because doing so requires different skills (e.g., managing group processes) to those required to deliver effective individual psychotherapy sessions (e.g., Yalom & Leszcz, 2020). Despite this, empirical research seeking to describe how group psychotherapy leaders can maximise their effectiveness has been limited. Indeed, research in group psychotherapy contexts has rarely conceptualised those delivering group psychotherapy sessions as *leaders* and has thus failed to capitalise on the considerable insights regarding the bases of effective leadership that are offered by leadership theories (which have been developed, and often extensively tested, in other domains). The present study sought to advance understanding of how group psychotherapy leaders can maximise their effectiveness by investigating the benefits associated with group leaders engaging in behaviours consistent with the *social identity theory of leadership* (e.g., Haslam, Reicher, et al., 2020; Hogg, 2001; for recent applications in the context of individual psychotherapy see Lee et al., 2021; Platow et al., 2020).

4.1.1. Theoretical Framework: Social Identity Theory of Leadership

The social identity approach recognises people's capacity to define themselves both in terms of their personal identity (as 'I' and 'me') and their various social identities (as members of the various groups to which they belong; Tajfel & Turner, 1979). Further, it contends that categorising oneself in terms of a social identity that is shared with others (e.g., as a member of a psychotherapy group) lays the foundation for various

group processes, including social influence (Turner, 1991). Social identity leadership theory proposes that leadership is a process of social influence, and that any given person's capacity to exert influence (i.e., to lead effectively) rests, at least in part, on their capacity to represent and embody the meaning of the group in a given social context (Haslam, Reicher, et al., 2020; Hogg, 2001). In other words, the theory proposes that any individual group member's ability to exert leadership varies as a function of their *ingroup prototypicality* (referred to simply as prototypicality from hereon).

Empirical research from a range of contexts has supported this proposition. For example, to the extent leaders are perceived as prototypical, research has indicated that (a) they are viewed as more charismatic (Platow et al., 2006), (b) they are more trusted to have the group's best interests at heart (Giessner & van Knippenberg, 2008), (c) they are perceived as more trustworthy in general (Jones et al., 2020), and (d) their actions are perceived as fairer (De Cremer et al., 2010). Additionally, and of particular relevance to the present study, there is also evidence that leaders' perceived prototypicality is positively associated with group members' motivation to pursue group goals (Vogt et al., 2021). In short, research has indicated that leaders (and indeed, all group members) are more influential and effective to the extent that they are perceived as prototypical (see also Steffens, Munt, et al., 2021 for a recent meta-analysis).

4.1.2. What Type of Prototypicality is Most Beneficial: Aspirational or Exemplary?

Despite relatively consistent evidence for the benefits of leaders being perceived as prototypical group members, debate remains regarding the specific way in which leaders should be prototypical. That is, there is conjecture regarding whether it is most beneficial for leaders to represent "who we are" (i.e., our current identity) or "who we want to be" (i.e., our aspired identity). A recent meta-analysis by Steffens, Munt, et al.

(2021) explored this question and found evidence that, although prototypicality of both forms is a robust predictor of positive outcomes, the aspirational notion of “who we want to be” is more strongly associated with key leadership outcomes (e.g., trust, perceived fairness), than how much leaders represent the average group member. This finding supports theorising by Abrams et al. (2008) and earlier, Hollander (1958), that it is more important that leaders represent who we aspire to be because this better positions them to effectively lead the group towards a desired future (by directing ‘us’ to achieve important group goals). These researchers suggested that, because a prototypical leader is viewed as working toward the group’s best interests, they are granted “innovation credits” (or idiosyncrasy credits for Hollander), which allow them to influence and drive the group toward their vision. Leaders who represent a group’s aspired identity may therefore more effectively direct the improvement of a group.

This appears particularly relevant in a group psychotherapy context because (a) the purpose of psychotherapy is to facilitate positive change for participants yet, at the same time, (b) therapists’ personal attributes may commonly be perceived to deviate from the typical attributes of their psychotherapy group (“who we are”) on relevant dimensions (e.g., more mentally healthy). These attributes may also, however, represent aspirational goals for group psychotherapy participants (e.g., who typically wish to improve their mental health). It therefore follows that the aspirational notion of prototypicality (“who we want to be”) may be particularly relevant for group psychotherapy leaders and be associated with positive outcomes for psychotherapy participants. More broadly, and from a practical perspective, investigating this is important because, although numerous texts have sought to outline how to effectively

lead psychotherapy groups (most notably Yalom & Leszcz, 2020), there is a lack of empirical evidence to support many of the recommendations they contain.

4.1.3. The Present Study

The aim of this study was to investigate whether group psychotherapy leaders are more effective to the extent that group members view them as aspirational (i.e., engaging in more positive thoughts and behaviours than group members), compared to exemplary (i.e., engaging in similar thoughts and behaviours to group members). This was explored in a body acceptance group psychotherapy program: The Body Project.

The Body Project is a cognitive behavioural group program designed for young women with body weight or shape concerns that seeks to reduce their risk of developing future eating disorders (Stice et al., 2013). Cruwys, Haslam, et al. (2015) previously analysed the data upon which the present study draws to examine the program's efficacy. Results demonstrated that, over the course of therapy, change in perceived group norms (specifically related to the approval of dieting) predicted and preceded improved mental health outcomes. The present study expands on this research by investigating the role that leader prototypicality might play in driving normative change. It is the first empirical study to investigate group psychotherapy leadership from a social identity perspective.

Different forms of group norms were central to our measurement of both leadership effectiveness and prototypicality. In line with the content and goals of the psychotherapy program, the key leadership effectiveness outcome was reductions in approval of dieting (i.e., participants' perceptions of their group's injunctive norms — "what we *should* be doing"; Cialdini et al., 1990). Because a key indicator of prototypicality is the degree to which leaders embody group norms (e.g., Hogg & Reid,

2006), prototypicality was conceptualised as participants' perceptions, when they began the program, of how similar they thought group members and leaders were in terms of their frequency of engagement in dieting thoughts and behaviours (i.e., participants' perceptions of the lack of discrepancy between their leader and the group's descriptive norms—"what we *are* doing"; Cialdini et al., 1990).

H1: We hypothesised that, over the course of the psychotherapy program, there would be a greater reduction in the degree to which participants perceived that group members approved of dieting (the desired outcome) to the extent that they perceived their leaders were aspirational at the start of therapy (i.e., perceived to engage in dieting thoughts and behaviours *less often* than group members). In other words, we predicted that leaders would be more effective when participants thought their leaders were aspirational (representing who we *want* to be), compared to when they thought their leaders were exemplars (representing who we *are*).

H2: We also hypothesised that aspirational prototypicality of leaders would predict two therapeutic outcomes (intention to diet and body satisfaction) at the end of therapy, via changes in group approval of dieting across therapy.

4.2. Method

4.2.1. Participants

Participants were drawn from a sample of individuals who responded to advertisements at either a major university or a community health service in Australia inviting girls and women aged 15 – 25 years experiencing body weight or shape concerns to participate in a Body Acceptance Program. After providing informed consent, eligible respondents were screened using the SCOFF tool (Morgan et al., 1999): "Do you often feel that you can't control what or how much you eat?" and "Do you often eat, within any

two-hour period, what people would regard as an unusually large amount of food?". Respondents who answered "Yes" to both questions were then asked to complete the Patient Health Questionnaire Eating Disorder Screening Tool (Spitzer, 1999). If their responses to this questionnaire indicated that they met the diagnostic criteria for an eating disorder, they were excluded from participation and referred to individual psychological treatment. Respondents were also screened for anorexia nervosa using their Body Mass Index based on self-reported height and weight, but this did not lead to the exclusion of any participants.

Eligibility criteria were met by 112 young women (M_{age} = 18.99; *SD* = 3.12). The majority were White (66.07%), spoke English at home (86.61%) and had a healthy Body Mass Index (75%; *M* = 21.74, *SD* = 3.97). During the study, participants were given the opportunity to complete up to five questionnaires (see below), resulting in a total of 519 observations.

4.2.2. Procedure

The Body Project group psychotherapy program was run over four one-hour sessions in accordance with the treatment manual (Stice et al., 2013). In each session, leaders encouraged participants to critique the thin ideal of beauty through verbal, written, and behavioural activities, aiming to create conditions in which participants would move toward holding healthier body image ideals and norms. Groups consisted of five to eight participants and were co-led by two facilitators. Facilitators were 16 clinical psychology graduate students (two men, 14 women) who received training and weekly supervision from a clinical psychologist and led between one and three of the 18 therapy groups in varying pairs. The Human Research Ethics committee at an Australian university approved the project (Reference #2013000261).

4.2.3. Measures

Details of all the measures participants completed during the program are reported elsewhere (Cruwys, Haslam, et al., 2015). Participants completed extended questionnaires immediately before the first session of the program (T1) and immediately after the final session of the program (T5), and a short one-page questionnaire immediately after sessions one (T2), two (T3), and three (T4). Measures for T1 were obtained during the first psychotherapy session, after informal discussion and introductions with the group had taken place. Prior to this, participants had all been led through the consenting process by their leaders. Additionally, all participants had met with their group leaders before the groups began to discuss the screening process and their involvement in the study. The T1 questionnaire therefore captured participants' first impressions of the leaders and group members prior to commencing the therapeutic program (and thus prior to any normative change resulting from the program). First impression measures have previously been shown to predict outcomes in group therapy at later time points. For example, Cruwys, Steffens, et al. (2020) found that participants' first impressions of similarity among therapy group members at the start of therapy significantly predicted how connected they felt with that group at the end of therapy (β = .31, p <.001).

4.2.3.1. Group injunctive norms: Approval of dieting. Four items were adapted from various sources (Åstrosm & Rise, 2001; Smith & Louis, 2008; White et al., 2009) to assess participants' perceptions of the approval of dieting among their psychotherapy group members (i.e., their injunctive norms around dieting). This measure was the study's primary dependent variable and has previously been established as a mechanism of change in individual eating disorder risk in the Body Project (e.g., Cruwys,

Haslam, et al., 2015). Items included: (1) "If I were to lose weight, members of my Body Acceptance group would…" (1 *Disapprove* – 7 *Approve*); (2) "Members of this Body Acceptance Group think that dieting is a good idea" (1 *Strongly Disagree* – 7 *Strongly Agree*); (3) "Members of this Body Acceptance group think I…" (1 *Should not lose weight* – 7 *Should lose weight*); and (4) "How many members of this Body Acceptance group would think that being thin is a good thing? …" (1 *None of them* – 7 *All of them*). The four items were summed to form a composite score (with a possible range of 4 – 28), where higher scores indicated greater perceived approval of dieting. The scale demonstrated excellent internal consistency across all time points except for T1 (α_{T1} = .56, α_{T2} = .90, α_{T3} = .91, α_{T4} = .93, α_{T5} = .83). This was likely due to the fourth item being non-significantly correlated with items one and three at T1 (note that key results are identical if this fourth item is dropped and therefore it was retained). However, at every other time point, all items were significantly correlated with each other (mean inter-item correlation, *r* = .68; range .38 – .81).

4.2.3.2. Group descriptive norms: Dieting thoughts and behaviours.

Participants' perceptions of their group members' engagement in thoughts and behaviours associated with dieting was assessed at baseline (T1) using the six-item Descriptive Norms for the Pursuit of Thinness Scale (Cruwys, Haslam, et al., 2015). This measure served as both a covariate (to control for the perceived level of dieting in the group before therapy commenced) and one component of the measure of prototypicality (to calculate a difference score between group members' perceptions of other group members and their leaders' dieting thoughts and behaviours). All items began with "How often do you think members of your Body Acceptance group…". This was followed by: "go on a diet", "feel bad about their bodies", "plan to lose weight", "wish

they were thinner", "speak negatively about their bodies", and "feel jealous of thin women". Items were rated on a seven-point scale (1 *Never* – 7 *Frequently*) and summed to form a composite score (with a possible range of 6 – 42), where higher scores indicated the thoughts and behaviours were perceived to be more common among group members. Internal consistency was excellent (α = .91).

4.2.3.3. Leader dieting thoughts and behaviour. Participants' perceptions of their leaders were also assessed using the same questions about dieting thoughts and behaviours. That is, the prompt "How often do you think your group leaders would…" was followed by the same six items. Participants provided a combined rating for the leadership pair (i.e., they did not rate their two group leaders separately on this measure). Again, the possible range for this measure was 6 – 42. Internal consistency was also excellent for this measure (α = .92).

4.2.3.4. Leader prototypicality. To measure leader prototypicality, the difference was calculated between how often participants thought their fellow group members engaged in dieting thoughts and behaviours (descriptive norms) and a rating of their group leaders on these same behaviours. The rationale was that a large difference between these perceptions (such that group leaders were seen to diet *much less* than group members), indicated that leaders were "aspirational" group members on this dimension. Conversely, if the difference between leaders and group members approached zero, this was thought to indicate that leaders were "exemplars" on this dimension (similar to average group members). We chose to calculate and use a measure of leader prototypicality from T1 because this afforded a test of whether perceptions of leader prototypicality predicted subsequent changes in our dependent variable across therapy.

4.2.3.5. Therapeutic outcomes. Participants' dieting intentions and body satisfaction at T5 were measured as therapeutic outcomes. Dieting intentions were measured using the Dieting Intentions Scale (Cruwys et al., 2013), which includes seven items rated on a seven-point scale. Two items ("In the next three months, I intend to go on a diet" and "In the next three months, I intend to reduce my calorie intake") ask participants to rate their agreement (1 *Strongly Disagree* – 7 *Strongly Agree*). The remaining five items begin with the prompt "If I diet in the next 3 months, this would be" and ask participants to rate their evaluation of how positive it would be to engage in dieting (e.g., 1 *Harmful* – 7 *Beneficial*). Items were summed such that higher scores indicated greater intentions to diet in the next 3 months (possible range 7 – 49). This scale has been shown to have excellent internal consistency in previous studies (e.g., α >.91 in four studies; Cruwys et al., 2013) and in the present study (α = .92). Cruwys et al. (2013) also found that scores predicted actual dieting behaviours three months later.

Body satisfaction was measured using the Body Image States Scale (Cash et al., 2002). This scale consists of six items measuring satisfaction with one's body (e.g., shape, weight, attractiveness). All begin with the prompt "Right now I feel", followed by nine descriptors that indicate differing levels of that feeling (e.g., 1 *Extremely dissatisfied with my weight* – 9 *Extremely satisfied with my weight*). Items are summed such that higher scores indicate greater body satisfaction (possible range 6 – 54). This scale has been shown to have acceptable internal consistency in prior studies (e.g., α = .77 for women; Cash et al. 2002) and the present study (α = .75).

4.2.4. Analytic Approach

Analyses were conducted using *R* (Version 4.04) and the accompanying user interface *RStudio* (Version 1.4.1106) for Windows 10®. R packages used included *lme4* (Bates et al., 2015), *lmerTest* (Kuznetsova et al., 2017), and *sjstats* (Lüdecke, 2021).

4.2.4.1. H1. A mixed-effects repeated measures analysis was conducted on the focal outcome of perceived group approval of dieting. Observations at each time point (*N* = 519) were nested within participants (*N* = 110), who were nested within psychotherapy groups (*N* = 18). Random intercepts were included for both participant and psychotherapy group. Note that two of the 112 women were not included in the analyses for H1, because they did not answer any of the questions related to any of the predictor measures.

The focal predictor was a two-way interaction between time and leader prototypicality (i.e., discrepancy between group descriptive dieting norms and the leader). The model also included main effects for time, leader prototypicality, and perceived group descriptive norms about dieting at baseline (to control for how often participants initially thought their fellow group members would diet). All were entered in the model as fixed effects. All variables were standardised before entry into the model. Leader prototypicality type was not split into categories (i.e., aspirational versus exemplar leaders) but instead conceptualised as a continuum ranging from exemplar to aspirational. It was possible to do this because there were only three negative scores on this leader prototypicality index (-4, -2, -1), indicating a perception that leaders dieted *more* than group members). Scores therefore ranged from close to 0 (exemplar-type leaders) to 30 (aspirational-type leaders). Removal of the three participants with negative scores did not affect the results, so they were retained in the analyses.

4.2.4.2. H2. Two mediation models investigated whether prototypicality would predict therapeutic outcomes via changes in group approval of dieting. These tested whether the extent to which leaders were perceived to be aspirationally prototypical at T1 would predict participants' (1) body satisfaction and (2) dieting intentions at T5, via changes in perceived group approval of dieting across therapy (between T1–T5). All 112 participants were retained in the models (as all had responded to the group approval of dieting and therapeutic outcomes measures).

4.3. Results

4.3.1. Preliminary Analyses

Most participants (71.43%) had no missing data. A significant Little's (1988) Missing Completely at Random test, $\chi^2(158) = 224.0$, $p < .001$, indicated that data were not missing completely at random. Upon further inspection, it was evident that these patterns were likely due to participants who missed one session also being more likely to miss other sessions. For both the mixed-effects and mediation models, Full Information Maximum Likelihood was used to manage missing data, ensuring that all observations with data for at least one predictor were included in the final models. The appropriateness of this sophisticated technique for use in longitudinal datasets has been repeatedly demonstrated (e.g., Lane, 2008; Larsen, 2011).

A normally distributed residual histogram (and non-significant Shapiro-Wilk's test, $p = .087$), no significant pattern or clustering in the residual scatterplot, no outliers, and no evidence of multicollinearity also suggested that the assumptions for a mixed-effects model were met.

4.3.2. Main Analyses

4.3.2.1. H1. The intraclass correlation coefficients in the null model with no predictors suggested that a mixed-effects approach was appropriate to investigate the effect of leader prototypicality on perceived group approval of dieting over time: 31.6% of the variance in perceived group approval of dieting was accounted for by differences across time points, 21.6% was associated with individual differences between participants, and 2.6% was associated with differences between therapy groups. The primary findings are summarised in Table 4.1. The final model appeared to be a good fit for the data; it explained 35.9% of the variance in perceived group approval of dieting and was a better fit for the data than both a null model with no predictors, $\chi^2(4) = 254.85$, $p < .001$, and a model with only main effects, $\chi^2(1) = 6.08$, $p = .014$.

Table 4.1 *Mixed-effect model for perceived group approval of dieting*.

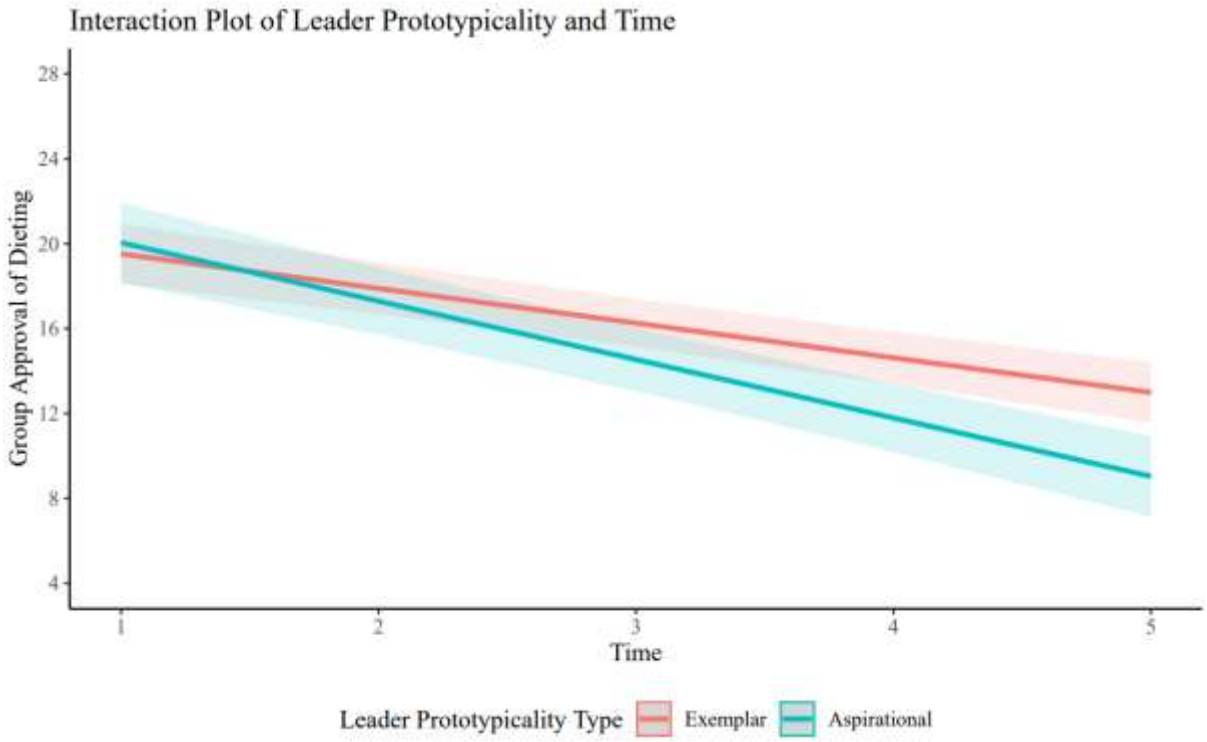
Predictor	**β [95% CI]**	***SE***	***df***	***p***
Time	-.37 [-.41, -.32]	.02	410.35	<.001**
Baseline group dieting thoughts and behaviour (covariate)	.30 [.20, .41]	.05	104.17	<.001**
Leader prototypicality	.02 [-.11, .16]	.07	257.53	.712
Time × Leader prototypicality	-.05 [-.09, -.01]	.02	410.08	.014*

Note. CI = Confidence Interval; * $p < .05$; ** $p < .01$; Model $R^2 = 35.9\%$.

The main effect of time was significant (β = -.37, 95% Confidence Interval [CI; -.41, -.32], $p < .001$). That is, perceived group approval of dieting significantly decreased over time. The covariate measure of perceived frequency of group dieting at baseline was also significant (β = .30, CI [.20, .41], $p < .001$), suggesting that participants who rated their group as engaging in dieting thoughts and behaviours more often at baseline

also rated their group as more approving of dieting on average over the course of therapy. The main effect of prototypicality was not significant (β = .02, CI [-.11, .16], *p* = .712). In support of the hypothesis, there was a significant interaction between leader prototypicality type and time (β = -.05, CI [-.09, -.01], *p* = .014). This interaction was such that the participants' perception of the group's approval of dieting decreased to a greater extent when they thought their leaders were prototypical in the aspirational (rather than exemplary) sense. It should be noted, however, that only an additional 0.6% of variance in the dependent variable was explained by the model that included this interaction term, compared to the model that did not. Figure 4.1 shows this interaction; participants who rated their leaders as *most similar* to them (i.e., the exemplar concept of prototypicality; a difference score of 0 between leader and group member frequency of dieting) experienced less change over time than participants who rated their leaders as *least similar* to them (i.e., the aspirational notion of prototypicality; the maximum difference score of 30 between leader and group member frequency of dieting).

Figure 4.1 *Change in group approval of dieting for different leader prototypicality types*



Note. This figure plots the pattern of change in group approval of dieting across therapy for two values of our continuous independent variable, leader prototypically. The aspirational notion of prototypicality (i.e., the blue line) represents the *maximum* difference observed between leaders and group members (or a difference score of 30). This predicted greater reductions in approval of dieting over the course of psychotherapy than the exemplary notion of prototypicality (i.e., the red line), which represents the *minimum* difference between leaders and group members (or a difference score of 0).

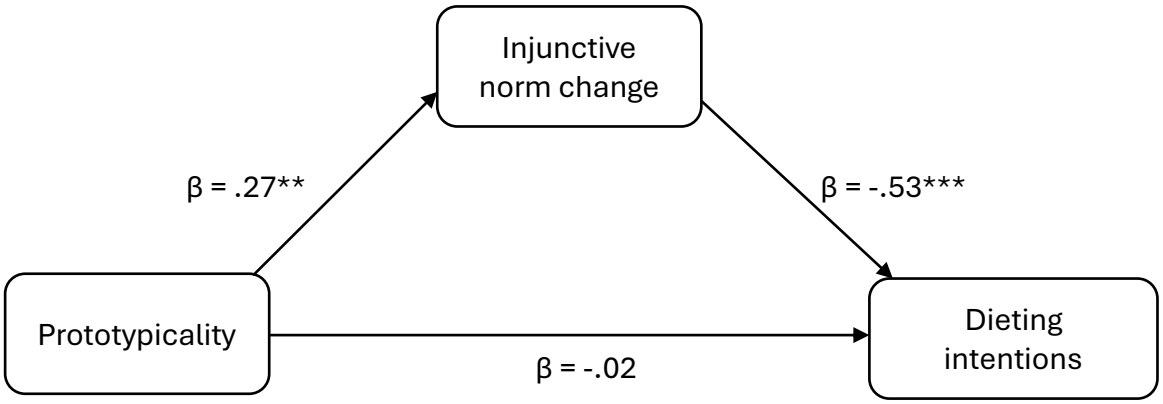
4.3.2.2. H2. Significant indirect effects were observed in each of the two mediation models (see Table 4.2 and Figures 4.2 and 4.3 for model details). Prototypicality had a positive indirect effect on body satisfaction ratings (β = .08, CI [.01, .16], *p* = .023) and a negative indirect effect on dieting intentions (β = -.14, CI [-.25, -.04], *p* = .007). The direct effects between leader prototypicality and both therapeutic outcomes were non-significant.

Table 4.2 *Results of mediation models.*

Clinical outcome	**Indirect effects**							**Direct effects**	
	Proto → IN Change (β)	*p*	IN Change → Clinical outcome (β)	*p*	Indirect effect (β[CI])	*p*	SE	Proto → Clinical outcome (β)	*p*
Dieting Intentions	.27	.003	-.53	<.001	-.14 [-.25, -.04]	.007	.053	-.02	.768
Body Satisfaction	.27	.003	.30	.001	.08 [.01, .16]	.023	.038	-.04	.635

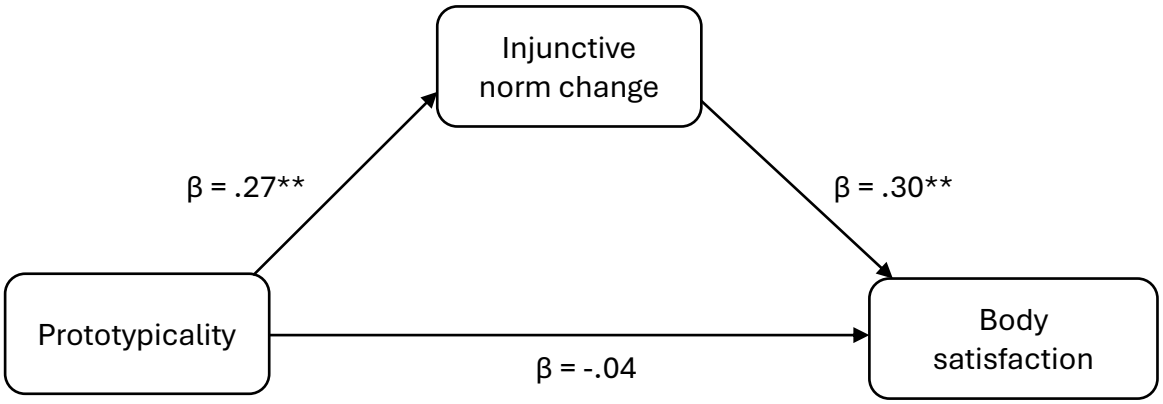
Note. Proto = prototypicality. IN Change = Change in injunctive norms (perceived group approval of dieting) score between T1 and T5. CI = 95% Confidence Intervals. *N* = 112. Standardised beta coefficients are reported.

Figure 4.2 *Mediation model examining how prototypicality affected dieting intentions via change in injunctive norms across therapy.*



Note. The extent to which participants thought their group therapy leaders were aspirationally prototypical predicted participants' reduced dieting intentions via its effect on their perception of their therapy group's approval of dieting (injunctive norms) across therapy. Injunctive norm change = change in participant ratings of group injunctive norms surrounding the approval of dieting between the start and end of therapy. Standardised indirect effect of prototypicality on dieting intentions through injunctive norm change: β = -.14 95% CI [-.25, -.04], p =.007, SE = .053. * p <.05; ** p <.01; *** p <.001.

Figure 4.3 *Mediation model examining how prototypicality affected body satisfaction via change in injunctive norms across therapy.*



Note. The extent to which participants thought their group therapy leaders were aspirationally prototypical predicted participants' increased body satisfaction via its effect on their perception of their therapy group's approval of dieting (injunctive norms) across therapy. Standardised indirect effect of prototypicality on body satisfaction through injunctive norm change: β = .08, 95% CI [.01, .16], p = .023, SE = .038.

4.3.3. Additional analyses

Given that we could also calculate leader prototypicality at T5, we conducted exploratory analyses to investigate how prototypicality ratings changed across therapy. We calculated the average change in participants' perceptions of how much they thought their leaders versus fellow group members would engage in dieting thoughts and behaviours (i.e., descriptive norms) across therapy (i.e., between T1 and T5). Participants viewed both their fellow group members *and* leaders as less frequently engaging in and thinking about dieting across therapy. Paired samples t-tests confirmed that participants perceived that their fellow group members were dieting significantly more frequently at the start of therapy (M = 31.86, SD = 6.07) compared to the end of therapy (M = 20.51, SD = 9.32), t(109) = 11.30, p <.001. Participants also perceived their leaders to be dieting significantly more frequently at the start (M = 19.88, SD = 7.85) than

at the end of therapy (M = 13.03, SD = 7.40), $t(107) = 9.31$, $p < .001$. A paired samples t-test also confirmed that the average perceived discrepancy between leaders and group members (i.e., leader prototypicality) reduced significantly between the start (M = 11.95, SD = 8.05) and the end of therapy (M = 7.62, SD = 5.55), $t(106) = 4.63$, $p < .001$.

4.4. Discussion

This study examined, for the first time, the role that psychotherapy leaders' prototypicality might play in facilitating positive outcomes among group psychotherapy participants. Addressing an ongoing debate in leadership research (e.g., Steffens. Munt, et al., 2021), it focused on whether it is more beneficial for group psychotherapy leaders to embody the aspirational notion of prototypicality (i.e., "who we want to be") or the exemplary notion of prototypicality (i.e., "who we are"). In line with H1, results indicated that perceived approval of dieting among psychotherapy group members (an undesirable attitude for participants to hold) decreased to a greater extent when group psychotherapy leaders were perceived as prototypical in an aspirational, rather than exemplary, sense. Additionally, and in line with H2, we found that the extent to which participants perceived their leaders to be aspirational also indirectly predicted important therapeutic outcomes via changes in perceived approval of dieting. Our findings therefore suggest that aspirational leaders may "help us change" in ways that positively impact our mental health.

It should be noted that the effect size for the key effect for H1 (the interaction between leader prototypicality and time) was relatively small. Nevertheless, it is possible that even small changes in perceived group approval of dieting could confer meaningful downstream benefits. Indeed, our analyses for H2 demonstrate this; change in perceived group approval of dieting was a medium to large predictor of two

therapeutic outcomes in the mediation models (βs = .30 and -.53). Moreover, several authors have argued that small effect sizes should not be dismissed in psychological research, in part because the effect of focal variables is usually only measured in the short term, and these small effects may translate into meaningful long-term consequences (Funder & Ozer, 2019). Additionally, due to the complexities of human cognition, emotion, and behaviour, outcomes in psychology are usually influenced by numerous factors that each have small effects (Götz et al., 2022). In the present study, we found that the way participants viewed their leaders had a small effect on their perception of how acceptable it was to engage in dieting and that this, in turn, had a downstream impact on their mental health (increasing their body satisfaction, reducing their intentions to diet) over a four-session program. These changes in mental health could have had meaningful future impacts. Our use of a mixed-effects model may have also affected the accuracy of the effect size estimate. Although there are several benefits of using mixed-effects models over ordinary least squares regression to analyse hierarchical and longitudinal datasets (e.g., reducing the Type-I error rate; e.g., (Richter, 2006; Robson & Pevalin, 2016), one downside is that they provide comparatively less accurate effect sizes for individual model terms, such as the effect of an interaction (see Kreft & de Leeuw, 1998; Nezlek, 2001, 2008; Rights & Sterba, 2019). It is therefore possible that the true effect size is larger and its estimate should be interpreted with some caution.

Given our interest in how group approval of dieting changed across therapy, we also conducted exploratory analyses to determine whether leader prototypicality changed over time. Interestingly, results demonstrated that perceptions of group members and leaders converged across therapy, such that both were perceived to diet

less frequently at T5 (with group members perceived to change positively to a greater extent than leaders)**.** One interpretation for this convergence may be that the leaders became less aspirational over time. Alternatively, the reduced discrepancy between leaders and group members over time may be evidence for the influence of leaders, who led the group to pursue the aspirational example that they had originally set. Further research into how group psychotherapy leaders are perceived over time will enhance understandings of group leadership and provide applied insights into therapy group dynamics.

4.4.1. Theoretical and Practical Implications

Our results suggest that group psychotherapy leaders can facilitate positive therapeutic outcomes by portraying themselves as embodying what group members aspire to be. These findings have a range of theoretical and practical implications. First, our findings provide evidence for the applicability of social identity leadership theory to a novel context: group psychotherapy. Building on evidence from research in contexts where leadership has traditionally been examined (e.g., organisations, politics, and sport; e.g., see Cicero et al., 2007; Haslam, Reicher, et al., 2020; Stevens et al., 2021; van Knippenberg & Hogg, 2003), our findings point to the role that group psychotherapy leaders' prototypicality can play in shaping their effectiveness, and provide initial evidence that such leaders might most effectively maximise their positive influence by striving to embody who group members want to be, rather than who they are (i.e., to be prototypical in an aspirational rather than exemplary sense). This aligns with findings from a recent meta-analysis of studies primarily focused on leaders in traditional leadership contexts (e.g., managers in organisations) and found that leaders' perceived aspirational prototypicality was a stronger predictor of positive leadership outcomes

than their perceived exemplary prototypicality (Steffens, Munt, et al., 2021). Thus, our findings demonstrate that the potential added value of aspirational leaders compared to exemplar leaders also applies in the novel context of group psychotherapy.

Second, our results suggest that it may be beneficial for therapists to emphasise that they represent the aspirational identity of the groups that they facilitate. This has implications for the ongoing debate regarding the value of therapists having "lived experience" of the mental health conditions experienced by their clients. On one hand, there is growing empirical support for consumer-led mental health interventions (e.g., Doughty & Tse, 2011; Grey & O'Hagan, 2015). On the other, researchers have raised concerns that consumer-led health care can create role conflict and blur professional boundaries (e.g., Faulkner & Basset, 2012)— a perspective supported by evidence that consumer-led interventions may be less beneficial for severe mental health conditions such as schizophrenia (Lloyd-Evans et al., 2014). However, when there is specific focus on *recovery*, that is, people with lived experience who have made progress towards the aspirational identity of the group, there is evidence that consumer-led programs can be effective even for severe mental health conditions. For example, the Hearing Voices Network's consumer-led support groups focus on recovery, coping, and shared identity and have been demonstrated to be beneficial for people experiencing psychosis (e.g., Longden et al., 2018). Our findings raise the possibility that one of the factors that affects whether disclosure of lived experience can enhance therapists' effectiveness may depend, at least in part, on the extent to which the therapist is perceived to embody a future state that group psychotherapy participants aspire toward (e.g., someone who is "in recovery" from their mental health condition).

Along these lines, research has already indicated (a) that connecting with others who are also in recovery is a key healing component of psychotherapy and mutual support groups (Moos, 2007; Rowlands et al., 2021), and (b) that positive therapeutic outcomes flow when individuals internalise new identities that emphasise recovery, rather than maintain mental illness identities (e.g., a person with depression) or identities defined by unhealthy behaviours (e.g., a substance user; Best et al., 2011, 2016; Cruwys, Stewart, et al., 2020; Cruwys & Gunaseelan, 2016; Dingle et al., 2015; McNamara & Parsons, 2016). Notably, Dingle et al. (2015) found that change in identification from a "user identity" to a "recovery identity" in people who attended group psychotherapy for substance use in a therapeutic community accounted for substantial variance in positive behaviour change up to six months after the end of therapy. In conjunction with this previous research on recovery identities, our findings are consistent with the idea that a leader who shares their personal story of recovery may facilitate positive outcomes, especially if this supports group members to work towards this aspirational representation of the group.

Third, our results may also suggest that, to maximise their influence therapists must not only understand who group members *currently* are, but who they *aspire* to be. However, this is easier said than done, as group norms change dynamically over time. Indeed, albeit outside a therapy context, these ideas have been explored in recent research on dynamic norms (i.e., group norms that are seen to be rapidly increasing or decreasing in a group over time; Loschelder et al., 2019). Sparkman and Walton (2017) found that people will change their behaviour to align with norms that appear to be growing in popularity, even if they (a) contrast what the group is *currently* doing and (b) are only endorsed by a minority of the group. Notably, research also suggests that

exposure to dynamic norms may help resolve barriers to personal change by providing evidence that change is possible (Sparkman & Walton, 2019). The concept of dynamic norms may therefore be relevant and useful in the context of group psychotherapy, where leaders are numerically in the minority and seek to change the norms and behaviours of a group. Howe et al. (2021) demonstrated that the influence of dynamic norms on behaviour may be particularly powerful when coupled with appeals that these norms align with collective goals (e.g., that we can "do it together", p. 215). Therapists might influence collective and dynamic norms by collaboratively setting explicit group goals at the commencement of therapy, as is recommended by most group psychotherapy texts (e.g., Chen & Rybak, 2004; Sobell & Sobell, 2011; Yalom & Leszcz, 2020).

4.4.2. Strengths, Limitations, and Directions for Future Research

This study had several strengths. These included its high ecological validity, novelty, and strong theoretical underpinning. The longitudinal design was also a strength, as it allowed group member norms to be tracked across a psychotherapy program. Indeed, although this did not afford the same conclusions regarding causality that an experimental study would have, the nature of the design (such that prototypicality was assessed at baseline and normative change was assessed across subsequent time points) increases confidence in the direction of the relationship between the variables we examined.

Despite these strengths, the nature of the research was not able to identify *specific behaviours* that should be pursued by group therapy leaders so as to enhance their aspirational prototypicality. Of course, these behaviours will vary as a function of the goals of the psychotherapy group in question (e.g., improved body acceptance).

Nevertheless, future research seeking to identify these behaviours and test their relative efficacy would be beneficial (e.g., see Stevens, Rees, Steffens, et al., 2019). Future research would also benefit from (a) assessing the impact of leaders' aspirational prototypicality on a wider range of outcomes, including the extent to which it ultimately leads to better individual health outcomes, and (b) examining other potential mechanisms through which these effects arise. For example, participants' perceptions of therapists' provision of social support may be one particularly promising potential mechanism for investigation (e.g., Foran et al., 2021). Future research could reasonably investigate whether aspirationally prototypical group leaders are better able to influence group norms compared to exemplar leaders because they provide support and advice that is more positively interpreted.

4.5. Conclusion

This study was the first to apply the social identity theory of leadership to a group psychotherapy context. The findings demonstrated that predictions from social identity leadership theory are relevant in a group psychotherapy context; specifically, group leaders may be more effective when they represent the aspirational identity of the psychotherapy group. This can enable them to influence group norms and, through this, facilitate positive therapeutic outcomes for group members.

Chapter 5. Leading by Example: Experimental Evidence that Therapist Lived Experience Disclosures can Model the Path to Recovery for Clients

Paper Rationale and Introduction

Having established in Chapter 4 that aspirational prototypicality was beneficial in group therapy contexts, I wanted to examine which identity leadership behaviours might lead to greater aspirational prototypicality. While Chapter 4 highlighted the role of embodying group norms in a leader's perceived prototypicality, it did not examine specific leader actions that might foster aspirational prototypicality. Drawing inspiration from the ongoing debate about lived experience in mental health care and the increasing employment of peer workers in health care settings (see Chapter 2), I focused on self-disclosure of lived experience as a starting point for a closer examination of identity leadership behaviours that might signal aspirational prototypicality.

Reading literature on self-disclosure, I noticed that a common guideline was to share *recovered* personal experiences with clients, rather than current struggles. Given my previous findings on aspirational prototypicality, I wanted to investigate whether therapists' recovery disclosures might be beneficial because they signal a therapist's embodiment of an aspirational identity for clients (i.e., being in recovery from mental ill-health). As I continued to engage with the self-disclosure literature, I also noticed that there appeared to be limited theoretical rationale and empirical support for the benefits of disclosing recovered (rather than current) mental health experiences. By examining self-disclosure through a well-established theoretical lens and using an experimental

design, my study could therefore contribute to both identity leadership theory and clinical practice.

My study comprised two experiments conducted with 545 participants, including therapy clients, therapists, and general population adults. I used vignettes describing different scenarios of therapist self-disclosure in a group therapy setting for depression, allowing for a systematic comparison of various types of disclosures.

It's worth noting that this study was conducted before the completion of Chapter 3, so I was not yet aware that self-disclosure did not predict identity leadership or social identification in that study (after correcting for multiple hypothesis tests). The finding that self-disclosure predicts prototypicality in this study, which used a larger sample and a more rigorous experimental design, suggests that the effect of self-disclosure on social identification in Chapter 3 might reflect a true effect, rather than a false positive.

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Author Contributions

I formed the research questions explored in the present study, with supervisory support from Tegan Cruwys, Mark Stevens, and Michael J. Platow. I also collected and analysed all data and wrote the original draft of the manuscript. All other authors (Tegan

Cruwys, Mark Stevens, and Michael J. Platow) assisted with editing and providing feedback on the manuscript.

Abstract

A common guideline for self-disclosure is that therapists should only share *recovered* personal experiences with clients (i.e., no longer distressing). However, theoretical rationale and empirical support for this claim is limited. Drawing on identity leadership theorising, we investigated whether recovery disclosures are beneficial to the extent that they signal a therapist's *aspirational prototypicality* (i.e., embodiment of an aspirational identity for clients). Across two experimental studies (N = 545), we recruited clients, therapists, and general population adults. Participants read a group therapy for depression vignette in which the therapist disclosed: nothing, professional experience with depression, current depression, recovered depression, or recovered anxiety. Participants rated the prototypicality of the therapist, the extent to which they perceived the therapist positively, the therapist's expertness, and the expected prognosis for therapy. Contrary to our hypotheses, the type of disclosure did not significantly affect positive perceptions, expertness, or expected prognosis ratings. However, the therapist disclosing a recovered and relevant condition (recovered depression) was rated as significantly more aspirationally prototypical than the other therapists. Given prior evidence that group therapists are more effective when viewed as aspirationally prototypical, our findings suggest that recovery disclosures may represent one way therapists can signal their prototypicality and enhance their effectiveness.

Key words

Group Psychotherapy; Therapist Self-disclosure; Lived experience; Social identity; Depression.

5.1. Introduction

Most therapists would agree that destigmatising mental health issues is an important endeavour. One way therapists could help reduce stigma is by honestly discussing their own lived experience of mental ill-health (something that many therapists have; Victor et al., 2022). Ironically, however, many therapists choose not to disclose this information to clients or other therapists precisely because of fears about stigma (Harris et al., 2019; McPhee et al., 2023; White et al., 2006). Indeed, this fear may be well justified, with evidence suggesting that even researchers who conduct self-relevant research on mental health (so-called "me-search) are often perceived negatively (Devendorf et al., 2023).

Several other factors may also prevent therapists disclosing. For example, in some countries (e.g., Australia), regulatory bodies mandate that health professionals report other professionals who are 'impaired' (Australian Health Practitioner Regulation Agency, 2023). Therapists may therefore consider disclosing mental health conditions a risk to their livelihood. Another possible reason not to disclose relates to concerns about client welfare: therapist self-disclosure has been described as a 'slippery slope' that can lead to boundary violations, harmful multiple relationships, and role confusion (e.g., Barnett, 2011; Strasburger et al., 1992).

Despite these stark warnings, however, evidence for the 'dangers' of self-disclosure is limited and is provided primarily by extreme case scenarios rather than targeted empirical investigations. A more robust body of research speaks to potential *benefits* of therapist self-disclosure and, more broadly, mental health care delivered by people with lived experience (Conchar & Repper, 2014; Henretty et al., 2014; Henretty & Levitt, 2010). Therapists (as well as researchers and teachers in psychology) with lived

experience therefore need to carefully weigh up the potential benefits and costs of disclosing this experience to clients, students, or colleagues (see Hinshaw, 2008).

We aimed to formally evaluate how therapists who disclose their own experience with common mental health conditions are perceived by clients, other therapists, and adults in the general population. More specifically, we examined experimentally whether the potential benefits of such disclosures vary as a function of whether therapists disclose that they have recovered from or are still experiencing the condition. To further advance understanding, we also sought to shed light on the psychological mechanisms through which the benefits of therapist disclosure operate.

5.1.1. What Should Therapists Disclose About Their Mental Health and When?

Part of the reason for the lack of consensus on therapist self-disclosure may be that its effects depend on what and how much is disclosed. To assist therapists, some researchers have proposed guidelines for self-disclosure. One common recommendation is that therapists should not disclose anything that is currently distressing to them (Gelso & Palma, 2011; Henretty & Levitt, 2010; Knox & Hill, 2003; Levitt et al., 2016). This recommendation has recently received some empirical support. Moody et al. (2021) asked 417 adults to read one of four vignettes in which therapists disclosed either: (a) nothing, (b) a mental health condition (bipolar disorder or depression) that happened in the distant past, (c) a mental health condition from the recent past, or (d) a mental health condition that they were currently experiencing. The researchers found that therapists who recounted a mental health condition from the distant or recent past were rated more favourably than both the non-disclosing therapist and the therapist currently experiencing a mental health condition in terms of their warmth, approachability, and ability to get along with clients.

Similarly, in another between-participants vignette study, Somers et al. (2014) asked undergraduates to evaluate a therapist who either did or did not disclose their prior experience with a psychological issue (depression, post-traumatic stress disorder, or alcohol dependence). Across all three presenting problems, participants rated the disclosing therapist more positively than the non-disclosing therapist. Participants also perceived the disclosing therapist to have a better working relationship with the client and were more confident that treatment would be successful. In another vignette study, McCormic et al. (2019) found that undergraduates rated therapists most favourably when they disclosed a moderate amount about a previous mental health condition (i.e., listed their symptoms but did not talk about negative impacts on their life). This provided some support for Gelso and Palma's (2011) claim that therapist self-disclosure is beneficial for clients only up to a certain level of frequency and intensity (i.e., an inverted U relationship).

These studies provide evidence that therapist disclosure can be received positively. However, they have some notable limitations. The samples consisted of adults from the general population or students, raising questions about the external validity of the findings. It is possible, for example, that recent therapy clients may perceive disclosures more positively than the general community, because they may view disclosing therapists as more similar to themselves in important ways. The opinions of therapists themselves regarding the appropriateness of therapist disclosure may also differ from these general community samples. Many therapists choose to keep their mental health issues secret from clients and colleagues due to fears that they will be judged or appear unprofessional (e.g., Victor et al., 2022; White et al., 2006; Zerubavel & Wright, 2012), and thus may rate therapists who choose to disclose more

negatively. Most importantly, research in this area has lacked a theoretical framework to guide investigations into why and how therapist self-disclosure might affect outcomes.

5.1.2. A New Theoretical Framework for Self-Disclosure: Identity Leadership Theory

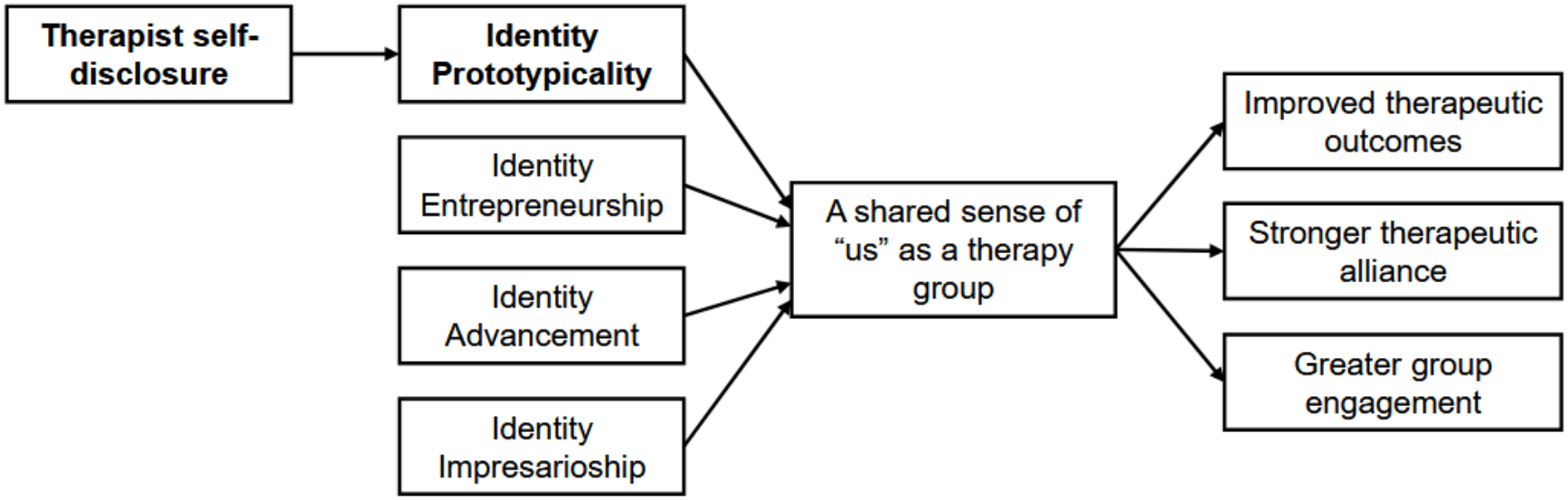
One theoretical framework that may help shed light on therapist self-disclosure is identity leadership theory (Haslam, Reicher, et al., 2020). This theory builds on the social identity approach, which proposes that people can, and do, define themselves not only as a unique individual (as 'I' and 'me') but also in terms of the social groups to which they belong (e.g., as 'us' members of this therapy group; Tajfel & Turner, 1979). According to the social identity approach, when people define themselves in terms of a particular group membership that they share with others, this lays the foundation for processes of social influence (Turner, 1991). The word 'leadership' is rarely applied in therapy contexts. However, like those responsible for leading groups in other contexts (e.g., business or sport), therapists seek to influence people (i.e., their clients) to change in positive ways and take steps toward important goals (Platow et al., 2020; Robertson et al., 2023 [Chapter 1]). Identity leadership theory provides novel insights into how this influence operates through shared social identities, positing that a leader's ability to achieve influence is tied to how successful they are in building a shared connection with those they lead.

The theory proposes four key processes through which leaders can build a sense of shared social identification among their followers and, consequently, achieve influence (see Haslam, Reicher, et al., 2020). First, *identity prototypicality* ('prototypicality' henceforth) refers to how well leaders embody important aspects of the group's identity (e.g., by disclosing ways that they are similar to the group). Second, *identity advancement* refers to how well leaders promote the group's collective interests

and act as a ‘champion’ for the group (e.g., by advocating for the unique needs of the group). Third, *identity entrepreneurship* refers to how well leaders actively craft and strengthen the specific identity of the group (e.g., through setting explicit norms and rules for the group). Finally, *identity impresarioship* refers to how well leaders create structures and opportunities for group members to express and develop their identity (e.g., through organising relevant activities).

Through these four processes, identity leadership theory provides a framework for understanding multiple therapy-related outcomes. Some examples of these are presented in Figure 5.1. The primary hypothesised mechanism through which these positive outcomes occur is enhanced social identification with the therapist or therapy group. However, other social psychological processes also play key roles (e.g., the development of health-promoting norms in the therapy group; Robertson et al., 2022 [Chapter 4]). Although we provide some examples of benefits that identity leadership might confer via social identification with an emergent therapy group identity, a much larger body of research speaks to the broader mental and physical health benefits of experiencing social identification with meaningful groups (e.g., Haslam et al., 2018; Jetten et al., 2017). For example, social identification has been linked to greater resilience (Koni et al., 2019), reduced depression (Postmes et al., 2019), improved post-traumatic symptoms (Muldoon et al., 2019), and more general psychological resources, such as a sense of belonging, control, hope, and purpose (Frings et al., 2019; Greenaway et al., 2016; Walter et al., 2016). According to this hypothesised model (see also Lee et al., 2021; Robertson et al., 2023 [Chapter 1]) therapist characteristics and behaviours—including carefully considered lived experience disclosures—can influence relevant outcomes by impacting important identity-based group processes.

Figure 5.1 *Conceptual Model of Identity Leadership in Group Therapy.*



Note. We were primarily focused on testing the bolded path in this study.

It is worth noting that these mechanisms align closely with established therapeutic processes. In particular, common factors theory posits that different therapeutic approaches all share several "common factors" that determine their effectiveness, including positive therapeutic relationships between therapists and clients (e.g., Messer & Wampold, 2002; Wampold, 2001, 2015). The therapeutic relationship is commonly termed the therapeutic alliance in individual therapy (i.e., the bond between the therapist and client; Horvath et al., 2011) and group cohesion in group therapy (i.e., the bond between the therapist and the group members but also *among* group members; Burlingame et al., 2018). Alliance and cohesion have long been recognised as key to unlocking positive therapeutic outcomes (Ardito & Rabellino, 2011; Burlingame et al., 2018).

Compared to these existing understandings of the therapeutic relationship, identity leadership theory: (a) offers new perspectives on how the therapeutic relationship is formed and operates, drawn from a long tradition of robust theory and research (i.e., since Tajfel & Turner, 1979) and (b) provides insights on specific therapist behaviours that might strengthen the therapeutic relationship (e.g., see tables in Lee at al., 2021 and Robertson et al., 2023 [Chapter 1]). According to identity leadership theory, the key to effective alliance or cohesion is that therapists and clients connect over meaningful, shared parts of their identity (Lee et al., 2021; Robertson et al., 2023 [Chapter 1]). This proposition has also received empirical support: clients' social identification with the therapist and ratings of their therapist's identity leadership were shown in recent studies to predict substantial variance in the therapeutic alliance (Cruwys et al., 2023; Lee et al., 2023). Critically, according to the theory, it is not enough for a therapist to be simply appointed as a leader or to be an exceptional individual.

Instead, influence depends on an emergent sense of a collective psychological community that includes both client(s) and therapist. Given this theoretical focus on the collective, we primarily focus on group therapy contexts in this article. However, conceptually, this approach is equally applicable to individual therapy, such that the therapist and client can bond over broader shared identities.

Importantly, the basis of this collective sense of 'us' as therapist and client(s) extends beyond superficial similarities between the therapist and clients that prior research has focused on, such as being from the same ethnic or racial group. Indeed, although it has intuitive appeal, meta-analytic evidence has indicated that simple demographic matching between therapists and clients has minimal therapeutic benefit (Cabral & Smith, 2011). Rather than assuming that similarity between the therapist and clients will necessarily lead to a strong therapeutic relationship, identity leadership theory emphasises the active role of the therapist in developing a meaningful shared therapy identity. This identity encompasses collective values, norms, and behaviours that facilitate therapeutic change and emerge through active processes of identity development and leadership by the therapist (see Lee et al., 2021 for further discussion). Through this lens, effective therapy relationships are built not on demographic matching or incidental similarities, but on cultivating a *purposeful* therapeutic identity, oriented toward recovery and mental health. A key benefit here is that directing therapists to cultivate new, therapy-based social identities is a far more actionable (and feasible) approach than ensuring that therapists are matched to clients on key demographic factors, which may be especially difficult in group settings.

Although it has not yet been tested, the prototypicality dimension of identity leadership appears particularly relevant to understanding the benefits of lived

experience disclosures. There are at least two different ways that therapists could present themselves as prototypical to clients. On one hand, a therapist could seek to show that they represent 'who we are now' (*average prototypicality*) – for example, by disclosing that they are currently experiencing the same mental health condition as group members. On the other, a therapist could seek to represent 'who we want to be' (*aspirational prototypicality*) – for example, by disclosing lived experience of *recovering from* the same mental health condition as group members. A recent meta-analysis of studies conducted primarily in organisational contexts found that, while there was evidence for the benefits of both types of prototypicality, aspirational prototypicality was a stronger predictor of positive outcomes than average prototypicality (Steffens et al., 2021). In a group therapy context, Robertson et al. (2022 [Chapter 4]) similarly found that clients' ratings of their group facilitators' aspirational prototypicality positively predicted desirable normative change across therapy. Specifically, in the context of an eating disorder prevention group, to the extent that clients perceived their group facilitator had a more positive body image than group members they increasingly came to believe that the group's approval of unhealthy dieting reduced during the therapy program. Prototypicality also indirectly predicted positive therapeutic outcomes via this normative change, including reduced intentions to diet in the three months post-therapy and greater body satisfaction.

5.1.3. The Present Research

Building on the abovementioned evidence for the benefits of group therapy leaders being prototypical, we examined whether therapist lived experience disclosures could be used to signal a therapist's prototypicality. We conducted two experiments to examine how therapists' disclosure of recovered or current mental health conditions

affected perceptions of their prototypicality and people's perceptions of them and their effectiveness. Our samples included therapy clients (Studies 1 & 2), therapists (Study 1), and general population adults (Study 2). Participants were randomly assigned to read a group therapy for depression vignette in which we varied what the therapist disclosed. Across both studies, we examined three key outcome variables: (1) positive perceptions of the therapist, (2) the expertness of the therapist, and (3) expected prognosis for therapy (which has been associated with better treatment outcomes; Constantino et al., 2018). We chose depression as the disclosure context to maximise comparability between our results and those of previous studies on this topic (McCormic et al., 2019; Moody et al., 2021) and because depression is one of the most common mental health conditions with the highest associated burden worldwide (Institute of Health Metrics and Evaluation, 2023). Despite this focus on depression, we did not specify experience with depression as part of our inclusion criteria. This decision was made so that we could examine a wider range of perspectives on therapist self-disclosure of lived experience, rather than only sampling therapists, clients, and general population adults with a history of depression. However, to gain some insight into participants' level of connection to the vignettes, in Study 1 we examined participants' connection with depression. Specifically, we measured their current depression symptoms, previous experience of depression, and identification as depressed as covariates of interest.

5.2. Study 1

In Study 1 we recruited a sample of clients and therapists to examine whether participants' perceptions of therapists differed across four scenarios: (1) the therapist discloses nothing about personal experiences with depression, (2) the therapist discloses years of *professional* experience with depression, (3) the therapist discloses

years of *personal*, *current* experience with depression, or (4) the therapist discloses years of *personal*, *previous* experience with depression. We predicted that a therapist disclosing previous experience with depression to a therapy group for people with depression would be perceived as more representative of the group's aspired identity ('who we want to be'), while a therapist disclosing current experience of depression would be perceived as more representative of the group's current identity ('who we are'). Our hypotheses (preregistered prior to data collection; https://doi.org/10.17605/OSF.IO/UWQFC) were as follows:

H1. The therapist disclosing *recovered* depression will be rated most favourably on positive perceptions (**H1a**), expertness (**H1b**), and expected prognosis for therapy (**H1c**). We also expected that the non-disclosing therapist would be rated least favourably.

As this was the first empirical study to examine therapist self-disclosure of a mental health condition in an intentional sample of real clients and real therapists, we were also interested in whether ratings of the therapist differed between the client and therapist samples. Given warnings against therapist self-disclosure and the stigma that surrounds health professionals with lived experience, we hypothesised the following.

H2. Clients will rate therapists who disclose information about their mental health condition (current or previous depression) significantly more favourably than therapists do on positive perceptions (**H2a**), expertness (**H2b**), and expected prognosis for therapy (**H2c**).

Finally, in line with identity leadership theorising, we hypothesised the following.

H3. Therapists disclosing recovered depression will be rated significantly higher on aspirational prototypicality (representing 'who we want to be') than therapists in the

other conditions (**H3a**). Along these lines, we also hypothesised that therapists disclosing current depression would be rated significantly higher on average prototypicality (representing 'who we are') than therapists in the other conditions (**H3b**).

Given that the context of the vignettes was disclosure of depression, we also pre-registered our plans to conduct several exploratory analyses examining the effect of participants' depression (past and current symptoms) and identification as a depressed person as covariates but did not make any specific hypotheses about these effects.

5.2.1. Study 1 Material and Methods

5.2.1.1. Participants

We recruited two subsamples: 160 clients who had received therapy within the last year and 160 therapists who had delivered mental health care services within the last year. The samples were primarily recruited via the research platform Prolific and were identified using a paid screener questionnaire. The screener included distractor items in addition to those designed to establish eligibility. This made it such that our specific eligibility criteria were unclear to participants and they were not incentivised to lie to gain access to the full study (see Chandler & Paolacci, 2017). Participants were paid the standard Prolific rate (i.e., £2.70 or equivalent AUD for their time completing the full survey plus £0.17 for completing the screener). For the client subsample, people whose Prolific profile indicated that they had attended a healthcare provider consultation and/or received NHS mental health support in the past year were eligible to complete the screener. Of the 270 people who completed the screener, 195 indicated that they had received mental health services in the last year and were invited to complete the full study (160 did). For the therapist subsample, people whose Prolific profile indicated that they worked in the 'health care and social assistance' or

'medical/health care' industry were eligible to complete the screener. Of the 470 people who completed the screener, 175 indicated that they had delivered mental health services in the last year and were invited to complete the full study (150 people). An additional 10 therapists were recruited via snowball sampling (i.e., known health professionals were invited via personal networks).

We aimed to recruit therapists and clients to better generalise our findings to the target population: people currently engaged in delivering or accessing therapy, who may therefore be the providers or recipients of a therapist lived experience disclosure. To provide a larger recruitment pool, we defined therapy broadly in our eligibility criteria, encompassing any mental health service in which clients receive mental health support from a health professional. In the screener, we provided participants with examples of what these services might entail (therapy, counselling, discussing mental health symptoms). Given this broad definition, participants likely delivered and accessed a variety of services, ranging from structured psychotherapy (e.g., in the case of a psychologist) to more informal or brief forms of support (e.g., a mental health consultation with a general practitioner).

The target sample size was determined using an *a priori* power analysis in *G*Power* (Faul et al., 2007) and preregistered. We calculated the sample size to detect an effect size of η^2=.08 (drawn from McCormic et al., 2019) with a power of .85 in a one-way fixed effects ANOVA with four groups. This suggested that the minimum sample size should be 152 (which we rounded up to 160). We aimed to recruit 160 therapists and 160 clients to provide adequate power for comparisons within each sub-sample.

All participants completed an attention check asking them about the primary symptom experienced by the group in the vignette they read (i.e., depression) and a

manipulation check asking them to identify what was disclosed by the therapist. Participants in the therapist subsample were also asked to describe their role to ensure that they were working as a therapist. These checks led to the removal of 38 participants (19 clients, 19 therapists): 32 failed the manipulation check, four failed the attention check, and two from the therapist subsample wrote that they were not therapists. We did not exclude two people who chose not to answer the question about their role. The final sample after these exclusions was 282 (141 clients and 141 therapists).

The two subsamples had comparable demographic characteristics (see Table 5.1). All participants resided in the United Kingdom except for the 10 therapists recruited via snowball sampling, who resided in Australia. The therapist participants reported working in a range of professions: psychotherapist/counsellor (*n* = 29), social worker (*n* = 27), mental health nurse/nurse (*n* = 24), mental health support worker/support worker (*n* = 16), psychologist (*n* = 15), and other health care worker (e.g., midwife, intake worker, speech therapist, occupational therapist; *n* = 20). An additional eight therapists specified multiple roles (e.g., counsellor and nurse) and two did not specify their role. Years of experience ranged from <1 year to 40 years (*M* = 10.84 years, *SD* = 8.40).

Table 5.1 *Sample 1 demographics.*

Subsample	**Mean Age (*SD*)**	**Gender, % (*n*)**	**Ethnicity, % (*n*)**
Therapists (*N* = 141)	41.50 (11.99)	Women = 70.2% (99) Men = 28.4% (40) Non-binary <1% (1) Rather not say <1% (1)	White = 85.1% (120) Black = 5.0% (7) Asian = 6.4% (9) Mixed = 3.5% (5)
Clients (*N* = 141)	38.43 (10.47)	Women = 71.6% (101) Men = 27.7% (39) Non-binary <1% (1)	White = 90.8% (128) Black = 2.1% (3) Asian = 2.1% (3) Mixed = 3.5% (5) Middle Eastern <1% (1) Latin(x) <1% (1)

5.2.1.2. Procedure and Materials

Participants were randomly assigned to read one of four scenarios (adapted from McCormic et al., 2019). Each scenario began with,

> "*Imagine you are in your first session of group therapy for the treatment of depression. Your group members are discussing what it feels like to have depression: a low mood, loss of interest in activities once enjoyed, trouble sleeping, feelings of worthlessness, and decreased appetite. The therapist explains the process of group therapy and how the group will work together to help decrease these depressive symptoms*."

These sentences were almost identical to McCormic et al.'s (2019) with the exception that the scenario referred to group, rather than individual, therapy. We also did not add the final sentence of their opening section (i.e., "*They tell you that they have many years of experience working with other clients like yourself and they are confident in their ability to help you*") as we deemed this a type of disclosure (professional

experience). Different sentences were added depending on the experimental condition (see Table 5.2). These sentences were constructed to be directly comparable across conditions. All referred to "years of experience", with the key difference being whether the therapist was disclosing years of professional experience, current depression, or recovered depression. After reading their vignette, participants completed the measures below and provided demographic information. Informed consent was obtained from all participants in both studies. The ethical aspects of both studies were approved by the authors' university Human Research Ethics Committee (#2022/795).

Table 5.2 *Details of scenarios provided to participants.*

Scenario	**Sentences Added**
Control	None.
Therapist discloses professional experience	*The therapist also tells the group that they have many years of experience working with people with depression. The therapist says that this means they really understand how difficult it is to live with depression.*
Therapist discloses recovered lived experience of depression	*The therapist also tells the group that they have personal experience with depression but are now recovered after many years of struggling. The therapist says that this means they really understand how difficult it is to live with depression.*
Therapist discloses current lived experience of depression	*The therapist also tells the group that they have personal experience with depression and are currently experiencing it. The therapist says that this means they really understand how difficult it is to live with depression.*

5.2.1.3. Measures

5.2.1.3.1. Positive perceptions. Participants' perceptions of the therapist were measured using Somers et al.'s (2014) scale (see also McCormic et al., 2019; Moody et al., 2021). Although the scale has not been formally validated, it has high internal reliability (Study 1 α = .93; Study 2 α = .92). The scale consists of nine items (e.g., "I think the psychotherapist is likeable") rated on a five-point scale (1 *Strongly Disagree* – 5 *Strongly Agree*). We added one item to examine the extent to which participants viewed the therapist as professional (i.e., "I think the psychotherapist is professional").

5.2.1.3.2. Expertness. The extent to which participants viewed the therapist as an expert was measured using the expertness subscale of the Counselor Rating Form – Short Version (CRF-SF; Corrigan & Schmidt, 1983). Participants rated the therapist on four adjectives (Expert, Experienced, Prepared, Skilful) on four-point scales (1 *Not Very* – 7 *Very*). This scale has been validated in prior research (Tracey et al., 1988) and had excellent internal reliability in the present study (Study 1 α = .94; Study 2 α = .92).

5.2.1.3.3. Prognosis. Expected treatment prognosis was measured using the Expectations for Treatment Scale (Barth et al., 2019). This consists of five items (e.g., "I expect the treatment (group therapy) would help me to cope with my complaints") rated on a four-point scale (1 *Partially disagree* – 4 *Definitely agree*). This measure has been validated and has excellent internal reliability (Barth et al., 2019; Study 1 α = .90; Study 2 α = .88). We found the wording of one item (i.e., "I expect the treatment would improve my physical problems") less relevant for this study, so changed it to refer to 'mental health'. We also adapted the phrasing for the therapist sample to refer to a client rather than themselves.

5.2.1.3.4. Prototypicality of the therapist. Prototypicality was measured using a modified version of the prototypicality subscale of the Identity Leadership Inventory (van Knippenberg et al., 2024). This version includes two subscales of six items each. The first measures average prototypicality – how much a leader represents a group's *current* identity (e.g., "The therapist is very similar to the members of the therapy group"). The second measures aspirational (also called "ideal") prototypicality – how much a leader represents a group's aspired identity (e.g., "This therapist embodies what the therapy group stands for"). Items are rated on a seven-point scale (1 *Not at all* – 7 *Completely*). Both the average prototypicality subscale (Study 1 α = .95; Study 2 α = .93) and the aspirational subscale demonstrated excellent internal reliability (Study 1 α = .94; Study 2 α = .93).

5.2.1.3.5 Depression. To measure participants' current levels of depression, we used the depression subscale of the *Depression Anxiety and Stress Scales-21* (DASS; Lovibond & Lovibond, 1995). This consists of seven items (e.g., "I couldn't seem to experience any positive feeling at all"), which are measured on four-point scales (0 = *Did not apply to me at all* – 3 = *Applied to me very much or most of the time*). Scores are summed, then multiplied by 2 (due to the scale being a shortened version of the DASS-42), such that higher scores indicate greater levels of depression. The scale had excellent internal reliability in the present study (Study 1 α = .94). We also asked, "Have you ever been diagnosed with depression by a health professional?" (Yes, No, Unsure, Rather not say).

5.2.1.3.6 Social identification as depressed. We measured participants' social identification with the identity of being a "depressed person" using the scale in Cruwys and Gunaseelan (2016). The scale consists of 11 items ("I feel a bond with other people

who have depression") rated on 7-point scales (1 *Strongly Disagree* – 7 *Strongly Agree*). The scale had good internal reliability (Study 1 α = .89).

5.2.2. Study 1 Results

Only six of the 282 participants had any missing data (2.1%). In most cases, these participants were only missing data for one or two items in a scale, so we calculated each measure based on the items they did complete rather than using listwise deletion (i.e., items in each scale were averaged to form composite scores). Unless otherwise specified, this means that all participants (N = 282) were included in all analyses.

The assumptions for an ANOVA (the primary analysis to test our hypotheses) were met with minor exceptions for all variables except for expertness, which demonstrated significant violations of normality in all four conditions due to negative skew and leptokurtosis (Shapiro-Wilk tests, ps <.05). A Levene's test also indicated violations to homogeneity of variance, $F(3,278) = 6.094$, p <.001. If available, we therefore used non-parametric tests where expertness was the outcome. Means, standard deviations, and correlations for each measure are summarised in Table 5.3. Means and standard deviations of measures by condition are also shown in Table 5.4.

Table 5.3 *Descriptive statistics of Study 1 key variables.*

Variable	Mean	SD	1	2	3	4	5	6
1. Average prototypicality	4.12	1.40	1					
2. Aspirational prototypicality	4.57	1.38	.59***	1				
3. Positive perceptions	3.87	0.72	.41***	.67***	1			
4. Prognosis for treatment	2.34	0.68	.31***	.50***	.62***	1		
5. Expertness	5.20	1.20	.26***	.64***	.81***	.56***	1	
6. Depression (DASS)	14.50	11.75	.03	.05	.09	-.14*	.12	1
7. Identification as depressed	4.02	1.02	.24***	.35***	.44***	.39***	.39***	.16**

Note. All correlations significant, p <.001. SD = Standard Deviation. According to Funder and Ozer (2019), the effect size of Pearson's r values can be interpreted such that r = .05 is very small, r = .10 is small, r = .20 is medium, r = .30 is large.

Table 5.4 *Means and SDs of variables by condition in Study 1.*

Variable	Control		Professional Experience		Recovered Depression		Current Depression	
	Mean	*SD*	*Mean*	SD	*Mean*	*SD*	*Mean*	*SD*
Positive perceptions	3.90	0.62	3.85	0.69	3.97	0.74	3.75	0.85
Expertness	5.35	1.05	5.31	0.99	5.31	1.10	4.80	1.55
Prognosis	2.32	0.66	2.31	0.69	2.46	0.71	2.24	0.65
Aspirational prototypicality	4.44[a]	1.13	4.02[a]	1.33	5.37[a]	1.26	4.40[b]	1.38
Average prototypicality	3.42[c]	1.07	3.18[c]	1.11	5.03[d]	1.27	4.82[d]	1.09

Note. Means with different superscript letters differ significantly, all p <.001.

5.2.2.1. Covariates

Using ANCOVA and moderation analysis (i.e., testing the effect of condition on key outcome variables with depression added as a covariate) and bootstrapped

regression for the expertness variable, we found that participants' depression was not a significant covariate or moderator in any model, nor did it impact any of the key results. We therefore do not report the results controlling for current or past depression. We report the results of models predicting the outcome variables with social identification as depressed added as a moderator below. We compared the level of depression in the therapist and client samples. Clients reported greater current depression (M = 20.26, SD = 11.51) than therapists (M = 8.75, SD = 8.84), $t(280) = -9.41$, $p < .001$. According to Lovibond and Lovibond (1995), the mean depression score of ~20 indicates a moderately severe level of clinical depression among clients, while the mean score of ~9 we observed for therapists is in the normal – mild depression range. Additionally, 86.5% of clients reported experiencing depression in the past, compared to 51.7% of therapists.

5.2.2.2. H1: Difference Between Disclosure Types

To test our hypothesis that participants would rate the therapist disclosing they had recovered from depression more favourably than the other therapists, we conducted two one-way ANOVAs, with positive perceptions and expected prognosis as the outcome variables. For expertness, we ran a Kruskal-Wallis test. Results are summarised in Table 5.5 (see also Table 5.4 for means and standard deviations in each condition). There were no significant differences between the four conditions for any of the outcome variables and thus H1a – H1c were not supported.

Table 5.5 *Omnibus effect of condition (disclosure type) on outcome variables in Study 1*.

Model term		Positive Perceptions (H1a)			Expertness (H1b)		Prognosis (H1c)		
	df	*F*	*p*	η^2	*H*	*p*	*F*	*P*	η^2
Condition	3, 278	1.166	.323	.01	4.987	.173	1.249	.292	.01

Note. Tests of H1a and H1c are ANOVAs, H1b is a Kruskal-Wallis test. According to Cohen (1988), the effect size for these η^2 values is small (i.e., $\eta^2 = .01$).

5.2.2.3. H2: Client versus Therapist Ratings

To test whether the client and therapist samples differed in their ratings of therapists, we specified an interaction term between sample (client vs. therapy) and condition (a) in two-way ANOVAs (for the positive perceptions and prognosis dependent variables), and (b) in a bootstrapped regression specifying 1000 repetitions (for the expertness dependent variable; Fox, 2008; Pek et al., 2018). Results are summarised in Table 5.6. The hypotheses were not supported: no significant interactions were observed between condition and sample for positive perceptions of the therapist (H2a), expertness (H2b), or expected prognosis (H2c). However, there was a significant main effect for expected prognosis, such that prognosis was rated more positively by therapists ($M = 2.51$, $SD = 0.62$) than clients ($M = 2.15$, $SD = 0.69$).

Table 5.6 *Effect of sample, condition, and their interaction on outcome variables in Study 1*.

Model term	Positive perceptions (H2a)				Expertness (H2b)		Prognosis (H2c)		
	df	*F*	*p*	η^2	χ^2	*p*	*F*	*p*	η^2
Condition (disclosure type)	3, 274	1.07	.350	.01	2.24	.524	1.29	.280	.01
Sample (therapist or client)	1, 274	0.88	.363	.003	0.15	.700	20.73	<.001***	.07
Condition*Sample	3, 274	1.32	.269	.01	4.25	.236	0.27	.847	.003

Note. *** p <.001. η^2 reported are partial. χ^2 values represent omnibus test of the joint significance of all levels of the variable. According to Richardson (2011) the effect size for partial η^2 can be interpreted in line with Cohen's cutoffs for η^2 (small = .01, medium = .06, large = .14).

5.2.2.4. H3: Type of Prototypicality

To test the effect of therapist disclosure type on aspirational prototypicality (H3a) and average prototypicality (H3b), we used one-way ANOVAs with prototypicality (aspirational or average) as the outcome and condition as the predictor. Results are summarised in Table 5.7 (see Table 5.4 for means in each condition). H3a was supported: Mean comparisons revealed that the therapist disclosing recovered depression was rated as significantly more aspirationally prototypical compared to (a) the therapist disclosing current depression, (b) the therapist disclosing years of professional experience and (c) the control therapist. H3b was partially supported: Mean comparisons revealed that the therapist disclosing current depression was rated as significantly more average prototypical than both the therapist disclosing years of professional experience and the control therapist, but not compared to the therapist disclosing recovered depression.

Table 5.7 *Effect of condition (disclosure type) on prototypicality in Study 1.*

Prototypicality Type	Condition			
	df	*F*	*p*	η^2
Aspirational (H3a)	3, 277	15.097	<.001***	.14
Average (H3b)	3, 278	49.031	<.001***	.35

Note. ****p* <.001; *N* = 280 for H3a model due to one participant missing data on all items. According to Cohen (1988), the effect size for η^2 can be interpreted such that η^2 = .01 is a small effect, η^2 = .06 is a medium effect, and η^2 = .14 is a large effect.

5.2.2.5. Exploratory Analysis

Relationship between prototypicality and outcomes. We did not make any *a priori* hypotheses about the relationships between the prototypicality measures and key outcomes (positive perceptions of the therapist, expertness, prognosis) given that they did not relate to the experimental manipulation. However, given the theoretical relevance of these relationships, we tested them in three regressions, one for each dependent variable and with average and aspirational prototypicality as independent variables (collinearity between prototypicality types was acceptable, VIF = 1.53, Tolerance = 0.66; Hair et al., 2010). For the expertness variable, the regression was bootstrapped specifying 1000 repetitions to handle the violations of normality. The overall regressions were significant for positive perceptions, $F(2, 278) = 115.73$, $p < .001$, $R^2 = .45$; expertness, $F(2, 278) = 106.19$, $p < .001$, $R^2 = .43$; and prognosis, $F(2, 278) = 45.74$, $p < .001$, $R^2 = .25$. According to Cohen (1988), the R^2 values for positive perceptions and expertness indicate a large effect size (>.26) and the R^2 value for prognosis is medium (>.13). Results are summarised in Table 5.8 and indicated that aspirational prototypicality was significantly and positively associated with all three outcomes (β's = .48 – .75). In contrast, average prototypicality was not associated with

positive perceptions or prognosis, and, surprisingly, was negatively associated with expertness (β = -.18).

Table 5.8 *Effect of average and ideal-type prototypicality on positive perceptions, expertness, prognosis in Study 1*.

Prototypicality Type	Positive Perceptions		Expertness		Prognosis	
	β (SE)	*p*	β (SE)	*p*	β (SE)	*p*
Average	.02 (.03)	.644	-.18 (.06)	.003**	.02 (.03)	.713
Aspirational	.66 (.03)	<.001***	.75 (.04)	<.001***	.48 (.03)	<.001***

Note. * *p* <.05, ** *p* <.01, *** *p* <.001. *SE* = Standard Error. *N* = 281. Model for expertness bootstrapped 1000 times. Coefficients are standardised betas and can be used to assess the relative importance of predictors. Following general guidelines (e.g., Cohen, 1988), we considered β = .10 a small effect, β = .30 a medium effect, and β = .50 a large effect.

Identification as depressed. We examined whether identification as depressed moderated the effect of condition on positive perceptions, expertness, and prognosis using the PROCESS macro for *R* (Model 1; Hayes, 2013). The independent variable was condition (dummy coded so that the control condition was the reference category), the moderator was identification as depressed, and we ran separate analyses for each dependent variable (bootstrapping the expertness model, specifying 1000 repetitions to handle the normality violations). All continuous variables were standardised before analysis. Results are displayed in Table 5.9. All three models were significant: positive perceptions, $F(7, 274) = 11.87$, $p<.001$, $R^2=.23$; expertness, $F(7, 274) = 9.94$, $p<.001$, $R^2=.20$; and prognosis, $F(7, 274) = 8.14$, $p < .001$, $R^2=.17$. According to Cohen (1988), these R^2 values all indicate a medium effect size. Identification as depressed had a significant positive main effect on all three outcome variables. The effect of condition varied across outcomes, with a significant negative effect of current depression (vs. control) on expertness, but no significant main effects of condition on positive

perceptions or prognosis (as would be expected given the results of H1). There were significant interactions between identification as depressed and condition for positive perceptions and expertness, but not for prognosis. Specifically, for positive perceptions and expertness, participants rated the therapists disclosing current depression more positively to the extent that they identified as depressed.

Table 5.9 *Effect of identification as depressed on positive perceptions, expertness, and prognosis, by condition in Study 1*.

Predictor	**Positive Perceptions**	**Expertness**	**Prognosis**
	β (SE)	β (SE)	β (SE)
Identification as Depressed (ID)	0.30** (0.11)	0.23* (0.11)	0.46*** (0.11)
Professional Experience (vs. Control)	-0.08 (0.15)	-0.04 (0.15)	-0.02 (0.16)
Current Depression (vs. Control)	-0.16 (0.16)	-0.41* (0.16)	-0.06 (0.16)
Recovered Depression (vs. Control)	0.16 (0.15)	0.01 (0.15)	0.25 (0.16)
ID × Professional Experience	0.01 (0.15)	0.04 (0.15)	-0.11 (0.15)
ID × Current Depression	0.31* (0.15)	0.39* (0.15)	-0.01 (0.16)
ID × Recovered Depression	0.30 (0.16)	0.19 (0.16)	-0.11 (0.16)

Notes. * p <.05, ** p <.01, *** p <.001. *SE* = Standard Error. *N* = 282. *ID* = Identification as Depressed. Model for expertness bootstrapped 1000 times. Coefficients are standardised betas and can be used to assess the relative importance of predictors. Following general guidelines (e.g., Cohen, 1988), we considered β = .10 a small effect, β = .30 a medium effect, and β = .50 a large effect. SE = standard error (in parentheses).

5.2.3. Study 1 Discussion

Study 1 represented the first attempt to test the effect of therapist lived experience disclosures among real clients and therapists and the first study to consider the effect of such disclosures on therapist prototypicality. The first two hypotheses were not supported: (1) participants in the four conditions did not differ in their ratings of the therapist on any of the outcomes (positive perceptions, expertness, expected prognosis), and (2) therapy clients did not rate disclosing therapists more favourably than therapists. These findings contrast with those observed by Moody et al. (2021) that therapists recounting past mental health conditions were rated more favourably than non-disclosing therapists or therapists disclosing a current mental health condition. This discrepancy may be at least in part due to differences in the vignette settings (group vs. individual therapy) and samples (real therapists and clients vs. general population) between our study and Moody et al.'s. Our findings also provide some initial evidence that therapists and clients have similar views about therapists disclosing mental health conditions.

Supporting Hypothesis 3, the therapist disclosing recovered depression was rated highest on aspirational prototypicality and the therapist disclosing current depression was rated highest on average prototypicality. Interestingly though, and contrary to our hypothesis, the therapist disclosing recovered depression was also rated highly on average prototypicality (and similarly to the therapist disclosing current depression). Notably too, exploratory analyses demonstrated that aspirational prototypicality (βs = .48 – .75) was consistently more strongly associated with positive perceptions of the therapist, ratings of their expertness, and expected prognosis than average prototypicality (βs = -.18 – .02). However, the results of this exploratory analysis

should be considered with caution given that the outcomes and the prototypicality types were measured at the same time point. It is thus unclear whether these outcomes led to higher aspirational prototypicality ratings or vice versa, necessitating additional longitudinal research.

There was no evidence that disclosing professional experience led to therapists being perceived as prototypical. In fact, our findings suggest this may even have had a 'backlash effect' that led therapists to be rated the lowest on both types of prototypicality, even lower than a non-disclosing therapist (although not a significant difference). One possible explanation for this is that talking about years of professional experience working with people who have depression may be considered an irrelevant disclosure in the context of therapy. Related to this, Knox and Hill (2003) stated that therapists sharing that they have worked with many clients who have experienced an issue being discussed is insufficient for building rapport with a client.

Planned exploratory analyses of the effect that participants' connection with depression had on the results revealed that the more participants identified as depressed, the more favourably they rated their positive perceptions, and the expertness, of the therapist disclosing current depression. One explanation for this is that people who identify strongly as depressed are more likely to view a therapist disclosing current depression as an ingroup member. This may lead to more positive views of the therapist, in line with a long history of research suggesting that people tend to view members of their ingroup more favourably than outgroup members (e.g., Tajfel, 1982). Interestingly, despite not being part of our eligibility criteria, a large portion of both clients and therapists reported past experience of depression, with many clients also scoring highly on current depression symptoms. Experience with current or past

depression did not affect our results. However, the high level of familiarity with depression in our sample may indicate that many participants could relate personally to the depression-focused vignettes.

5.3. Study 2

Study 2 aimed to replicate and extend the findings of Study 1. We sought to establish whether the *relevance* of the lived experience disclosure affected the way it was perceived and to compare clients and the general population in their perceptions of disclosure. To this end, Study 2 was identical to Study 1 in most respects, except that we replaced the professional experience condition with a disclosure of less relevant lived experience (recovered anxiety). We theorised that the therapist disclosing professional experience in Study 1 may have been rated the lowest on prototypicality due to the irrelevance of this disclosure and wanted to determine whether a less relevant recovery disclosure would have a similar effect (i.e., indicating that the disclosure should be recovered *and relevant* to signal prototypicality). Our hypotheses were as follows:

First, we wanted to investigate why Study 1 departed from previous research that found significant differences between how different types of therapist self-disclosure were received (using the same scale: positive perceptions). We hypothesised that this may be due to the difference in samples: our study recruited clients and therapists whereas Moody et al. (2021) recruited general population adults. To test this, we recruited samples of both clients and general population adults. We hypothesised a significant interaction between sample (client or general population adult) and condition (the disclosure type that the therapist made) for ratings on the positive perceptions variable, such that only participants in the general population adult sample

would rate a therapist disclosing recovered depression more positively than therapists making other disclosures (**H4**).

Additionally, we sought to provide a more conservative test of the link between recovery disclosures and aspirational prototypicality. We hypothesised that a therapist disclosing recovered anxiety would be rated significantly lower on both aspirational and average prototypicality compared to the therapist disclosing recovered depression (**H5**).

5.3.1. Study 2 Material and Methods

5.3.1.1. Participants

We recruited two subsamples via Prolific: 175 clients who had received therapy within the last year and 177 adults in the general population. For the client subsample, recruitment progressed in the same way as Study 1: 260 respondents completed a paid screener, from which 195 respondents were deemed eligible and invited to complete the full study (175 did). From the standard pool of Prolific participants (excluding any participants who had already participated in the study), we recruited 177 general population adults (we aimed for 175 but two extra participants were recruited due to a Prolific error). As in Study 1, all participants completed an attention check and manipulation check. These checks led to the removal of 89 participants (47 clients, 42 general population adults): 79 participants failed the manipulation check (at a similar rate across all conditions), four participants failed the attention check, and six participants failed both. The number of excluded participants was substantially greater than for Study 1, which may simply reflect us opening the recruitment on Prolific at a different time of day. There were comparable demographic characteristics across the two subsamples (Table 5.10). All participants resided in the United Kingdom.

Table 5.10 *Sample 2 demographics*.

Subsample	Mean Age (*SD*)	Gender, % (*n*)	Ethnicity, % (*n*)
General population adults (*N* = 135)	37.42 (10.65)	Women = 71.1% (96) Men = 27.4% (37) Rather not say = 1.5% (2)	White = 80.0% (108) Black = 5.9% (8) Asian = 7.4% (10) Mixed = 3.7% (5) Middle Eastern <1% (1) Rather not say = 2.2% (3)
Clients (*N* = 128)	35.44 (9.86)	Women = 65.6% (84) Men = 32.0% (41) Non-binary = 2.3% (3)	White = 89.1% (114) Black = 5.5% (7) Asian = 3.9% (5) Mixed <1% (1) Middle Eastern <1% (1)

5.3.1.2. Procedure, Measures, and Materials

The procedure and measures used were the same as in Study 1. The only differences were that: (a) the professional experience condition was replaced by a condition in which the therapist disclosed recovered anxiety and (b) we did not measure the depression covariates. For the new condition, the last two sentences of the scenario were: *The therapist also tells the group that they have personal experience with anxiety but have now recovered after many years of struggling. The therapist says that this means they really understand how difficult it is to live with depression*.

5.3.2. Study 2 Results

Of the 263 participants, 17 participants had missing data (6.5%), which was managed using the same approach as in Study 1. We used mean comparisons to examine H4 and H5. Assumptions for ANOVA (the primary analysis to test our hypotheses) were tested with Levene's tests, Shapiro-Wilk tests, skewness and kurtosis

statistics, and inspection of the histograms within each condition and for each dependent variable. These were met with minor exceptions. Levene's tests were non-significant for all variables (*p*s <.05) and Shapiro-Wilk tests were non-significant in most cases (*p*s <.05). Where there were significant Shapiro-Wilk tests, this appeared to be due to negative skewness. However, the skewness value was still within the acceptable range of -2 to 2 in all cases (e.g., Kim, 2013). As a sensitivity test, all analyses were run as Kruskal-Wallis tests with planned mean comparisons using Dunn's tests. The results were identical, so we report the parametric test results. As in Study 1, we used ANOVA and Chi-square tests to examine whether there were any baseline differences between participants in the experimental conditions on age, gender, and ethnicity. These were non-significant except for ethnicity, $\chi^2(12) = 28.84$, $p = .005$. However, we could not add ethnicity as a covariate to our analyses due to several small cell counts ($n < 2$).

Descriptive statistics are summarised in Table 5.11. We also present descriptive statistics for each measure, split by condition, in Table 5.12. Consistent with Study 1, none of the mean differences between conditions were significant for perceptions, expertness, or prognosis, but there were differences for aspirational and average prototypicality (in line with H5; see below).

Table 5.11 *Descriptive statistics of Study 2 key variables*.

Variable	Mean	SD	1	2	3	4	5
1. Average prototypicality	4.66	1.28	1				
2. Aspirational prototypicality	5.05	1.29	.59	1			
3. Positive perceptions	3.97	0.63	.43	.67	1		
4. Prognosis for treatment	2.42	0.72	.36	.51	.55	1	
5. Expertness	5.46	1.05	.38	.65	.76	.55	1

Note. All correlations are significant, $p < .001$. SD = Standard Deviation. According to Funder and Ozer (2019), all correlations indicate a large effect size (r > .30).

Table 5.12 *Means and SDs of key outcomes by condition in Study 2.*

Variable	Control		Current depression		Recovered depression		Recovered anxiety	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Positive perceptions	3.98	0.59	3.89	0.66	4.06	0.63	3.93	0.65
Expertness	5.55	1.02	5.36	1.05	5.61	0.99	5.27	1.14
Prognosis	2.38	0.72	2.34	0.70	2.57	0.76	2.36	0.68
Aspirational prototypicality	4.60[a]	1.24	4.88[a]	1.45	5.60[b]	1.12	4.99[a]	1.21
Average prototypicality	3.67[c]	1.13	5.38[d]	0.99	5.01[d]	1.10	4.41[e]	1.21

Note. Means with different superscript letters differ significantly, p <.05.

5.3.2.1. H4: Client versus General Population Ratings

We conducted a two-way ANOVA with positive perceptions as the outcome and condition, sample, and their interaction as predictors. The focal test for the hypothesis was the significance of the interaction coefficient, indicating differences between subsamples in the effect of therapist disclosure condition on perceptions. Results did not support the hypothesis; the interaction was nonsignificant (as were the main effects; see Table 5.13). Additional analyses indicated that there were also no significant interactions for expertness or prognosis. This suggests that participants in both samples viewed the different disclosures similarly.

Table 5.13 *Effect of condition (disclosure type) and sample on positive perceptions.*

Model term	*df*	*F*	*p*	η^2
Condition	3, 255	0.986	.400	.01
Sample	1, 255	2.316	.129	.01
Condition*Sample	3, 255	0.927	.428	.01

Note. η^2 reported are partial. According to Richardson (2011), these all indicate a small effect.

5.3.2.2. H6: Effect of Recovered Anxiety Disclosure

Two one-way ANOVAs with prototypicality (aspirational or average) as the outcome and condition as the predictor were used to test H5. Both ANOVAs were significant (see Table 5.14 for results and Table 5.12 for mean comparisons). Supporting H5, the therapist disclosing recovered anxiety was rated significantly lower on both aspirational and average prototypicality compared to the therapist disclosing recovered depression.

Table 5.14 *Effect of condition (disclosure type) on prototypicality.*

Prototypicality Type	Condition			
	df	*F*	*p*	η^2
Aspirational (H6a)	3, 257	8.527	<.001***	.09
Average (H6b)	3, 259	29.968	<.001***	.26

Note. ***p <.001; N = 260 for aspirational model; N = 262 for average model. According to Cohen (1988), the effect size for η^2 can be interpreted such that η^2 = .01 is a small effect, η^2 = .06 is a medium effect, and η^2 = .14 is a large effect.

5.3.3. Study 2 Discussion

Study 2 extended the findings of Study 1. Interestingly, and not supporting Hypothesis 4, ratings of the different disclosures on the outcomes were similar between the sample of clients and the general population sample. This provides preliminary evidence that clients view therapist self-disclosure of lived experience similarly to

general population adults, suggesting that prior research recruiting general population samples may accurately capture the perspectives of clients. This also suggests our findings that depart from Moody et al. (2021) may simply be due to the use of a group therapy scenario rather than an individual therapy scenario, or the use of a United Kingdom versus United States sample, highlighting the possible importance of the broader context on how therapist self-disclosures are perceived. We also examined whether *any* recovery disclosure would allow the therapist to be viewed as prototypical, or whether it had to be relevant to the mental health condition experienced by the therapy group. Supporting Hypothesis 5, results indicated that disclosing recovered and *relevant* conditions was key to being viewed as aspirationally prototypical. By contrast, *any* lived experience disclosure (whether recovered or current, irrelevant or relevant) led to therapists being viewed as prototypical of an average group member (compared to no disclosure), with maximally positive effects when the disclosure was of the same condition experience by the clients (recovered or current depression).

5.4. General Discussion

We aimed to examine how therapists were perceived by clients, other therapists, and adults in the general population depending on what kind of lived experience disclosure they made. We tested this in the context of group therapy for depression and were specifically interested in whether therapists were rated more positively if they disclosed that they had recovered from depression, compared to disclosing: (a) current depression, (b) recovered anxiety, (c) professional experience with depression, or (d) nothing. Contrary to several of our preregistered hypotheses, we found no differences across conditions or samples in how participants rated the therapists on our key outcomes of interest (positive perceptions, expertness, prognosis). Specifically, in Study

1, we found no support for our first hypothesis that different types of disclosure would affect positive perceptions of the therapist, ratings of their expertness, or expected prognosis, nor for our second hypothesis that clients and therapists would rate disclosures differently. Similarly, in Study 2, our fourth hypothesis predicting differences in how clients and general population adults would view the disclosures was not supported and we again found no difference across the positive perceptions, expertness, and prognosis outcomes between conditions. This provides evidence that neither experience of therapy, nor working as a therapist, necessarily leads people to hold different perspectives on therapist self-disclosure and raises interesting questions about how views on therapist self-disclosure might be shaped by broader societal understandings of therapeutic relationships rather than specific therapeutic experiences.

The limited support for H1 was also unexpected given that, in a study using a similar design, Moody et al. (2021) found that therapists disclosing a condition from the distant past were rated more favourably than therapists disclosing a current condition. As mentioned in the Study 1 Discussion, these differences may reflect our use of a group rather than an individual therapy vignette (which Moody et al., 2021 used). Another possible explanation for these contrasting findings is that there may be cultural differences in attitudes toward therapist self-disclosure between the United States (where many of the participants in Moody et al.'s study likely resided given their use of the MTurk recruitment platform) and the United Kingdom (where most of our participants resided).

We found more support for our hypotheses derived from identity leadership theory. In Study 1, H3a was supported: participants rated therapists who disclosed

recovered depression higher on aspirational prototypicality (“who we want to be”) compared to other therapists. Extending this, in Study 2, H5 was also supported, such that the therapist disclosing recovered depression was rated higher on aspirational and average prototypicality than the therapist disclosing recovered anxiety. This indicates that to signal aspirational prototypicality, disclosures should be of recovered *and relevant* conditions. These findings help to provide a new theoretical reason for the previous finding that the similarity between what therapists disclose and the client’s experience has important consequences for therapeutic outcomes (Levitt et al., 2016). That is, relevant disclosures may be more impactful because they are uniquely able to signal a therapist’s aspirational prototypicality.

Interestingly, across both studies, recovered depression disclosures were rated similarly to current depression disclosures on average prototypicality (“who we are”). This was contrary to H3b. Disclosure of recovered depression, therefore, allowed therapists to represent *both* “who we are now” and “who we want to be” for clients. Comparatively, other types of disclosure only allowed therapists to represent “who we are now”. Although we had hypothesised otherwise, our findings suggest that recovering from a condition may not necessarily diminish a therapist’s perceived ability to understand clients’ current experiences of that condition. This finding has important implications for identity leadership theory, as previous studies in this area have tended to examine whether leaders embody average *or* aspirational prototypicality (e.g., Robertson et al., 2022; Steffens et al., 2021), rather than considering the possibility that leaders may embody both types simultaneously. Future research should continue to consider the possibility that behaviours which signal aspirational prototypicality (such

as recovery disclosures) might also involve signalling some degree of average prototypicality.

By demonstrating the benefits of recovery disclosures for signalling aspirational prototypicality (which has been linked to positive therapeutic outcomes; Robertson et al., 2022), our findings also provide support for the growing 'lived experience movement' in mental health care research and delivery (e.g., Sunkel & Sartor, 2022) and suggest that therapists should not be overlooked as a source of lived experience (as they often are, despite the high prevalence of current or past mental health conditions in this population; de Vos et al., 2016; Victor et al., 2022). However, we demonstrate that the positive effects of lived experience disclosures may be maximised when therapists discuss recovered, rather than current, lived experience. This speaks to the appropriateness of the recommendation that therapists should not disclose experiences that are still currently negatively affecting them (e.g., Gelso & Palma, 2011; Henretty & Levitt, 2010; Knox & Hill, 2003).

5.4.1. Strengths, Limitations, and Future Research

Our Our studies had several strengths, including a strong theoretical underpinning, novelty (i.e., the first investigation of self-disclosure in a group therapy context), use of an experimental design, and recruitment of diverse samples. Nevertheless, our findings should be considered in light of some limitations. Perhaps most saliently, we examined therapist self-disclosure using vignettes, rather than in a natural therapy setting. Research in real-world therapy contexts is required to evaluate the ecological validity of these findings. Such research has some key barriers. For example, there would be ethical concerns associated with using experimental designs in which some therapists are asked to disclose mental health conditions during therapy

while others are not. Although it would lack the ability to make causal inferences, future research could compare the extent to which clients perceive their therapists engage in disclosure during real therapy sessions and assess the relationships between this and key therapy outcomes.

The cross-sectional nature of our study also limited our ability to examine whether prototypicality mediated the relationship between therapist disclosure types and our outcome variables (perceptions of the therapist, ratings of expertness, and expected prognosis). Our exploratory findings regarding the effects of disclosures on prototypicality and the association between prototypicality and outcomes speak to a potential mediation effect. However, longitudinal research assessing both the prototypicality types and the outcomes at multiple time points would be required to provide insight into the direction of the relationships between these variables (noting evidence from other contexts that relationships between identity leadership and positive outcomes may be bidirectional; e.g., Bruner et al., 2022).

Additionally, there are limitations associated with our sampling approach. As mentioned, we did not specifically recruit participants with depression. Notably, our Study 1 sample demonstrated relatively high depression symptoms and identification with depression, suggesting they could likely relate to the therapy scenarios presented. However, this would still have varied across participants. Future research specifically targeting participants with depression would therefore be beneficial, particularly given identity leadership theory's emphasis on the importance of connections over shared identities.

We also recruited participants who had received or delivered broadly-defined "mental health services" in the previous year and did not collect information about

participants' therapeutic experiences. Moreover, although we collected information about the role that the therapists worked in, we did not ask client participants about the clinician who provided mental health care to them. These broad inclusion criteria may have resulted in a heterogeneous sample with varying levels and types of therapeutic engagement, which may have affected how participants viewed the scenarios. For example, some clients may have been deemed eligible due to seeing peer workers – individuals who are known to commonly share their lived experience with clients (Jacobson et al., 2012). Where practical, future research should aim to minimise differences between the type of mental health care accessed by clients and delivered by therapists. This research could also seek to compare attitudes across, for example, different health professionals (e.g., psychologists versus general practitioners).

5.5. Conclusion

Across two experiments, we examined how different types of therapist lived experience disclosures were perceived in the context of group therapy for depression. Contrary to our expectations and some previous research, we found no evidence that different types of disclosure directly affected positive perceptions of the therapist, their expertness, or expected prognosis for treatment. Additionally, there were no differences in how clients, therapists, or general population adults rated the different disclosures on these outcomes. We obtained more support for our hypotheses drawn from identity leadership theory. Our results suggested that the content of disclosure matters for determining whether a therapist is viewed as a prototypical member of the therapy group. Specifically, therapists who disclosed a *recovered and relevant* condition were seen to represent both "who we are now" (average prototypicality) and "who we want to be" (aspirational prototypicality). In contrast, disclosure of less relevant or current

conditions signalled average (but not aspirational) prototypicality. This is important to consider in light of evidence that group therapy facilitators are more effective to the extent they are seen as aspirationally (rather than averagely) prototypical. Our findings extend on this prior research by highlighting one way therapists can signal their aspirational prototypicality: by disclosing information about their own relevant prior experiences.

Chapter 6. Goldilocks Disclosures: A Qualitative Exploration of when Therapist Self-Disclosure of Lived Experience is "Just Right"

Paper Rationale and Introduction

Having established the importance of an identity leadership behaviour (self-disclosure of relevant and recovered experiences) in enhancing perceptions of a leader's aspirational prototypicality in Chapter 5, I wanted to broaden my focus to more holistically consider the impacts of this behaviour. Given the contention surrounding whether it is appropriate for therapists to self-disclose (or even have) lived experience, I anticipated that in real-world settings—as opposed to experimental contexts—the effects of self-disclosure would not be so straightforwardly positive.

Given my aim to understand perceptions and experiences of lived experience disclosures more broadly and holistically, as discussed in Chapter 2, this chapter does not use the same theoretical framework (identity leadership theory) as the rest of the thesis. It also does not focus solely on group therapy. Instead, I took a data-driven approach. Taking this data-driven (rather than theory-driven) approach meant that, although self-disclosure of lived experience is conceptualised as an identity leadership behaviour in this thesis, it is not framed as such in this chapter. Nevertheless, this study contributes to the wider goals of my thesis by providing a more nuanced understanding of the effects of lived experience disclosures and the complexities in getting the behaviour "right". Indeed, I anticipate that all of the identity leadership behaviours

outlined in my thesis require considerable skill and reflection to implement effectively. Context, as this chapter illustrates, matters significantly.

It is worth noting again that this study draws from the same sample of clients and therapists as Study 1 in Chapter 5 (see Chapter 2 for more details on the methodology). By revisiting this sample with a different analytical approach, I aimed to extract deeper insights into the complexities surrounding therapist self-disclosure of lived experience.

Publication Status

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Author Contributions

I formed the research questions explored in this study, with supervisory support from Tegan Cruwys, Mark Stevens, and Michael J. Platow. I also collected all the data and wrote the original draft of the manuscript. Data analysis and coding were done collaboratively between myself and Anika Quayle. All other authors (Tegan Cruwys, Anika Quayle, Mark Stevens, Michael J. Platow, and Brett Scholz) assisted with editing and providing feedback on the manuscript. Our collaborative process is also described in more detail in the Methods section of this chapter.

Abstract

Despite increasing employment of peer workers, primarily hired for their lived experience of mental health issues, concerns remain regarding clinical health professionals (e.g., psychologists, counsellors, other therapists) disclosing their own lived experience. This qualitative study examined how therapists' lived experience disclosures are perceived by clients and other therapists. Participants (160 clients and 158 therapists) shared their experiences with therapist disclosure and responded to one of four hypothetical scenarios. Reflexive thematic analysis identified key themes that highlighted the tension between disclosures demonstrating humanity versus professionalism, openness versus a client-centred approach, and empathy versus competence. Themes also highlighted the challenge of getting disclosures "just right," ensuring therapists: had established rapport, kept disclosures brief and relevant, and shared experiences from which they had recovered. The findings underscored the trade-offs between the potential benefits and harms of disclosure, highlighting some conditions under which disclosure is considered appropriate and best supports the client and therapeutic relationship.

Keywords

Lived experience, self-disclosure, recovery, psychotherapy, therapeutic relationships.

Impact statement

This qualitative study found that when therapists share their lived experience with clients, each benefit (greater perceived humanity, openness, and empathy) comes with a corresponding cost (greater perceived unprofessionalism, selfishness, and incompetence). The benefits were maximised when therapists first established strong

therapeutic relationships, and then made brief disclosures about recovered and relevant experiences. These findings highlight the need for clearer self-disclosure guidelines and reduced stigma surrounding therapist lived experience

6.1. Introduction

Evidence suggests that mental health care can be better received and more effective when it is delivered by practitioners with lived experience of mental health conditions (Conchar & Repper, 2014; Repper & Carter, 2011). These findings have contributed to the growth of a mental health care workforce of non-clinical peer workers who are employed primarily to share and advocate based on their lived experience of mental ill-health and recovery, rather than because they possess specific professional qualifications (Sunkel & Sartor, 2022). At the same time, debate remains surrounding the appropriateness of clinical professionals (e.g., psychologists, counsellors) who have lived experience (in addition to their discipline-based professional qualifications) disclosing this to clients (e.g., King et al., 2020; 2023). Clinical professionals are henceforth referred to as 'therapists' for brevity, a word that we use to refer to a health care worker employed primarily because of a professional qualification, rather than lived experience. Similarly, 'therapy' is used to refer to mental health support provided by that clinician, ranging from structured and long-term psychotherapy (e.g., in the case of a psychologist) to more informal or brief forms of support (e.g., a mental health consultation with a general practitioner).

Therapists may consider lived experience disclosures inappropriate for several reasons. These include stigma (Harris et al., 2019; White et al., 2006) and professional guidelines and training that explicitly warn against self-disclosure (e.g., because it might be a 'slippery slope' leading to extreme boundary violations and other harms; Barnett, 2011; Mahalik et al., 2000; Strasburger et al., 1992). These concerns remain despite growing evidence that clients and organisations can benefit when therapists disclose their lived experience with mental health conditions (Jones & King, 2014; McCormic et

al., 2019; Moody et al., 2021; Somers et al., 2014). The present study adopted a qualitative approach to understand how therapist self-disclosure of lived experience is perceived, and particularly the conditions under which it is perceived most positively by clients and therapists.

6.1.1. To Disclose or not to Disclose: Evidence and Debate

As alluded to above, perspectives regarding the appropriateness of disclosure can differ according to the employment role of the discloser. A large body of literature has examined therapist self-disclosure more broadly, finding that it is largely beneficial for clients (e.g., see Henretty et al., 2014; Henretty & Levitt, 2010; Hill et al., 2018; Knox & Hill, 2003 for reviews). However, less research has examined therapist self-disclosure of their experience with mental health conditions. Where research does exist, it is often marked by contention. One key reason that there is still debate regarding the appropriateness of therapists disclosing their mental health conditions relates to role clarity (Gillard et al., 2014; McPhee et al., 2023; Scholz et al., 2017, 2018). Here, one argument is that disclosures from therapists can blur the boundaries between the role of 'clients' (who typically have mental ill-health) and the role of 'therapists' (who are supposedly mentally healthy; e.g., Carlson et al., 2001; Kraus & Moran, 2019; McPhee et al., 2023). This can raise doubts about the therapist's suitability to fulfil their role, given stigmatising beliefs that exist about the capabilities of people experiencing mental ill-health. However, this perspective is grounded in an assumption that mental health is dichotomous (i.e., people can be straightforwardly categorised as 'healthy' or 'unhealthy'). Counter to this dichotomous way of thinking, contemporary perspectives hold that mental health is better conceptualised as a continuum, such that even if a

therapist has never been diagnosed with a disorder, they have likely experienced multiple points along the continuum (Keyes, 2014; Lamers et al., 2011).

On the other side of the debate, empirical evidence speaks to the benefits that can arise from therapists disclosing lived experience. Findings from quantitative vignette studies recruiting undergraduate and general population samples suggest that people typically anticipate positive effects of therapists disclosing their lived experience of mental health conditions to clients (McCormic et al., 2019; Moody et al., 2021; Somers et al., 2014). For example, compared to non-disclosing therapists, therapists disclosing information about their mental health conditions tend to be perceived as warmer, more sincere, more likeable, more likely to have a good working relationship with a client, and more likely to provide a successful treatment (Somers et al., 2014).

Few qualitative studies have explored perspectives on therapist disclosure of mental ill-health. King et al. (2021; 2023) did, however, explore and uncover factors that contribute to therapists' willingness to disclose their status as a person with lived experience to their employer (e.g., feelings of safety), as well as factors that inhibit this (e.g., fear of judgement). Although this research did not explore client perspectives, the benefits of therapists being able to share their lived experience more generally at work with their colleagues and employers (e.g., increased job satisfaction resulting from greater authenticity in the workplace) might translate to benefits for clients.

Another consideration in the debate about what constitutes appropriate disclosure is whether the disclosed experience is currently occurring or something that the therapist has recovered from. Specifically, distinctions have been made in the literature between the 'impaired professional' (i.e., whose work is negatively affected by their mental ill-health) and the 'wounded healer' (i.e., who uses their experiences to

heal others; Jackson, 2001; King et al., 2020; Zerubavel & Wright, 2012). One key difference is that impaired professionals are usually conceptualised as currently unwell, whereas wounded healers are in recovery. This distinction mirrors the (flawed) dichotomous thinking described above, such that a person currently experiencing mental ill-health is assumed to be impaired but a person not currently experiencing mental ill-health is not.

Serious consequences arise from this way of thinking. One practical consideration is that some regulatory authorities mandate reporting of so-called 'impaired professionals' (e.g., in Australia; Australian Health Practitioner Regulation Agency, 2023; Edwards & Crisp, 2017). This means that therapists in certain professions may put their registration at risk by disclosing lived experience, especially of a current condition.

An important theoretical model to consider here, and one that we drew upon in the present study, is the recovery model of mental health (e.g., Jacobson & Greenley, 2001). This model suggests that connection with other people in recovery is a key predictor of positive outcomes for clients (in addition to a variety of other processes such as hope, healing, empowerment, and access to recovery-oriented services). Supporting this, empirical research has found that having more connections with people in recovery consistently predicts better recovery outcomes than having fewer connections with people in recovery (e.g., Bathish et al., 2017; Beckwith et al., 2019). Importantly, Jacobson and Greenley (2001) suggested that to create a positive culture of healing for clients and enable recovery, therapists should engage in a collaborative relationship where clients and therapists see each other as human beings.

In sum, there are arguments both for and against therapists disclosing mental health conditions, and growing evidence that those who choose to disclose should consider nuances such as whether only past experiences should be disclosed. Further targeted investigations are needed to advance understanding and inform practical recommendations for therapists. In particular, more research is needed that (a) does not rely solely on vignettes, (b) draws on samples of real therapists and clients (instead of students or the general population), and (c) captures actual (rather than hypothetical) disclosure experiences.

6.1.2. The Present Study

The present study sought to extend understandings of when therapist self-disclosure of lived experience is beneficial, by qualitatively examining the perspectives and experiences of mental health clients and therapists. A large sample (N = 318) comprising both clients and therapists was asked to (1) respond to hypothetical scenarios in which therapists disclosed information about their lived experience (aligned with those used in previous quantitative studies); and (2) recall and respond to any real-life experiences they had had in which a therapist disclosed information about their mental health. We sought to provide novel and rich insights beyond those generated by extant research, which has primarily been quantitative and recruited samples of undergraduate students or general population adults. For example, we hoped to shed further light on why there may be a greater benefit to therapists disclosing previous as opposed to current mental health conditions.

6.2. Materials and Methods

6.2.1. Participants

We recruited 160 mental health clients (i.e., people who had seen a mental health professional within the last year) and 158 therapists (e.g., social workers and psychologists, who had worked as a therapist within the last year). Apart from 10 therapists, who were recruited via snowball sampling in the researchers' professional networks, all participants were recruited from Prolific. Prolific is an online research participant recruitment platform where individuals can register to participate in paid research studies. The platform is widely used in psychology research and produces high-quality data that is both comparable to traditional methods (such as undergraduate participant pools) and superior to other online recruitment platforms (Douglas et al., 2023). Prolific enables researchers to only display their study advertisements to participants who meet certain criteria (based on the answers they provide to Prolific about their demographics and lifestyle; see Prolific, 2024). We used these criteria to identify people who a) indicated that they had attended a healthcare provider consultation and/or received NHS mental health support in the past year (for our client subsample), and (b) listed their occupation as being in the 'healthcare and social assistance' or 'medical/healthcare' industry (for our therapist subsample). Prolific respondents who met these criteria were invited to complete a brief, paid screener, which aimed to determine their eligibility (i.e., they had provided or received mental health care services in the last 12 months). Using a paid screener, which included distractor items to obfuscate the specific eligibility criteria, allowed us to be more confident that the participants were eligible, compared to relying on participant self-selection to the study based on their (self-determined) eligibility (see Chandler &

Paolacci, 2017). That is, it helped us to be more confident that all participants had either delivered or received therapy in the preceding year. All respondents were reimbursed £2.87 (or equivalent Australian dollars) for their time, consistent with the standard Prolific payment rate.

There were comparable demographic characteristics across the two subsamples (see Table 6.1). All respondents resided in the United Kingdom, except for the 10 therapists recruited via snowball sampling, who resided in Australia[5]. Participants in the therapist subsample were employed in a range of roles, including psychotherapist/counsellor (*n* = 31), social worker (*n* = 30), mental health nurse/nurse (*n* = 26), mental health support worker/support worker (*n* = 20), psychologist (*n* = 15), and other health care worker (e.g., "midwife seeing women with perinatal mental health difficulties", occupational therapist; *n* = 26). An additional eight therapists specified multiple roles (e.g., counsellor and nurse) and two therapists did not specify their role. Years of experience ranged from <1 year to 40 years (*M* = 10.74 years, *SD* = 8.53). We also collected data from two additional respondents, who were excluded from analysis because they stated that they were therapists in the screener, but explicitly wrote that they were not a therapist in response to the question asking them to describe their role.

Table 6.1 *Sample Demographics*

Subsample	**Mean Age (*SD*)**	**Gender, % (*n*)**	**Ethnicity, % (*n*)**

[5] There are some differences in the regulation of health professionals between the United Kingdom (UK) and Australia. In particular, the UK is less restrictive about health professionals experiencing mental ill-health compared to Australia. However, the UK health professional regulatory body standards do specify that professionals must (1) understand the importance of their mental health in maintaining fitness to practice and (2) develop and adopt strategies for self-care and self-awareness to ensure they continue to provide effective services and a safe working environment (Health and Care Professions Council, 2018).

Therapists (*N* = 158)	41.38 (12.04)	Women = 68.99% (109) Men = 29.75% (47) Non-binary/Rather not say = 1.3% (2)	White = 82.91% (131) Black = 6.25% (10) Asian = 6.88% (11) Mixed/Middle Eastern/Latinx/Rather not say = 3.75% (6)
Clients (*N* = 160)	38.03 (10.35)	Women = 69.38% (111) Men = 30.0% (48) Non-binary/Rather not say = <1% (1)	White = 91.25% (146) Black = 1.88% (3) Asian = 1.88% (3) Mixed/Middle Eastern/Latinx/Rather not say = 5.00% (8)

Note. To reduce identifiability, we combined categories with only a few participants.

6.2.2. Materials, Measures, and Procedure

This qualitative study was part of a larger mixed methods research project examining perceptions of therapists who disclose information about their mental health in group therapy (see https://doi.org/10.17605/OSF.IO/UWQFC for preregistration of the quantitative project; see also Chapter 5). Informed consent was obtained from all participants. The study was approved by the Human Research Ethics Committee at the authors' university (Protocol 2022/795).

For the qualitative component of the project (i.e., the present study), all participants were first randomly assigned to read one of four scenarios (adapted from McCormic et al., 2019). All scenarios began with a few sentences setting the scene (i.e., a therapy group for people experiencing depression, symptoms that group members are discussing, that the therapist will work with everyone to improve their symptoms; see preregistration for specific wording). We chose depression as the context of lived experience disclosure for our scenarios to help make these more concrete and because

it is one of the most common mental health conditions worldwide (World Health Organisation, 2017). However, we acknowledge that focusing on depression, rather than capturing the full diversity of lived experience, may have limited the range of perspectives elicited by our scenarios. Different sentences were added for each scenario, serving as relevant experimental manipulations (see Table 6.2). Scenarios were used to elicit participant opinions about disclosures of interest (e.g., disclosure of recovered versus current conditions).

Table 6.2 *Details of scenarios provided to participants*.

Scenario	Sentences Added
Control scenario	None.
Therapist discloses professional experience	*The therapist also tells the group that they have many years of experience working with people with depression. The therapist says that this means they really understand how difficult it is to live with depression.*
Therapist discloses recovered lived experience of depression	*The therapist also tells the group that they have personal experience with depression but are now recovered after many years of struggling. The therapist says that this means they really understand how difficult it is to live with depression.*
Therapist discloses current lived experience of depression	*The therapist also tells the group that they have personal experience with depression and are currently experiencing it. The therapist says that this means they really understand how difficult it is to live with depression.*

After reading their scenario, participants were asked to respond to two free-response questions. The first, "What do you think about the therapist in this scenario?", was designed to capture more nuanced information about participant responses to disclosure vignettes than has been afforded by previous research (which has asked participants to rate disclosing therapists on numeric scales, rather than to write freely

about their opinions of the therapist's disclosure). The second question was designed to explore participants' real-world experiences related to therapist disclosure of personal experience of mental health. Clients were asked: "Has your therapist ever disclosed their personal experiences with mental health to you? Briefly describe what happened", while therapists were asked: "Have you ever disclosed your own experiences with mental health during therapy? Briefly describe what happened".

6.2.3. Analytic Approach

Data were analysed inductively and collaboratively by two coders (AR and AQ) using Braun and Clarke's (2019) six-stage reflexive thematic analysis. First, the coders independently read and familiarised themselves with the data and met to discuss overall thoughts and interpretations. Second, the coders independently coded all responses in the data by clustering related participant responses together (e.g., all statements about 'recovery'). Third, they met to discuss these clusters and collaboratively generated initial themes (e.g., broader benefits of self-disclosure) and subthemes (e.g., specific benefit of humanising the therapist). Fourth, the coders continued to collaboratively develop the themes, meeting on three occasions to reduce the number and overlap, build greater connection between the themes, and choose indicative quotes. Throughout this stage, the coders consulted with a supervisor (TC) twice for guidance in developing the themes. Fifth, the themes were refined, named, and defined collaboratively among all coauthors in the process of writing and editing the manuscript (i.e., stage six, which was led by AR).

A reflexive approach acknowledges the existing perspectives of researchers and their role in shaping the generation of themes. Although the coders took an inductive approach, the study was conducted as part of a broader project that examines social

identity processes and the importance of recovery in group therapy (i.e., AR's PhD project), and this background influenced the themes (in particular, Theme 4.4). However, supporting the salience of the recovery theme, AQ, who was not involved in the broader project, independently formed a theme about the specific benefits of recovery self-disclosures. Indeed, although AQ was not involved in the data collection or design of the project, she formed very similar themes to AR in the independent coding stage and there was a high level of agreement between the coders about the overarching themes of the data. AQ's background in English Literature influenced the refining of themes and selecting quotes, as she drew attention to rhetorical devices such as metaphors used by participants (e.g., for Theme 1, comparisons between the quotes about warm 'humans' and those about cold 'machines').

During supervision, TC contributed knowledge and perspectives drawn from her experience as a clinical psychologist (e.g., about the mandated requirement to report 'impaired professionals' in the psychology profession in Australia). This drew added attention to participant remarks that therapists who self-disclose lived experience could possibly be breaking "*codes of conduct*" or require "*monitoring*", which we included as quotes in our themes. Some members of the research team also have lived experience of mental health issues, including in decisions about whether to disclose lived experience to others in the workplace. This influenced the way that the first three themes were constructed: as costs and benefits that need to be considered when deciding whether to disclose. Finally, all authors conduct research on health topics using a social-psychological determinants approach. This influenced some of the

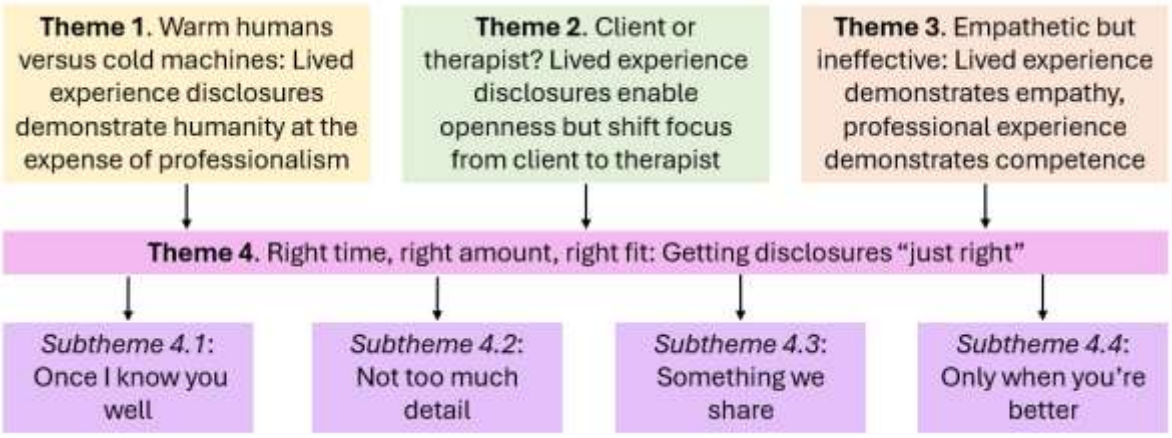
literature and theory used to interpret and explain the themes (e.g., the recovery model of mental health).

6.3. Results

Among the 318 participant responses, 87 (27.4%) contained a recount of a real-life therapist disclosure experience (29 clients, 58 therapists). There was large variation in the kinds of disclosure experiences that participants recalled. Some common disclosures included information about therapists' experience of specific symptoms (anxiety, intrusive thoughts, depression, substance use), as well as broader issues such as traumatic experiences, problems at work, or relationship issues. Others were less specific (e.g., recounts about disclosure of "*personal struggles*").

We present four key themes (see Figure 6.1) that were developed across both questions and samples. Combining the themes in this way was a data-driven decision: we could not identify themes unique to one sample or question. Each theme highlighted tension or complexity in therapist self-disclosure of lived experience: (1) lived experience disclosures demonstrate humanity at the expense of professionalism; (2) lived experience disclosures enable openness but shift focus from client to therapist; (3) lived experience demonstrates empathy, professional experience demonstrates competence; and (4) the challenge of getting disclosures "*just right*". Below, we provide the age, gender, and whether the participant was a client or therapist for unique quotes. We do not provide this information for words or phrases that appeared in several participant responses.

Figure 6.1 *Themes present in disclosure recounts and responses to the scenarios.*



6.3.1. Theme 1. Warm humans versus cold machines: Lived experience disclosures demonstrate humanity at the expense of professionalism.

This theme concerned the *person* – the qualities attributed to therapists who chose to self-disclose lived experience versus those who did not. Disclosing therapists were described as "*human*", and therefore "*warm*", but were also described as "*unprofessional*", "*inappropriate*", "*oversharing*", "*overstepping boundaries*", and possibly even "*[breaking] codes of conduct*". Comparatively, the therapist in the non-disclosing scenario was described as "*professional*" but also "*cold*" and "*clinical*". Further illustrating this distinction, disclosing lived experience was described as a way for therapists to "*admit to being human and not some machine made for delivering therapy*" (29 years, woman, therapist). Similarly, one participant suggested that self-disclosure gave life to the therapy session, such that it was "*not one book talking to another book, as it were, but one human talking to another*" (63 years, man, therapist). The metaphors of the machine and book (i.e., inanimate objects) highlighted the cold yet predictable nature of a non-disclosing therapist, who follows the often-unspoken convention that therapists should not talk about their lived experience with clients.

Comparatively, self-disclosure allowed the therapist to be viewed as a human: warmer, but perhaps also unpredictable in ways that threatened their occupational role.

Some clients highlighted the benefits of the humanity created when therapists self-disclosed lived experience. For example: "*It made me feel like I had a bit of a kindred spirit…it helped to know that they are human too*" (44 years, woman, client). For this participant, the therapist's disclosure appeared to have strengthened the bond between them. Yet, echoing the potential costs of this humanity, some clients viewed therapist self-disclosure as violating their expectations, suggesting that therapists should be "*a mirror, a foil. They should be blank so I can project and work through my issues*" (41 years, woman, client). The desire for the therapist to be "*blank*" suggests that, for some clients, therapists should not bring their "*human*" selves into the therapy room.

This theme demonstrated that disclosure of lived experience allowed therapists to be perceived by clients as a fellow human being, which enhanced the perception that they were warm and animated (compared to inanimate objects, such as machines, books, or mirrors). However, this came at the cost of their perceived professionalism. Conversely, non-disclosing therapists were perceived as professional but cold. This suggests that therapists may need to weigh up the benefit of connecting with clients on a human level with the cost of compromising their perceived professionalism. Given that there were also both positive and negative views of the humanity afforded by self-disclosure, this decision may also depend on individual client needs and preferences.

6.3.2. Theme 2. Client or therapist? Lived experience disclosures enable openness but shift focus from client to therapist.

Where Theme 1 concerned the person, Theme 2 concerned the *dynamic* arising from lived experience disclosures, in particular, the impacts of, and opinions about, therapists using clients' session time to discuss their own experiences of mental health. Therapists' sharing of their lived experience appeared to violate the usual expectation that clients share, while therapists listen.

On a positive note, this meant that therapists who stepped into the role of client and shared information about their lived experience were described as "*honest*", "*truthful*", "*open*", "*vulnerable*", and "*brave*" (words that were not used to describe non-disclosing therapists). This openness on the part of the therapist was anticipated to translate into a positive dynamic between therapists and clients, creating a "*safe space*" that allowed clients to "*open up more without the fear of being judged*" (31 years, woman, client). Therapists' openness was therefore linked to greater client openness. One therapist also commented that this openness demonstrated "*a good commitment to honesty, transparency and sincerity which are beneficial within the working relationship*" (29 years, woman, therapist). Aligned with this, some therapists who mentioned disclosing information about their mental health to clients did so to be more "*open*", "*deepen the connection between client and therapist*" (31 years, woman, therapist), and "*strengthen the therapeutic relationship*".

On a more negative note, some clients anticipated that lived experience disclosures would reduce their own willingness to be "*fully*" open. Clients with this view appeared to anticipate that therapist self-disclosure of lived experience (i.e., the therapist stepping into the role of client) would require clients to step into the role of

'therapist' to the extent that they felt responsible for the therapist's welfare. For example:

> "*I would be concerned that sharing my problems and leaning on them emotionally would make [the therapist's] current episode worse*" (33 years, woman, client).

Interestingly, anticipating this possibility, one therapist stated that she used self-disclosure intentionally, in a way that would not "*upset the dynamic such that the client feels that they have to commiserate or have sympathy for me*" (55 years, woman, therapist). One risk of disclosure, then, may be that therapists stepping into the client role could prompt clients to step into the therapist role (e.g., being concerned about the therapist's welfare, sympathising with the therapist).

Another negative impact of therapist self-disclosure of lived experience was that some participants (both therapists and clients) felt that therapy was no longer focused on the client. Therapist participants especially appeared to be concerned that it violated the "*client-centred*" nature of therapy and could act as a signal to clients that the therapist is "*more focused on helping themselves*" (45 years, woman, therapist). As an example:

> "*The therapy is not about me, it's about the client. So my personal experiences with my own mental health are not important to the client's journey. It is more important for me to focus on the client and their experience and make sure they are heard, than to add details of my own experiences*" (43 years, woman, therapist).

Echoing this, clients stated things like "*the session should be about me, particularly as a paying service user*" (33 years, man, client), suggesting that they expected the

therapist to listen and not share, at least in part because they are paid to do that. These experiences and opinions suggested that therapists sharing information about their mental health may shift the focus away from the client, who might not be "*heard*" if the therapist is talking about themselves.

Some recounts also suggested mixed feelings about shifting the dynamic in therapy. As an example, one client recounted:

> "*I was touched that they felt comfortable enough to be so open about their own struggles but, to be honest, it kind of put me off a bit. It was like seeing a GP [general practitioner] about a sore knee and them telling me about theirs. It may sound selfish but if I'm receiving any kind of treatment, I hope and expect that it will be focused on me*" (43 years, man, client).

Although touched by their openness, this client appeared to think that his therapist's disclosure violated the expectations he had about their role in providing treatment, likened to the experience of a general practitioner talking about their physical health problems to a patient. Similarly, another client recounted:

> "*It was good at first. It felt friendly but that friendliness soon led me to question the boundaries. Who was the therapist and the client?*" (52 years, woman, client)

Both experiences highlight the dissonance that can be present in client experiences of therapist self-disclosure (i.e., touching but off-putting; friendly but confusing).

This theme highlighted the costs and benefits of therapists stepping into the client role by sharing their lived experience. Therapists sharing lived experience appeared to violate expectations about how therapy works. For some participants this was positive, shifting the dynamic in a way that felt safer and allowed them to be more open. For others it was negative, making them feel that the therapy had become

therapist-centred rather than client-centred. There were also participants who liked some aspects of the shifting dynamic but disliked others. Like Theme 1, this demonstrates the importance of considering how disclosure may shift the dynamic of the therapeutic relationship, and carefully weighing up the potential costs and benefits of this.

6.3.3. Theme 3. Empathetic but ineffective: Lived experience demonstrates empathy, professional experience demonstrates competence.

Beyond disclosing lived experience, this theme concerned the benefits and costs of simply *having* lived experience, and whether it was preferable for therapists to gain expertise about mental health conditions through lived experience or professional experience. Each form of expertise had a cost and benefit. Lived experience demonstrated that therapists had a "*special*" understanding of what it is like to experience mental health concerns (i.e., greater capacity for "*empathy*") and "*what works*" for alleviating symptoms. However, it meant that the therapist was viewed as "*incompetent*", requiring "*monitoring*", and "*not qualified*" (29 years, man, client). Conversely, professional experience demonstrated that the therapist was "*competent*" and "*able to help*", but lacking empathy, and even "*patronising*", such that they could "*only sympathise but not empathise*" (57 years, woman, client).

Further illustrating this, one client stated that lived experience allowed therapists to be "*a person who would have more understanding than a therapist who has learnt everything from a text book*" (48 years, man, client). Another remarked that,

> "*Just studying depression does not mean you are the best at helping…I think the best way to be an expert in helping others is to have suffered yourself in some*

> *way and the understanding gained from that far surpasses just vocational experience. The empathy cannot be matched*" (35 years, woman, client).

This echoed the metaphor in Theme 1 of books versus humans, perhaps indicating that "*studying*" and learning from "*a textbook*" can provide knowledge but only 'suffering' can provide understanding (i.e., the ability to empathise). However, the cost of this understanding was often perceived incompetence:

> "*I think the therapist needs to focus on their own battles before trying to help others…They would definitely have empathy but possibly no answers or solutions*" (48 years, woman, client).

This theme highlighted the costs and benefits of therapists gaining expertise from lived experience or from professional experience. Interestingly, once a therapist was categorised as someone with lived experience, the virtues afforded by their professional experience (i.e., assumptions that they were capable and competent) were minimised. It appeared difficult for participants to accept the idea that a therapist could both be a person with lived experience (demonstrating empathy) *and* a person with professional experience (demonstrating competence).

6.3.4. Theme 4. Right time, right amount, right fit: Getting disclosures "just right"

Many therapists specified that there were only specific "*right*" conditions under which they would (or did) choose to make a lived experience disclosure and consider it appropriate. These conditions included (1) having a strong rapport with the client, (2) disclosing only brief details about the experience, (3) disclosing a similar experience that is relevant to the client, and (4) disclosing an experience from which they had recovered. One therapist summarised this theme well by stating that the decision to disclose is "*a professional judgement task*" (42 years, woman, therapist). This theme

was primarily evident in therapists' recounts of instances where they had self-disclosed. However, positive client recounts echoed many of the conditions under which disclosures were seen by therapists as appropriate.

6.3.4.1. Subtheme 4.1 Once I know you well: Disclosure should come after building rapport. Therapists explained that lived experience disclosures should only be made "*once rapport was built*". For example, one therapist recounted that they disclosed their lived experience to a client "*when I had been working with [them] for quite a long time and therefore had a fully intact relationship with them and insight into how they might react to a self-disclosure*" (53 years, woman, therapist). This suggested that knowing a client well was important because it allowed insight into how the disclosure might be received. Another therapist said that this is why she had *not* disclosed information about her mental health to clients:

> "*I have not been working long enough to build that kind of rapport with my clients and feel at this stage it's better to focus fully on their condition rather than speaking about my own*" (35 years, woman, therapist).

This connected to elements of Theme 2 (i.e., that self-disclosure can be used as a tool for building a stronger therapeutic relationship but can also shift the focus of therapy away from the client), such that it highlighted the need for therapists to use self-disclosure to strengthen the therapeutic relationship only once there was already a solid connection. This may suggest that a key factor determining whether lived experience disclosures enable openness or impact the client-centred nature of therapy is whether there is already rapport between the therapist and client.

6.3.4.2. Subtheme 4.2 Not too much detail: Disclosure should be brief or indirect. Therapists said that they would (or did) disclose only "*very brief detail*" about

their experiences to clients, for example, "*in a very vague superficial way*" (39 years, woman, therapist) or "*in a fairly oblique way if the situation is common*" (44 years, man, therapist). Some clients also reported positive experiences when their therapist did not disclose information about their mental health directly, but in an implied way. For example, one client wrote, "*Not explicitly but they did talk about personal experiences in such a way that implied that they had experienced depression*" (42 years, man, client). One therapist also suggested that disclosure could merely be hinted at, through the simple use of "*we*" *and* "*us*" pronouns. This theme connects to Themes 1, 2, and 3, such that providing only brief detail and taking up only a short amount of session time may (1) show humanity whilst retaining the professionalism of the therapist, (2) not shift the focus away from the client, and (3) show empathy without providing enough detail to make clients question the therapist's competence.

6.3.4.3. Subtheme 4.3 Something we share: Disclosure should map onto client experiences. The use of the word "*relevant*" in several positive disclosure recounts suggested that a key component of an appropriate lived experience disclosure was that it explicitly related to the client's experience. Some recounts clearly illustrated this, such as one client who recounted that their therapist:

> "*Told me a bit about her own experience of anxiety and how it affected her, as part of a discussion around my own anxiety*" (37 years, woman, client).

Therapists stated that disclosing similar lived experience was a way of "*normalising*" and "*de-shaming*" these experiences. Client responses also suggested this was a key benefit, helping them to "*understand that even people that seem to have a good hold on their mental health can be depressed*" (38 years, man, client). Perhaps not viewed as controversially as disclosing personal mental health concerns, some

therapists reported disclosing their own experiences receiving *treatments* they were recommending to clients to advocate for their effectiveness from personal experience (i.e., give recommendations "*a personal weight*") and destigmatise their use. For example, one therapist said that she shared her positive group therapy experiences "*with clients who feel nervous and unsure about attending group therapy*" (31 years, woman, therapist). This suggests that highlighting shared experiences between the therapist and client can help to normalise experiences and reduce shame around mental health conditions and treatments.

However, other clients mentioned that, when timed inappropriately, the similarity could also make the disclosure come across as "*belittling*" or smug (i.e., a way of saying "*I have it and look how good I'm doing*", 37 years, man, therapist). For example:

> "*I had a therapist who disclosed their own abusive background. The disclosure at that stage felt ill timed and just left me with a sense of inadequacy that I hadn't been able to overcome certain difficulties*" (53 years, woman, client).

Perhaps anticipating such concerns from clients, therapists iterated the importance of highlighting that everyone's experience is "*unique*". One therapist reported that he explicitly addressed this when disclosing, by "*letting [clients] know that everyone's experience can be different, and how I felt/coped is not necessarily what they should do*" (62 years, man, therapist). This suggested that the match between the therapist's story and the client's story could be useful, but only when presented in the right way and at the right time, aligning with Subtheme 4.1 and 4.2 (i.e., ensuring there is a strong relationship that affords insight into how the disclosure will be received and making the disclosure brief).

6.3.4.4. Subtheme 4.4 Only when you're better: Recovery disclosures are hopeful, current illness disclosures are disheartening. Another key factor determining the appropriateness of disclosures was that the disclosure was "*past-tense*" and about recovered (not current) experiences. For example, "*I am careful to not disclose too much information about how I am currently feeling [but] I am willing to be honest and disclose my past experiences*" (32 years, woman, therapist). One of the reasons for this was that there were specific benefits reported for disclosure of recovered experiences. The central benefit was that therapists' own stories of recovery could provide clients with "*hope*", which was explicitly described by some therapists as their intention for disclosure: *"to give hope to clients that things can improve and it doesn't always have to be like this*" (45 years, woman, therapist). The capacity of recovery disclosures to provide hope was supported by client recounts, who said that they demonstrated that it was "*possible to recover from depression, which is something you sometimes forget is possible when you are suffering yourself*" (21 years, woman, client). One client recounted:

> "*my previous mental health nurse, suffered from severe anxiety disorder. Knowing this helped a lot as it gives hope to know that a normal life can be achieved*" (38 years, man, client).

The provision of hope afforded by recovery stories also appeared to translate to positive perceptions of the therapist as a person, in much the same way that lived experience disclosures translated to perceptions of warmth and humanity in Theme 1. Participants who read the scenario in which the therapist disclosed recovered depression described this therapist as inspirational and "*someone to aspire to*" and positive assumptions were made about their motivations for choosing the profession,

such that they were "*using their experiences as a positive to try and help others*" (34 years, woman, therapist), had "*a purpose*", and were "*not just doing it as a job, but as a vocation*" (38 years, man, therapist). In contrast, the therapist in the non-disclosing scenario was described as "*just doing their job*" (23 years, woman, client). This may suggest that being able to overcome mental health struggles was viewed in a heroic and inspiring way. Directly contrasting this, therapist disclosures of *current* experiences of mental ill-health were viewed as "*disheartening*", and reflected poorly on the effectiveness of therapy, for example:

> "*The fact that he's living through depression might not be the best way to promote the effectiveness of his methods. Who would trust a fat dietician*?" (40 years, man, client).

This connected back to Theme 3, in which therapists with lived experience were viewed in stigmatising ways (e.g., incompetent) and it was suggested that they should "*focus on their own battles before trying to help others*". This theme may therefore highlight the added benefits when therapists share their story after they have successfully 'won the battle' against mental ill-health.

6.4. Discussion

The present study advanced research on therapist self-disclosure of lived experience by exploring (1) therapists' and mental health clients' reactions to scenarios describing different types of therapist self-disclosure and (2) what happened in actual instances of therapist disclosure of lived experience. A key feature of the themes was their inherent tension, such that each benefit of lived experience disclosure had a corresponding cost. First, lived experience disclosures can show clients that their therapist is 'human', but this may come at the cost that they are no longer viewed as a

‘professional’. Second, lived experience disclosures can create a safer space where the therapist’s openness empowers clients to open up; however, this shift in dynamic can be harmful if clients feel the focus of therapy has shifted from their needs. Third, having lived experience can foster perceptions that the therapist is empathetic and truly understands mental ill-health, but at the cost that they may be viewed as incompetent or ineffective due to their previous or current mental health struggles. Overall, our findings therefore provide further evidence for the trade-off between the potential benefits of therapists disclosing lived experience (McCormic et al., 2019; Moody et al., 2021; Somers et al., 2014) and the potential risks of doing so (Barnett, 2011; Mahalik et al., 2000; Strasburger et al., 1992).

Our fourth theme could be considered to bring together the other themes, such that if therapists can get disclosures ‘just right’, the benefits may outweigh the risks. The fourth theme outlines some conditions for these ‘Goldilocks disclosures’. For example, in line with previous research by McCormic et al. (2019)—who found that positive effects of disclosure were maximised when therapists talked about their symptoms but not the negative impacts on their life—we found that sharing a brief amount of detail may maximise the positive effects of lived experience disclosure. Similarly, in line with research and theory described earlier, therapists speaking about recovered conditions rather than current conditions may result in their disclosure being perceived to demonstrate humanity (a wounded healer) without affecting their perceived professionalism (an impaired professional).

We found that participants perceived disclosures to be humanising (Theme 1). This builds on propositions of the recovery model (Jacobson & Greenley, 2001) to suggest that one way of connecting with clients on a human level is by disclosing lived

experience. However, disclosure of lived experience was also viewed as unprofessional. Perhaps anticipating this, Jacobson and Greenley (2001) stated that creating a positive culture of healing and recovery sometimes means that therapists need to think beyond their training, especially around "boundary issues" (p. 484) so they can relate to clients on a human level. This also relates to prior research by King et al. (2023), who found that feelings of safety in teams that accepted imperfections and humanity in their staff enabled therapists to feel comfortable sharing their lived experience whereas feeling pressured to be a 'professional' was one factor that constrained therapists' comfort sharing. It is possible that when weighing up the costs and benefits detailed in Theme 1, therapists might consider the orientation of their workplace. Promoting recovery-oriented mental health services (as is recommended in the recovery model of mental health; Jacobson and Greenley, 2001), may therefore be beneficial for clients both directly and indirectly via an increase in therapists' comfort levels when discussing their own lived experience.

The tension in Themes 2 and 3 surrounded the dichotomy of roles – therapist versus client and lived experience versus professional experience. In particular, these themes highlighted that these roles and concepts— 'client' (sick) and 'health professional' (healthy)—are usually thought of as non-overlapping, such that a therapist's client status precludes them from being an effective 'health professional' (e.g., Helmus et al., 2019; King et al., 2020). Indeed, Theme 3 demonstrated that participants seemingly disregarded the professional experience and identity of therapists when provided with information that they had lived experience. However, this dichotomy is inaccurate; therapists, psychology graduate students, and psychology faculty members experience mental ill-health at equal or greater prevalence compared

to the general population (e.g., 80% prevalence; Victor et al., 2022). Given the negative impacts of stigma around mental ill-health both broadly and for health professionals, this finding highlights the need for more advocacy and research that highlights the capabilities and strengths of people experiencing mental ill-health.

Finally, we found that disclosures about previous or *recovered* shared experiences may be particularly beneficial (Theme 4.4). This provides qualitative support for Moody et al.'s (2021) quantitative findings that therapists are perceived more positively when they disclose recovered, rather than current, mental health conditions. Our finding also supports prior research and theory (Bathish et al., 2017; Beckwith et al., 2019; Jacobson & Greenley, 2001) indicating that connecting with other people who have experienced recovery is key to healing, in part because it can inspire hope. It also relates to recent research demonstrating that therapists are more effective to the extent that clients perceive them to represent the aspirational identity of a therapy group (i.e., 'who we want to be') rather than its current identity (i.e., 'who we are'; Robertson et al., 2022 [Chapter 4]). Building on this research, our finding may indicate that recovery disclosures act as a signal that the therapist embodies a future, aspired identity for clients (i.e., a person in recovery), whereas disclosing current mental health concerns may signal they share a current, stigmatised identity (i.e., a person experiencing mental health conditions).

6.4.1. Clinical Implications

One key implication of our findings is that therapists may be currently overlooked as a valuable source of lived experience in mental health care. We found benefits of therapists disclosing lived experience that closely align with research on the benefits of mental health care delivered by non-clinical mental health professionals (e.g., peer

workers). For example, Otte et al. (2020) found that receiving care from peer workers increased the perceived level of empathy and understanding provided, reduced professional distance in a way that enabled open communication, and increased hope, due to viewing the peer worker as a role model for recovery. Similarly, O'Neill et al.'s (2024) findings suggested that peer self-disclosure promotes greater empathy, trust, rapport, and openness, and indicated that peer workers are most helpful to clients when they are in a comfortable place of recovery. Some of the motivations and "right" conditions for disclosure expressed by therapists in our study also aligned with those reported in a prior study of peer workers. For example, findings converged in suggesting that disclosing is only appropriate when it is relevant to the client and is designed to build rapport and demonstrate empathy and understanding (Truong et al., 2019).

However, there may also be specific harms associated with therapists disclosing lived experience. In addition to negative impacts for clients when therapists violate expectations in this way, therapists may also risk facing harms to themselves. Participant comments about therapists with lived experience violating codes of conduct and requiring monitoring provide stark reminders that therapists who open up about their mental ill-health could be reported to regulatory authorities. This is one place where the experiences of therapists (especially those working in registered health professions like psychology) may not align with the experiences of non-clinical mental health professionals, for whom the risk of losing registration as a health professional due to disclosing mental ill-health does not apply. Interestingly, some research highlights the potential for the presence of peer workers to facilitate the creation of safe spaces for clinical mental health professionals to disclose their own lived experiences whilst also increasing the perceived value of peer workers to mental health

professionals (Byrne et al., 2022). This may indicate that further integration of peer workers into mainstream health services could improve workplace culture around discussing employee mental health.

Finally, we found some specific conditions under which therapist disclosure of lived experience was 'just right'. These included: having enough existing rapport with the client, providing appropriately limited detail, disclosing experiences that are relevant to the client, and disclosing only recovered experiences. Although more research is needed to facilitate more nuanced recommendations, our findings provide some initial guidance for therapists considering disclosing information about their lived experience to a client. Our findings also provide support for existing guidelines around appropriate therapist self-disclosure. For example, and directly echoing our findings, Gelso and Palma (2011) recommended that therapists should only disclose once there is a positive relationship or strong working alliance between the therapist and client, provide only the necessary information, and only disclose past experiences that are relevant to the client and no longer distressing to the therapist.

6.4.2. Limitations and Future Research

This study had several strengths, including its examination of real therapists, real clients, and real instances of self-disclosure. However, our sample all resided in Western countries and were predominately White women. Related to this, one possibility is that the dichotomous thinking present in our findings regarding (a) mental health and (b) therapist and client roles may align with Western cognitive styles. Dichotomous thinking is theorised to be more prevalent in Western cultures than, for example, East Asian cultures, where people tend toward more dialectical thinking (e.g., see Berlin, 1990; Nisbett et al., 2001; Peng & Nisbett, 1999). Future research should

therefore continue to examine experiences and perspectives on therapist self-disclosure in more diverse populations and contexts.

The online nature of the study and the large sample size offered both strengths and limitations. On one hand, it enabled us to capture the perspectives of hundreds of different individuals (which is unusual in qualitative research) and provided a high degree of anonymity for participants, which was likely beneficial given that we were asking about therapists engaging in a contentious practice. On the other hand, the online, brief nature of the study (i.e., only two questions) led to less detailed responses from each participant than might have been afforded by, for example, semi-structured interviews. Interview or focus group studies would therefore be beneficial to help capture a greater depth of information about the experiences and perspectives of therapists and clients and help shed light on questions such as what happens before, during, and after therapist lived experience disclosures. Future research could also employ a similar design to ours but use a different qualitative method, such as content analysis. In a large dataset, content analysis could be used to investigate the prevalence of particular perspectives on, and experiences of, disclosure.

The use of Prolific to recruit participants online may have also affected the composition of our sample and, consequently, our findings. People who register on Prolific to participate in paid research studies may differ systematically from the broader population of therapists and clients. For example, participants comfortable with disclosing personal information in online studies may hold more positive attitudes toward therapist disclosure, potentially meaning that favourable views toward disclosure were overrepresented in our study.

Additionally, although we were interested in the experiences of and opinions about clinical mental health professionals disclosing lived experience to clients, we did not think to specifically recruit therapists in professions that are registered with regulatory bodies (e.g., psychologists, social workers) or ask clients only to write about experiences with such professionals. This is important to consider given the potentially more serious consequences (e.g., losing registration due to 'impairment') for registered health professionals who disclose lived experience to clients. Future research could seek to specifically examine opinions about and experiences of lived experience disclosures made by registered health professionals and determine whether this differs from non-registered professionals.

Finally, although participants recounted real instances of disclosure about a wide range of conditions and experiences, it is worth noting that our scenarios focused solely on depression as the disclosed mental health condition. While depression is common, perceptions of therapist disclosure may differ substantially for other conditions, particularly those with greater stigma attached, that are less common, or that are viewed as more severe, such as psychosis or personality disorders. Some research indicates that interventions led by peers with lived experience may be less beneficial for severe mental health conditions, such as schizophrenia (Lloyd-Evans et al., 2014). However, our findings regarding the importance of recovery in shaping perceptions of disclosure align with evidence that, when there is an intentional focus on recovery, peer-led programs can be effective even for severe mental health conditions (e.g., Hearing Voices Network groups for people experiencing psychosis; Longden et al., 2018). Future research should nevertheless examine how therapists' and clients'

perceptions of disclosures vary as a function of the condition being disclosed and the extent to which recovery is emphasised.

6.5. Conclusion

Our study extended research and theory on the benefits and risks of therapists disclosing information about their mental health to clients. We used a qualitative experimental approach to examine the experiences and perspectives of real therapists and clients regarding both actual and hypothetical self-disclosure scenarios. Our findings revealed a fundamental tension between the perceived benefits and potential harms of therapists revealing their personal lived experiences. We also unveiled some specific conditions under which disclosure was deemed appropriate: when there is an established relationship between the therapist and client, when the disclosure is brief, when it relates to experiences shared with the client, and when the experience is something that the therapist has recovered from. A key implication of our findings is that, like non-clinical professionals, it may be beneficial when clinical professionals disclose their lived experience. However, there may be specific risks that arise when clinical professionals do so (e.g., perceived incompetence, possible reporting to regulatory boards). These findings underscore the need to challenge the stigma surrounding therapists with lived experience, create safer spaces for therapists to share, and move away from a simplistic ‘sick/clients’ versus ‘healthy/therapists’ dichotomy.

Chapter 7. General Discussion and Conclusion

This chapter first revisits the aim and research questions of the thesis before summarising the key empirical findings. Following this, I outline the theoretical and practical implications of these findings for both clinical and social psychology. Finally, I discuss the strengths and limitations of this research and provide suggestions for future research.

7.1. Review of Thesis Aim and Research Questions

The high global prevalence of mental ill-health highlights the need for effective and accessible mental health care solutions. However, despite the high demand for mental health care services, there remains a shortage of funding and trained professionals available to deliver these services. Group therapy offers a promising solution due to its cost-effectiveness (i.e., several people can be treated at once by the same therapist) and demonstrated efficacy across various mental health conditions. However, existing literature on group therapy is limited and often lacks theoretical and empirical foundations, particularly regarding effective facilitation strategies. The lack of research on group therapy facilitation exacerbates the challenges in providing quality mental health care, emphasising the need for new, theory-driven, and evidence-based approaches to guide effective group therapy practice.

My thesis aimed to address this gap in theory-driven and evidence-based approaches to group therapy facilitation across several empirical studies informed by identity leadership theory. As mentioned throughout, identity leadership theory posits that effective leaders create, embody, advance, and represent a shared sense of “we”

and “us” among group members. To address my aim, I examined three key research questions:

1. What identity leadership behaviours are observed in group therapy?
2. What are some of the specific *benefits* of engaging in identity leadership in group therapy?
3. What are some of the *mechanisms* through which group therapy identity leadership might enhance group therapy effectiveness?

By exploring these questions, this research has sought to contribute to both (a) the theoretical understanding of identity leadership and group therapy processes and (b) the practical implementation of effective identity leadership and group facilitation strategies.

7.2. Empirical Findings

The first empirical study of this PhD (Chapter 3) developed and provided initial validation for a framework of identity leadership behaviours in Groups 4 Health therapy groups for people with social anxiety, directly addressing Research Question 1. The development process was iterative and collaborative, given that there was no existing corpus of identity leadership behaviours (except for those outlined in Chapter 1). This process involved working alongside collaborators with expertise in identity leadership and consulting clients of the therapy groups. Interestingly, the rate at which facilitators engaged in these behaviours was not associated with client ratings of facilitators on the most common, well-validated measure of identity leadership, the Identity Leadership Inventory (ILI; Steffens, Haslam, Reicher, et al., 2014). This may have been due to problems with the scale in the group therapy context, rather than the behaviours not being examples of identity leadership. Evidencing this, clients’ ratings of the therapists

on the ILI did not predict increases in participants' social identification with the therapy group over time (except for impresarioship), as would be expected based on previous research. The extent to which facilitators engaged in some of the proposed identity leadership behaviours, however, did. Investigating whether the behaviours predicted social identification also addressed the second and third research questions, as social identification is a key outcome of identity leadership and a mechanism through which it is hypothesised to confer benefits.

The remaining empirical chapters of this thesis (Chapters 4 to 6) focused on one specific facet of identity leadership: identity prototypicality. These examined whether it was more beneficial for therapists to be viewed as prototypical in an aspirational or average sense. This focus was chosen to contribute to an ongoing debate in social identity literature regarding which of the two types of prototypicality is most impactful (i.e., Steffens, Munt, et al., 2021) and add to the growing body of literature examining the utility and appropriateness of mental health care providers having lived experience of the conditions they seek to treat (e.g., Sunkel & Sartor, 2022). It was theorised that therapists demonstrating that they have personal lived experience of mental ill-health might signal their prototypicality to clients.

Chapter 4 explored identity prototypicality in a study of young women attending body acceptance groups. Results indicated that facilitators were more effective to the extent that they were viewed by their clients as *aspirationally* prototypical (i.e., as someone who accepted their body, did not engage in dieting, and was not jealous of other women's bodies). Specifically, greater ratings of aspirational prototypicality led to greater change across therapy in how much clients believed their group members would approve of them dieting. Importantly, this positive change in norms around dieting also

predicted therapeutic outcomes at the end of therapy, including improved body satisfaction and reduced intentions to diet in the 3 months post-therapy. This study contributed to the second and third research questions by demonstrating two key points: (1) that improved therapeutic outcomes are a significant benefit of identity leadership, and (2) that positive changes in group norms serve as a mechanism through which identity leadership achieves these benefits. However, the design of this study did not provide information about *how* therapists demonstrated to clients that they represented the aspired ideal for the group.

Building on these findings and addressing the first research question of this thesis, Chapter 5 examined whether a specific identity leadership behaviour—self-disclosure of relevant mental health experiences—would enable therapists to be viewed as aspirationally prototypical. This was investigated through two experimental studies. The results showed that therapist self-disclosure of *recovered and relevant* conditions was most beneficial (compared to other types of lived experience disclosure) because it uniquely signalled aspirational prototypicality. This type of prototypicality had a stronger positive effect on participants' ratings of the therapist (including positive perceptions, expertness, and prognosis) than average prototypicality. Contributing to the second research question, this study found that a key benefit of making recovered and relevant disclosures (an identity leadership behaviour) was its positive impact on how therapists are perceived.

Although the experimental studies in Chapter 5 provided valuable insights, the use of vignettes limited the study's ability to capture real-world experiences of therapist self-disclosure. To address this limitation, Chapter 6 explored actual experiences of therapist self-disclosure in a qualitative study. Participants, screened to ensure they

were either therapy clients or therapists, were asked to recount experiences of therapist disclosure of lived experience. Clients described instances where their therapist had disclosed lived experience and therapists recounted times they had shared their own lived experience. Participants also provided qualitative responses to the vignettes in Chapter 5's first study. These responses were then analysed using reflexive thematic analysis. The themes demonstrated that, as expected, the way therapists and clients view therapist self-disclosure of lived experience is highly complex. For every benefit of disclosing lived experience to clients (e.g., appearing warmer and more human), there was a corresponding cost (e.g., being viewed as less professional). This added nuance to the findings of Chapter 5, indicating that the effects of lived experience disclosures are not so straightforwardly positive, even for recovered and relevant conditions. Importantly, and aligned with the third research question, this study highlighted the conditions under which the benefits of lived experience disclosures (an identity leadership behaviour) are maximised.

In sum, the research in this thesis demonstrated that identity leadership provides both (a) a sound theoretical basis for understanding effective group therapy facilitation and (b) a robust empirical framework for studying it. Addressing Research Question 1, the studies yielded a framework of facilitator identity leadership behaviours (in particular, Chapter 3). Regarding Research Question 2, the studies uncovered potential benefits of facilitator identity leadership in group therapy, such as increased client social identification with their therapy group (Chapter 3), improved therapeutic outcomes (Chapter 4), and more positive perceptions of the therapist (Chapter 5). Finally, addressing Research Question 3, the studies identified mechanisms that may explain how these benefits are conferred, such as through changes in group norms

(Chapter 4). Chapter 6 also provided information about the conditions under which an identity leadership behaviour (therapist self-disclosure) is most likely to have beneficial outcomes.

7.3. Implications

The findings of this thesis have a range of implications for both clinical and social psychology. Implications for each field are discussed separately below.

7.3.1. Theoretical and Practical Implications for Clinical Psychology

7.3.1.1. A new perspective on effective group therapy facilitation. This thesis drew from identity leadership theory to develop a new framework for understanding effective group therapy facilitation. This framework offers several advantages over existing models (which are limited in number and specificity). First, it provides deeper, mechanistic explanations for what constitutes effective group therapy facilitation and what makes group therapy treatments effective. Second, it offers more concrete, evidence-based recommendations for facilitators wishing to improve their effectiveness. Third, it provides novel theoretical explanations for why existing facilitation strategies (e.g., normalising experiences, self-disclosure) work and a theoretical basis upon which to develop new strategies.

To further illustrate the advantages of this new framework, it is useful to compare it with one of the most popular models for understanding effective group therapy: Yalom's 12 therapeutic factors (Yalom & Leszcz, 2020). This model identifies 12 factors that underpin effective group therapy, including (1) instilling clients with a sense of hope, (2) showing clients that they are not alone, (3) allowing clients to learn from others in the group, and (4) providing clients opportunities to support others (see Yalom and Leszcz, 2020 for the entire list). Although these factors have good face validity and are

grounded in extensive clinical experience, the model has some limitations. There is minimal theoretical rationale provided for *why* they lead to better therapeutic outcomes or *how* they emerge. Moreover, empirical evidence supporting these factors is limited (although see Kivlighan & Holmes, 2004).

In contrast, the framework proposed in this thesis offers several key advantages. First, it is more parsimonious, distilling effective facilitation into the core principle of identity leadership rather than a list of 12 distinct factors. Second, it has a stronger theoretical grounding, firmly rooted in the social identity approach to leadership. Third, it has a stronger evidence base, drawn from both the research in this thesis and a long history of social identity research and theory development spanning multiple disciplines and built over the last 50 years (i.e., since Tajfel et al., 1971).

The findings in this thesis suggest that engagement in identity leadership may incidentally promote many of Yalom's therapeutic factors. Although not explicitly tested, this connection could be argued based on the likely outcomes of some of the identity leadership behaviours explored. For example, therapists who disclose information about their own relevant and recovered mental health experiences or normalise clients' experiences may be able to (1) instil clients with a sense of hope and (2) show them that they are not alone. The quotes and themes detailed in Chapter 6 provide good initial evidence for this. As another example, therapists engaging in co-leadership with clients and organising activities that bring them together (such as the social identity mapping activity; Cruwys, Steffens, et al., 2016) may provide clients with opportunities to (3) learn from and (4) provide support to each other. Some initial evidence for this possibility can be obtained from the interviews detailed in Chapter 3.

Given that social identification is the key outcome of identity leadership, the connection between identity leadership and Yalom's therapeutic factors can be further argued using evidence that social identification provides psychological resources closely related to them. For example, a sense of belonging, control, hope, and purpose (Frings et al., 2019; Greenaway et al., 2016; Walter et al., 2016), opportunities for prosocial behaviours such as giving and receiving social support (Avanzi et al., 2015; Cruwys, Haslam, Dingle, Haslam, et al., 2014; Häusser et al., 2023) and a framework for understanding the world (Cruwys, Haslam, Dingle, Haslam, et al., 2014). That is, by fostering social identification in therapy groups, identity leadership likely enhances group members' access to these important psychological resources, many of which align with Yalom's factors. In sum, this new framework explains the mechanisms underlying effective group therapy practice (both for existing and novel strategies) more effectively and efficiently than existing frameworks like Yalom's therapeutic factors.

7.3.1.2. Conceptualising therapists as leaders. A second important implication of this research is the need to conceptualise therapists as leaders who play an influential role in group treatment effectiveness. Traditionally, group facilitators have been viewed as passive conduits of treatment, with research primarily focused on comparing the effectiveness of different manualised treatments (e.g., cognitive behaviour therapy or mindfulness therapy; Arch et al., 2013). The inherent assumption in such research is that therapists' skill, style, and approach in delivering these treatments are equivalent. However, the findings of this thesis challenge this assumption, demonstrating that therapy outcomes can be affected by a range of therapist factors, such as the extent to which they are viewed as embodying the group's aspirational identity (Chapter 4). These results suggest that therapists should instead be

conceptualised as leaders and, more specifically, identity leaders. The argument that effective therapists are necessarily identity leaders was reiterated by Haslam (2024) in his recently published commentary on my conceptual paper (i.e., Chapter 1 in this thesis).

Conceptualising therapists as leaders raises important questions about the nature of their influence in therapeutic settings. From a social identity theoretical perspective, effective leaders are viewed as using 'influence' rather than 'power' to guide their followers towards collaboratively defined goals. Turner (2005) made the important distinction between power, which emanates from a hierarchical position (comes from "them"), and influence, which arises from a shared identity with the group (comes from "us"). This distinction is particularly relevant to therapists, as it aligns with how they typically view their role: as supportive guides helping people to improve their mental health and achieve their goals, rather than as powerful authority figures. Moreover, this view of leadership as influence rather than power mirrors how therapists act in practice; the client-centred and collaborative nature of identity leadership strategies mirrors the values inherent in existing best practice therapy principles. For example, the American Psychological Association's (2021a) best practice guidelines for intervention include aiming "to cultivate and maintain effective therapeutic relationships, therapist characteristics, and change principles" and endeavouring "to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness" (p.7). Considerations about building relationships and the unique needs and identities of followers are embedded deeply in the principles of identity leadership.

The conceptualisation of therapists as identity leaders also has broader implications for developing theory and practice in the related field of health leadership. This relatively new field has emerged from increasing recognition of the significance and impact of leadership skills in clinical settings (e.g., Fassinger & Shullman, 2017; Fulop & Day, 2010; Gauld, 2017; Guibert-Lacasa & Vázquez-Calatayud, 2022; Khan et al., 2022; Prasath et al., 2021). However, contrary to the theoretical position of my thesis, proponents of health leadership often (over)emphasise the development of skills related to management or business ownership. This approach also positions leadership skills as distinct from clinical skills. For example, the advertisement for a health leadership course offered by an Australian university promises to transition students "from a clinician to a healthcare leader". Such framing implies a false dichotomy between clinical practice and leadership that is challenged by the findings of my thesis.

An alternate perspective is that effective clinicians already engage in leadership within their healthcare roles. A similar position was recently argued by the Australian Psychological Society (APS), the professional membership body for psychologists in Australia, which called for psychologists to seek leadership training. While the APS still emphasised the need to develop management skills, it also highlighted that effective leadership skills are the "same skills as being a good therapist or psychologist" and involve "leading with a servant's heart" and "a desire to always be advocating for those in need of support" (APS, 2024). This perspective offers a more accurate and empowering view of health leadership, aligning well with the principles of identity leadership.

The integration of identity leadership principles into health leadership frameworks would respond to previous (mostly unanswered) calls to move away from

individualistic, leader-centred approaches to understanding health leadership and toward follower-centred, relationship-based understandings (e.g., Fulop & Day, 2010). One of the key reasons to move away from existing individualistic approaches, according to Fulop and Day (2010), is that they promote an ineffective leadership training process of: "(1) study and fix the person; (2) give them a position or title; and (3) make them responsible for results". In contrast, the identity leadership approach is follower-centred and relationship-based (e.g., Platow et al., 2015). It also offers a more effective process for training leaders, directing them to consider the identity of the people they seek to lead (e.g., Haslam, Reutas, et al., 2023).

By positioning therapists as leaders who can and do influence the effectiveness of treatments, the findings of this thesis also make theoretical contributions to the ongoing clinical psychology debate known as the 'dodo bird argument' (e.g., Wampold et al., 1997). This debate—named after a line in Lewis Carroll's book 'Alice in Wonderland' where the dodo bird declares after a race that "Everybody has won, and all must have prizes"—considers whether all psychotherapy modalities are equally effective. Although this thesis did not explicitly examine differences between treatment modalities, a range of modalities were represented in the research, and identity leadership was found to be relevant across them. Specifically, Groups 4 Health is a social identity-based modality (Chapter 3), the Body Project is largely cognitive behaviour therapy-based (Chapter 4), and the participants in Chapter 6 had received or provided many different treatment modalities. Rather than simply speaking to the equivalence of different treatment modalities, though, the findings of this thesis demonstrate that therapists' engagement in *identity leadership* supports positive therapeutic relationships and enhances treatment outcomes across these diverse

approaches. This aligns with the pro-dodo side of the debate (especially Norcross & Wampold, 2018) by suggesting that the key to effective therapy may not lie solely in the specific type of treatment delivered, but in the therapist's ability to build a positive therapeutic relationship with clients through identity leadership.

This thesis therefore provides a new theoretical rationale for why effective facilitation strategies may matter more than the specific treatment used. That is, because therapists' ability to advance, create, represent, and embed positive shared identities may be what provides groups (including dyads, as in individual therapy; Lee et al., 2021) with many of their healing properties. In this view, clients' connections to their therapy groups and therapists may ultimately be more influential than the specific content explored in the group. As a compelling illustrative example of this, although not focused on the role of the group facilitator, Gleibs et al.'s (2011) observed improved health outcomes even in their "control" groups, which entailed people simply catching up on what was happening in their residential care facility (i.e., containing no health-related content).

Although I have argued that the connection between clients and their therapy group is more important than the specific content explored, I do not wish to minimise the importance of using evidence-based treatments. Their use is crucial to the principles of effective therapy (American Psychological Association, 2021a), and certain groups may indeed benefit from one treatment over another (e.g., Tolin, 2010). Speaking to this, Wampold (2023), one of the academics who initiated the dodo bird debate, reflected on its 25-year history to conclude that effective therapy requires both positive relationships *and* choosing the right evidence-based treatment. This balanced view aligns with the identity leadership approach to group therapy facilitation proposed in

this thesis, which would position choosing and adapting treatments to align with the goals, identity, and needs of a group as a crucial part of effective facilitation. Indeed, one of the key behaviours highlighted by clients in Chapter 3 was the ability of the facilitator to adapt the manualised treatment in ways that maximised client safety and allowed exploration of the most meaningful topics.

Shifting the focus from debating the equivalence of treatment modalities to examining how facilitators implement and tailor these modalities has significant implications for therapist training and research. Highlighting some of these implications, Westra (2023) expressed concern about current training practices. She argued that if clinical skill in managing processes and building effective relationships matters more than the specific treatment used, current training for therapists is likely ineffective due to its overemphasis on implementing particular therapies rather than building relationships. Similarly, Marmarosh (2024) recently stated:

> "Given the strong findings supporting group therapy as an intervention in all of these different disorders, we have to wonder why we continue to fail to prioritize group therapy as a primary mode of intervention. Why do we not require graduate students in psychology to have specialized training and supervision in group therapy[?]" (p. 249).

A potential solution to this problem is to reform therapeutic education to focus less on treatment modalities and more on therapeutic process and relationship-building skills. This thesis has provided an initial theoretical and empirical evidence base to argue that training therapists in identity leadership represents one way that therapists could improve their ability to foster positive therapeutic relationships (see Future Directions for Research section).

Viewing therapists as influential leaders also has practical implications for research design, prompting group therapy researchers to consider how therapist factors may affect treatment efficacy. For example, pre-existing differences may exist in therapists' belief in the effectiveness of the treatments they deliver. Prior research on therapist allegiance effects suggests that this may impact their effectiveness (McLeod, 2009). Additionally, there may be variations in therapists' personal connection to treatment-relevant identities (e.g., therapists with personal experience of social anxiety who are running a social anxiety group). In addition to measuring these pre-existing variables of interest, researchers might consider controlling for them by randomising therapists to which treatment they deliver in the same way that participants are randomly allocated to which one they receive.

In conclusion, conceptualising therapists as identity leaders offers a new perspective on clinical practice and underscores therapists' influential role in determining treatment success. Adopting this perspective provides new insights into maximising therapy effectiveness and prompts a new way of thinking about other existing health care frameworks (e.g., health leadership), training approaches, and research methodologies.

7.3.1.3. A new perspective on therapist lived experience. The findings of this thesis highlight the need for a paradigm shift in how therapist lived experience is viewed. The findings of this thesis (particularly Chapters 5 and 6) demonstrate both (a) the benefits of therapists having and disclosing lived experience and (b) the stigma faced by therapists with lived experience. These findings have significant theoretical and practical implications for how therapist lived experience and its disclosure is viewed, highlighting the need to embrace and destigmatise mental ill-health among

therapists. In doing so, a more compassionate approach to therapist mental ill-health may be promoted, which is ultimately more beneficial for therapist and client welfare.

The high prevalence of mental ill-health among therapists underscores the need to destigmatise these experiences within the profession. As discussed throughout this thesis, therapists experience mental ill-health at rates equal to or higher than the general population (e.g., 80% prevalence; Victor et al., 2022). Despite this prevalence, stigmatising ideas about the capabilities of people with mental ill-health mean that therapists are reluctant to disclose their issues to clients, colleagues, and even health professionals. This culture of silence is concerning given that studies from both clinical and social psychology have shown that concealing parts of one's identity at work, such as lived experience status, can be harmful (e.g., Crabtree & Pillow, 2020; Jones & King, 2014).

This stigma is also deeply embedded, beginning as early as professional training. A recent study by Bailey et al. (2024) revealed that psychologists are discouraged from disclosing their distress to colleagues from the onset of training. Furthermore, as mentioned briefly in Chapter 2, regulatory body reporting requirements exacerbate this stigma, particularly in Australia where my research was conducted. The Australian Health Practitioner Regulation Agency (AHPRA, 2020) mandates that health professionals report 'impaired professionals', which can be interpreted to mean professionals experiencing mental ill-health. Concerningly, this requirement applies even if information about the impairment is obtained by the reporting professional in the process of treating them.

The potential to be reported by a treating practitioner creates a significant barrier to help-seeking for health professionals, who fear negative consequences if they are

found to be experiencing mental ill-health (Edwards & Crisp, 2017). Examining the usual scenario in which health professionals are reported by their treating practitioner also suggests that intergroup status dynamics may play a role. For example, reporting practitioners are usually men (62.5%) and reported practitioners are usually women (68.8%; Bismark, Spittal, et al., 2016). Paradoxically, preventing the help-seeking behaviour of health professionals may inadvertently *increase* public risk rather than mitigate it. Health professionals experiencing issues who are afraid to seek help are arguably at greater risk of working while truly 'impaired' than professionals who are being supported (Bismark, Mathews, et al., 2016). Recognising these concerns, some Australian state governments, including in Western Australia and Queensland, have taken steps towards a more compassionate approach by seeking and receiving exemptions from the requirement for treating practitioners to report. This approach moves away from a punitive model towards one that encourages help-seeking behaviour among health professionals.

In line with this trend towards a more compassionate approach, AHPRA has recently made efforts to address the perception that their regulations prevent practitioners from seeking help. In their August newsletter, AHPRA (2024) acknowledged that, "too often, practitioners struggle in silence…There is a common misconception that if you seek help, your treating practitioner will automatically be required to report you". To dissuade this perception, they reassured practitioners that "The need for a mandatory notification to be made is not often met. If you are managing your health and getting the help you need, you can usually continue to practise." While these statements suggest progress in AHPRA's approach, their careful use of qualifying language ("not often", "usually") may leave some practitioners feeling unconvinced.

Other Western nations have already adopted more compassionate approaches to therapist mental health. For example, the United Kingdom's Health and Care Professions Council (2018) standards specify that professionals must understand the importance of their mental health in maintaining fitness to practice and develop and use self-care and self-awareness strategies to ensure they deliver effective services and create a safe working environment. Notably, there appears to be no legal obligation to report an impaired colleague. Instead, practitioners have an *ethical* obligation to do so if they believe this person might harm clients, the public, or the reputation of the profession. This shift towards a more compassionate approach to practitioners' mental health reflects a growing recognition of the importance of supporting healthcare professionals' wellbeing, not only for their own sake but also for the benefit of patients and the public.

In addition to making the healthcare industry safer for both practitioners and clients, supporting and celebrating the strengths of people who have "been there" and lived through mental ill-health may also lead to more effective treatments for clients. The benefits of practitioners with lived experience are exemplified by the work of Marsha Linehan. Her development of Dialectical Behaviour Therapy (DBT; Linehan, 2015) as a person with borderline personality disorder (the condition for which this therapy is primarily designed) showcases how lived experience can inform and enhance treatments. In a famous New York Times article, Linehan recounts the encounter with a client that led to her decision to disclose her own experience with borderline personality disorder:

> "Are you one of us?" The patient wanted to know, and her therapist—Marsha M. Linehan…had a ready answer. It was the one she always used to cut the question

> short, whether a patient asked it hopefully, accusingly or knowingly, having glimpsed the macramé of faded burns, cuts and welts on Dr. Linehan's arms: "You mean, have I suffered?"
>
> "No, Marsha," the patient replied… "I mean one of us. Like us. Because if you were, it would give all of us so much hope" (Carey, 2011).

This account illustrates the strengths of practitioners with lived experience and a key finding of this thesis: the benefits of therapists being aspirationally prototypical. Linehan's personal understanding of the experiences, identity, and needs of people with borderline personality disorder provided her with unique insights into what was missing from existing treatments. Supporting the impact of this, DBT is now widely considered the gold-standard treatment for people with borderline personality disorder (Miller, 2015).

This leads to the final clinical implication of the research in this thesis, which is that therapists connecting with clients over other stigmatised identities in therapy may be similarly impactful. Some evidence for this proposition can be found in the broader literature on therapist self-disclosure. As some examples, Bennett et al. (2022) present a case study of a client whose therapist disclosed a shared experience of sexual assault. The client reported of this encounter: "when you told me you were a survivor, and that you were able to look at my trauma and call it sexual violence, I felt validated for the first time" (Bennett et al., 2022, p. 119). Other research indicates that therapist disclosure that they are part of the LGBTQIA+ community predicts better outcomes for LGBTQIA+ clients in therapy (e.g., Johnsen & Ding, 2022; Jones et al., 2003). Future research could continue to examine this, especially through the lens of the social identity approach.

Central to all of these points is the idea that the way researchers and clinicians view lived experience needs to be modernised, especially as lived experience is increasingly being promoted at all levels of health care (e.g., Sunkel & Sartor, 2022). The persistence of outdated ideas is starkly illustrated by the continued citation of Sigmund Freud's century-old assertion that "the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p.331). This norm is not even one that Freud himself appeared to follow, given reports that he shared personal childhood memories with his clients (Goldstein, 1994). This thesis contributes to the necessary modernisation of these views by providing empirical evidence for the benefits of therapist lived experience and its judicious disclosure, paving the way for more authentic and effective therapeutic relationships.

7.3.2. Theoretical and Practical Implications for Social Psychology

7.3.2.1. Extending and challenging identity leadership theory. This thesis represents the first attempt to study group therapy leadership through the lens of identity leadership theory, thus expanding the theory to a new applied area. This context differs significantly from the contexts in which identity leadership is usually studied, such as organisational, sporting, and political settings. As found in these prior settings (e.g., Haslam, Fransen, et al., 2020; Haslam, Reicher, et al., 2020), my research highlights the power of incorporating principles of identity leadership to improve leadership effectiveness, especially identity prototypicality. This reinforces the importance of social identities and harnessing social identity processes in effective leadership.

Where my research diverges from previous studies is in finding that the Identity Leadership Inventory (ILI) did not predict the expected outcome: followers' social

identification with the group (e.g., Krug et al., 2021; Steffens et al., 2019, 2024; van Dick et al., 2018). In Chapter 3, client ratings of facilitator identity leadership did not predict their social identification with the group, except for the impresarioship facet. Other issues with the scale were also observed, such as ceiling effects (i.e., almost all therapists were endorsed at nearly the maximum possible score on the scale, even in the first session of therapy), and wording related to the organisational context in which the scale was developed that clients reported to be confusing (e.g., referencing "events" that the leader organised). Together, this indicates that in the context of group therapy, the ILI may not function as expected. This thesis, therefore, not only extends identity leadership theory into new domains but also challenges the assumption that the ILI is universally applicable across different contexts.

Although future research is needed (and such research is proposed in the Future Directions for Research section below), some initial ideas can be formed about what the scale may measure in the group therapy context instead and how it may be improved. One explanation is that, due to their training in relationship building and group process management, therapists generally excel at identity leadership. The scale may measure levels of identity leadership that are easily met by most therapists, creating a ceiling effect. This may be particularly true for the facilitators in Chapter 3's study, who all received training in Groups 4 Health. Although not explicitly about identity leadership, this training provides information about the social identity approach. Indeed, part of why I chose this therapy modality was because I anticipated that it would readily generate identity leadership behaviours.

Comparatively, in the organisational settings where the scale was developed, there may be more variability in endorsement of items like "When this leader acts, they

have [the group's] interests at heart." Although organisational leaders likely vary widely in their perceived motivations and behaviours, therapists are generally expected to act in their clients' best interests as a core aspect of their professional role. Evidencing this, client interviewees in Chapter 3 automatically assumed that their therapists had their best interests at heart simply because they were therapists. This baseline expectation could make it difficult for clients to differentiate between average and exceptional identity leadership in therapists.

To remedy this, items could be modified to reflect higher levels of identity leadership, improving the sensitivity of the measure. In addition, items could refer to therapy-specific behaviours that clients can more easily distinguish or that are expected to change more noticeably over time (e.g., the therapist's ability to foster a shared recovery identity). This would also address issues with confusion about existing items in the therapy context (e.g., "events" could be changed to "therapy activities"), which may also make it easier for clients to determine the level of identity leadership displayed by their therapist.

In addition to revealing potential limitations in the widely used and well-studied ILI, my research also explores a relatively understudied facet of identity leadership theory: identity impresarioship, which was the only facet that did predict client social identification. The lack of focus on impresarioship is evident in the existing literature; for example, in van Dick et al.'s (2018) list of indicative references for each facet of identity leadership, the only reference for impresarioship provided is Haslam, Reicher, et al.'s (2020; they cited the first edition, published in 2010) identity leadership book. This scarcity of research highlights a gap in understanding regarding some identity leadership processes. The findings of Chapter 3 suggest that impresarioship may be a

currently overlooked but crucial process for identity leadership researchers and practitioners to consider, especially in therapy contexts. The results indicate that a leader's ability to embed the group identity in relevant structures and activities (the core of impresarioship) plays a vital role in fostering social identification and connection among group members.

As well as contributing to addressing the gap in research regarding identity impresarioship, this thesis also contributes to the well-established body of evidence highlighting the importance of identity prototypicality. My thesis extends this prior work by closely examining the distinction between aspirational and average-type prototypicality conceptualisations. Across several operationalisations, the findings of this thesis suggest that leaders who represent the *aspirational* type of prototypicality are more effective than those who represent the average type. This aligns with and contributes to a growing body of evidence demonstrating the benefits of aspirational prototypicality over average prototypicality (Robertson et al., 2022 [Chapter 4]; Steffens, Munt, et al., 2021; van Knippenberg et al., 2024), thus shifting the debate toward favouring an aspirational conceptualisation of prototypicality. Notably, van Knippenberg et al. (2024) recently argued that the aspirational conceptualisation more accurately reflects original theorising about prototypicality, pointing to Turner et al.'s (1987) proposition that the prototype should emphasise the group's positive distinctiveness. Moving forward, prototypicality should therefore be conceptualised more precisely as the extent to which a leader embodies the aspirational identity of the group, rather than merely representing average group characteristics. Doing so will provide a more precise framework for analysing leadership effectiveness and the influence of prototypicality.

In summary, this thesis makes several significant contributions to social psychology, particularly in the field of identity leadership theory. By extending the theory into the novel domain of group therapy, it demonstrates both its broad applicability and its limitations in new contexts. Importantly, it offers practical implications for both researchers and practitioners, suggesting more nuanced approaches to measuring identity leadership in diverse contexts and emphasising the importance of aspirational prototypicality in effective leadership. Overall, this research not only reinforces the importance of social identity processes in leadership but also pushes the boundaries of identity leadership theory, offering new insights and directions for future investigation in both academic and applied settings.

7.3.2.2. Identifying and implementing identity leadership behaviours.

Another implication of this research for social psychology is that it has highlighted the need for a better understanding of the behaviours that constitute identity leadership. As mentioned throughout this thesis, there is a significant gap in research regarding specific behaviours of identity leadership. Some research has examined the role of leaders' use of collective ("we") versus personal ("I") language (Fladerer et al., 2021; Hornsey et al., 2005; Steffens & Haslam, 2013; Stevens, Rees, Steffens, et al., 2019). However, research has yet to extend past this behaviour.

The lack of concrete behaviours available to complement identity leadership theory poses a problem because it makes it difficult to determine whether a leader is engaging in identity leadership. Additionally, if we conclude that a leader is engaging in identity leadership (based on, for example, high scores on the ILI), it makes it difficult to identify what they did that led to this conclusion. As mentioned in Chapter 3, this point was emphasised by Stevens et al. (2021), who highlighted the "need for the identity

leadership approach to be falsifiable", encouraging researchers: "to tackle the challenge of identifying concrete forms of identity leadership, rather than 'hiding behind' notions that (a) effective identity leadership behaviours vary across groups, and (b) what constitutes identity leadership is, to some extent, in the 'eye of the beholder'" (p. 7).

While this call for concrete behaviours is valid and important for advancing the field, it is crucial to balance this need with the inherent contextual nature of identity leadership. A core tenet of identity leadership theory is that the leader should adapt their style to best meet the needs and goals of their followers, which makes it hard to provide a catalogue of context-independent behaviours. Indeed, a leader who rigidly followed a generic framework of identity leadership behaviours would probably not be a very good identity leader. Speaking to this, the belief in a universal set of behaviours that inherently constitute effective leadership was identified by Haslam, Alvesson, et al. (2024) as one of the key components of *zombie leadership*; that is, 'dead' ideas that continue to walk among us despite being weakly supported by available evidence.

A potential solution to this dilemma is for identity leadership theory to incorporate both (a) a guiding set of principles *and* (b) a catalogue of illustrative identity leadership behaviours, which can guide leaders in developing the strategies most appropriate for their specific leadership context and followers. My thesis contributes to this solution by compiling a catalogue of relatively context-independent behaviours (particularly in Chapter 3) to complement the guiding principles of identity leadership (i.e., prototypicality, entrepreneurship, advancement, impresarioship). Throughout this work, I have also emphasised the importance of context, ensuring that therapists aiming to improve their effectiveness through identity leadership consider the identity, needs, and aspirations of their therapy group. For instance, therapists must carefully

consider whether a potential disclosure of lived experience is relevant to the group and highlights the therapist's embodiment of an aspired identity.

Practically, this catalogue of behaviours serves two important functions: (a) it provides a foundation from which new guidelines and recommendations can be developed for clinicians and other leaders aiming to enhance their practice through identity leadership, and (b) it offers a framework for future research in this area. As this was the first investigation of multiple identity leadership behaviours, there are likely other behaviours that were not captured in the data or were outside the scope of the investigation. Future studies should continue to investigate these behaviours in diverse contexts—such as sports, organisations, and other clinical contexts—to validate and expand upon the list of identity leadership behaviours.

7.3.2.3. Expanding the definition of leadership. A final theoretical implication of this research for social psychology is its contribution to broadening the definition of leadership. By positioning therapists as leaders and examining their leadership behaviours, this thesis challenges the bounds of the usual applications of leadership theories and the narrow definitions of leadership and social influence that are commonly used. The traditional view of leadership as a process of domination and power stems from the "zombie leadership" model often implicit in leadership discourse and training (Haslam, Alvesson, et al., 2024). This model emphasises so-called 'special' qualities that good leaders inherently possess, and (mis)attributes leader success to their power and charisma, rather than the collective efforts of their followers.

In contrast, the identity leadership framework applied in this thesis promotes a more supportive approach to leadership, focusing on building strong relationships and inspiring people to progress toward group-relevant goals because they want to.

Leaders, in this view, are not exceptional, charismatic people, but rather everyday people who represent “who we are” and advocate for our collective interests. Therapists exemplify this model of leadership by building strong relationships that inspire clients to improve their health, thus demonstrating that effective leadership manifests even in non-traditional contexts.

Expanding the definition of leadership highlights the leadership capacity of people in professions not traditionally associated with leadership. For example, a teacher modelling persistence in solving difficult mathematics problems to their class, a nurse advocating for a patient whose needs are not met by the medical system, or an engaged neighbour organising a walking group to get locals out in nature and improve their health. While identity leadership theory has been applied to some of these less traditional leadership contexts (e.g., see Fransen et al., 2022; Haslam, 2017), research still predominantly focuses on traditional contexts such as organisations, politics, and sports. Future research should continue to expand the contexts in which identity leadership (and leadership more broadly) is examined, potentially revealing new insights into the nature of effective leadership across diverse societal roles. In sum, by challenging conventional notions of leadership, this research contributes to a more inclusive understanding of leadership and opens up new avenues for exploring how leadership manifests in various aspects of social life.

7.4. Strengths and Limitations

The research in this thesis has several strengths and limitations, many of which have already been discussed throughout. I now examine the strengths and limitations of the thesis as a whole.

A key strength of this research is its grounding in identity leadership theory, providing a robust theoretical framework for investigating group therapy facilitation and aligning well with the conceptualisation of facilitators *as leaders*. The use of this well-established and validated theory also means that its conclusions are supported by evidence beyond the specific studies included. For example, extensive literature on the social cure (e.g., Jetten et al., 2017) helps to further support the proposition that social identification with therapy groups can lead to improved health outcomes.

Another strength is examining identity leadership within real therapy settings, enhancing the ecological validity of the findings. Where practical or ethical concerns prevented data collection from real therapy sessions, conceptually relevant samples (i.e., people with recent experience receiving or delivering therapy) or accounts of therapy sessions approximated real-life settings. Key variables of interest like facilitator identity leadership were not experimentally manipulated in the study of real therapy sessions, precluding causal claims. However, longitudinal and experimental data from other studies in this thesis helped to mitigate this limitation.

The in-depth investigation of identity prototypicality is another strength of this thesis, allowing conclusions drawn from multiple studies to cohesively demonstrate the benefits of therapists being aspirationally prototypical. However, this focus also limits the evidence I captured about other facets and behaviours of identity leadership, presenting opportunities for future research. Experimentally manipulating other identity leadership facets and behaviours in vignettes (as in Chapter 5) and gathering real-world perspectives from therapists and clients (as in Chapter 6) represent practical next steps for research in this area.

The mixed methods approach taken is another strength, enabling the integration and triangulation of data from multiple sources (surveys, interviews, video footage) and perspectives (therapists, clients, researchers). This approach provided a more nuanced understanding of identity leadership in group therapy than would be afforded by a thesis consisting of only experimental studies. For example, in Chapters 5 and 6, the qualitative data added depth to the quantitative findings on the benefits of self-disclosure, revealing that such benefits depend on a multitude of different factors. Obtaining data from interviews with followers (i.e., clients) is also a strength, not least because it is uncommon in identity leadership research, which tends to favour asking followers to complete quantitative surveys or presenting participants with vignettes (methods also used in this thesis). These interviews provided a deeper and more nuanced understanding of identity leadership from the most critical perspective: the recipients of the leadership. A limitation related to this is the lack of facilitator perspectives obtained, especially in the study in Chapter 3. Conducting further studies examining how facilitators view their practice through the lens of identity leadership could provide a more holistic view and generate new identity leadership behaviours.

Recruiting clinical samples and samples of people engaged in therapy is another strength, allowing better generalisation of the findings to the target population (i.e., people engaged in therapy) compared to recruiting convenience or undergraduate samples. A limitation of this is that it resulted in smaller sample sizes. Another limitation of the samples is that they were predominately White and from Western countries, which constrained the diversity of experiences and perspectives captured.

It is worth noting that the way I conceptualised group therapy and the role of facilitators (see general introduction) drew from Western ideas about therapy. This may

mean that Western samples were the most relevant and appropriate for study. Evidencing this, some research suggests that people in non-Western countries may prefer to consult with traditional healers or spiritual leaders before pursuing Western health care (e.g., Koç & Kafa, 2019) and find Western, collaborative approaches to building therapeutic relationships at odds with expectations that health professionals will be directive (e.g., Ng et al., 2017). Consequently, the strategies for group therapy identity leadership developed in this thesis may not be well-received or applicable in non-Western contexts. At the same time, as mentioned in Chapter 2, there is likely a wealth of valuable knowledge about group facilitation strategies held by members of non-Western cultures. Future research should employ cross-cultural methods to gain new insights into group therapy facilitation.

Lastly, the studies in this thesis primarily examine identity leadership at the *start* of therapy, predicting changes over time or initial perceptions of therapists. Especially for behaviours like self-disclosure of lived experience, this focus on the start of therapy may seem unusual because it precedes any work to build rapport between the therapist and client. It also limits understanding of identity leadership during the middle or end of therapy. Part of the reason for this analytic strategy was to examine changes in group processes over time, which necessitates examining identity leadership at the start of therapy to prevent logical flaws in the longitudinal modelling of the data (i.e., facilitator behaviours in the middle of therapy cannot predict changes that occurred at the start). Additionally, therapists arguably have more influence over what happens in the first therapy session before the group dynamics have formed, so it is a practical point of time to investigate what can be done to foster a positive group environment. Future studies

should examine the effects of identity leadership during the middle or end of therapy, including the antecedents of identity leadership behaviours.

7.5. Directions for Future Research

In addition to those listed already, I propose four key projects for future research.

7.5.1. Develop and Test Identity Leadership Training for Therapists

Perhaps the most impactful future research direction would be to develop and test the effectiveness of an identity leadership training program for group therapists. This program could be adapted from the existing "5R" identity leadership training program, which has already proven efficacious in organisational and sporting leadership contexts (e.g., Haslam et al., 2017; Fransen et al., 2022). While some of this prior work has involved health leaders (e.g., leaders in hospitals), the program has yet to be used to help therapists develop identity leadership skills. The existing 5R training has five modules involving: (1) *Readying* participants through education that explains the importance of social identity for leadership, influence, and health; (2) *Reflecting* on the nature of the groups with which they work; (3) *Representing* the values, norms, and aspirations of those groups; (4) *Realising* these aspects through collaborative strategising and goal-setting; and (5) *Reinforcing* the program's impact through ongoing activities (Haslam et al., 2017; Haslam, Reutas, et al., 2023). Interestingly, rather than dedicating each module to one of identity leadership theory's four facets (prototypicality, entrepreneurship, advancement, and impresarioship, as outlined throughout this thesis), the 5R training program is structured such that each module addresses a broader leadership task and explores how strategies aligned with several of the facets could be applied to accomplish this task. For example, in the Representing module, participants reflect on the task of building a strong sense of group identity in

the groups they lead, both through taking actions that demonstrate to group members what it means to be part of the group (entrepreneurship) and also considering ways that they themselves represent key aspects of the group identity (prototypicality).

To test the effectiveness of an adapted 5R for therapists, a possible research program could first pilot it with a small number of therapists and assess its acceptability and effectiveness through focus groups and surveys. Ideally, this would be followed by a randomised controlled trial in which a sample of the therapists receives identity leadership training. To address some of the limitations in my PhD research, this future research should include post-program interviews with both clients *and* therapists to explore how identity leadership was perceived and experienced during therapy. This would help to assess the effects of the training program more holistically and to develop additional identity leadership behaviours.

Understanding more about therapist perspectives could also illuminate benefits that arise for therapists as they learn about and strive to embody the principles of identity leadership. My anecdotal observation from therapist feedback after receiving training in Groups 4 Health delivery (i.e., in the process of conducting the study reported in Chapter 3) was that therapists found it useful to learn about the influence of social factors on mental health, not just for implementation with clients but for their own lives. Training in identity leadership may have similar effects, given that the first module provides education about the importance of social identity for health.

Identity leadership training may also help to provide a community for clinicians who wish to improve their practice and are cognisant of the benefits of social ties for mental health. Supporting a similar idea, Professor Martyn Whittingham, president of the *APA Society of Group Psychology and Group Psychotherapy* remarked that:

> "Group therapy isn't just individual therapy in a group… It has its own techniques, its own processes and its own strategies, and unless you really understand those, you're going to struggle. You need to be part of a community of people who are committed to learning and growing in this work." (Novotney, 2019).

Participating in a 5R training may provide this community for group therapists, in addition to providing practical strategies for group therapy identity leadership.

Here I have proposed adapting the 5R program; however, this research direction also represents a broader call to action: the need to develop clinician training that takes therapist factors and group processes seriously, treats them as modifiable, and offers evidence-based and theoretically grounded suggestions for improvement.

7.5.2. Adapt the Identity Leadership Inventory for Clinical Contexts

Given the issues with the ILI scale discussed in Chapter 3 and above, future research should aim to develop a modified version of the scale that is better suited to clinical settings. Such research could follow the example of two recent adaptations of the ILI: Steffens et al.'s (2024) adaptation to a single-item version and Butalia et al.'s (2024) adaptation for youth sporting contexts. Reducing the number of items, as in Steffens et al.'s recent adaptation, could be useful for quick measurement in clinical contexts and where interest in the four distinct facets is less applicable. Adapting items to be easier to understand in context and by a wide range of people (e.g., people who speak English as a second language), following the lead of Butalia et al.'s adaptation process for young people, would also be advantageous.

In addition to developing a new tool for identity leadership research, creating a new, psychometrically sound scale for measuring client perceptions of their therapists' identity leadership would benefit group therapy research and practice more broadly. A

systematic review and quality assessment of existing scales used to measure therapeutic processes in group therapy found that most had serious psychometric issues (Orfanos et al., 2020). These issues appeared to result in part from scales developed without theoretical rationale or proper psychometric evaluation.

An important consideration for future researchers is that the wording of a scale developed for group settings, such as therapy groups, may not be readily interpreted in health contexts involving dyads, such as individual therapy. In previous research by Lee et al. (2023, 2024) this issue has been overcome by viewing the dyad as a group (see also Cruwys et al., 2022), adding the following preamble to the ILI instructions:

> "Thinking of [your therapist] and yourself as two members of a group in therapy, please judge to what extent you believe [your therapist] engages in the following behaviours and activities listed by selecting the corresponding number using the following scale".

In Cruwys et al. (2023), the scale was directly adapted, with items including: (1) "My therapist creates a sense of cohesion with me" (entrepreneurship), (2) "My therapist creates structures that are useful for me" (impresarioship), (3) "My therapist acts as a champion of my best self" (advancement), and (4) "My therapist is a model for me" (prototypicality). In all of these studies, no issues were observed with the ILI. Similar adaptations could be made when measuring identity leadership of health professionals in other dyadic health contexts, such as consults with general practitioners or physiotherapists.

7.5.3. Investigate the Effect of Clinician Identity Leadership in Other Healthcare Contexts

Following efforts to develop an identity leadership scale suitable for a range of health contexts, another avenue for future research would be to conduct identity leadership studies in other healthcare contexts. Another context in which building therapeutic relationships with clients is important is general practice (Fuertes et al., 2007, 2017). Similar to my argument about therapists, it has also been argued that doctors should be conceptualised as leaders (e.g., Huynh et al., 2018; Huynh & Sweeny, 2014). However, no work has examined identity leadership in general practice (although see Hallier & Forbes, 2005 for a social identity approach to understanding doctors' clinical management). Drawing inspiration from the methodology used in this thesis, future research could seek to understand the role of identity leadership in general practice effectiveness and the formation of practitioner-patient therapeutic relationships (e.g., using the general practice working alliance scale from Sturgiss et al., 2019).

Building directly from the research focus for the second half of this thesis, future research could also examine general practitioner self-disclosure from an identity leadership perspective. Similar to debates in therapy contexts, there is ongoing contention about the appropriateness and usefulness of self-disclosure by general practitioners (Allen & Arroll, 2015; Arroll & Allen, 2015; Lussier & Richard, 2007; Mann, 2018; Robinson, 2018; Volkman, 2021). There is also limited research on practitioners' disclosure of their own illnesses. Where such research exists, it tends to produce mixed findings that are very similar to those found in Chapter 6 about therapists (e.g., Bolger et al., 2019; Chang et al., 2022). For example, Bolger et al. (2019) found that illness

disclosures allowed doctors to seem more human, normalised patients' experiences, and added weight to their recommendations. At the same time, such disclosures led to patient concerns about the competence and professionalism of their doctor and irritation that the doctor was using consultation time to talk about their issues.

A key consideration is that therapists focus on treating mental health concerns, while general practitioners address both mental and physical health. Consequently, general practitioners may disclose both types of conditions to build rapport and normalise health issues for patients. Since mental ill-health carries more stigma than physical ill-health (e.g., Chen & Lawrie, 2017), patients and practitioners might be less concerned about the disclosure of physical health conditions. Supporting this, one study found that more doctors were willing to disclose information about their physical health experiences (87.5%) than mental health experiences (12.5%; Allen & Arroll, 2015).

Taking an identity leadership approach to understanding when and why doctor illness disclosures are beneficial represents an interesting avenue for future research. By applying similar methodology to that used in Chapters 5 and 6, moderating factors could be examined, such as whether the illness is current or recovered (which does not seem to have attracted much research or theoretical attention in this area) or whether the disclosure is of a physical or mental health concern.

7.5.4. Investigate the Role of *Group Member* Identity Leadership

A final direction for future research is examining the influence and leadership of group members, in addition to facilitators. Identity leadership theory contends that it is not always the assigned leader who is the 'actual' leader, but the most influential and prototypical group member (e.g., Haslam, Reicher, et al., 2020). The influence of group

members is not explored in this thesis, both to limit its scope and due to ethical constraints (e.g., the ethics committee did not allow me to capture or analyse any information about the group members in the recorded sessions detailed in Chapter 3). However, it is possible that harnessing the power of group member leadership could positively impact therapy effectiveness. Indeed, Tang et al. (2017) argued that clients are one of the most underutilised resources in the health care system.

The influence of group members who are not the assigned leader has been explored from an identity leadership lens in research on informal athlete leadership (Cotterill & Fransen, 2016; Fransen et al., 2015, 2016, 2018; Mertens et al., 2021) and peer or shared leadership in organisations (D'Innocenzo et al., 2016). This research demonstrates that, like formally appointed leaders, informal leaders are effective to the extent that they are identity leaders (e.g., Edelmann et al., 2020, 2023; Mertens et al., 2020). Considering the role of informal leaders in group therapy has implications for both theory (the way we understand influence in therapy groups) and practice, such that facilitators may seek to enhance or minimise the influence of group members. Future research should seek to examine this and could readily adapt the methodology and designs used in research on athlete leadership in sports teams.

7.6. Conclusion

This thesis represented the first exploration of group therapy facilitation using a social identity approach. By conceptualising facilitators as identity leaders, this thesis proposed a new framework for understanding their critical role in the success of therapy. First, a conceptual paper laid the theoretical groundwork for identity leadership in group therapy, hypothesising potential benefits and behaviours. Following this, a corpus of behaviours from a group therapy trial were analysed to identify and validate

the first set of identity leadership behaviours. The latter part of the thesis focused on one facet of identity leadership: prototypicality. This focus contributed to two key debates: (1) whether it is appropriate and useful for therapists to have lived experience of mental ill-health and (2) whether the aspirational or average-type conceptualisation of prototypicality is most important in identity leadership theory. Addressing these debates, a longitudinal study demonstrated that facilitators' aspirational prototypicality predicted positive changes in group norms and therapeutic outcomes, while two experiments underscored the value of therapists signalling their aspirational prototypicality through self-disclosure of recovered and relevant mental health conditions. Finally, a qualitative study provided nuanced insights into the real-world experiences of therapist lived experience disclosures, affirming the importance of recovery and relevance in self-disclosure.

By extending identity leadership theory into the group therapy context, this thesis has made significant contributions to both clinical and social psychology. For clinical psychology, it provides a new framework for understanding effective group therapy facilitation and the value of therapists' lived experience. The conceptualisation of therapists as leaders who can and do influence therapeutic success also highlights the importance of considering therapist factors in group therapy research and developing better training. For social psychology, this research expands and challenges existing ideas about identity leadership and identifies specific behaviours that constitute it, something that had not yet been done in any other identity leadership context. This research also challenges traditional, narrow definitions of leadership, advocating for a more inclusive and empowering view.

Several directions for future research naturally follow from this work, including the development of identity leadership training, the adaptation of identity leadership measures for clinical contexts, the extension of identity leadership to new health contexts, and the exploration of group member (in addition to facilitator) identity leadership. Ultimately, this thesis offers a compelling argument for the necessity and value of conceptualising facilitators as identity leaders. In the face of increasing demand for mental health care and limited resources, enhancing group therapy facilitation—and, as a consequence, group therapy effectiveness—could have far-reaching benefits for global mental health.

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Appendix A: Benjamini-Hochberg Method Information (Chapter 3)

To implement the Benjamini-Hochberg method, the *p*-values of a set of tests (usually all related to a particular hypothesis) are listed and ranked from smallest to largest. Benjamini-Hochberg adjusted *p*-values are then calculated using the following formula: $(i/m)*Q$, where: i = a particular *p*-value's rank, m = total number of tests, and Q = the false discovery rate (a value chosen by the researcher, reflecting their accepted percentage of false positives). For example, the adjusted *p*-value for the smallest *p*-value in a set of 25 tests and specifying a 10% FDR would be (1/25) * 0.10 = .004. After doing this calculation for all *p*-values, each unadjusted *p*-value is compared to its adjusted *p*-value, which acts as the new critical value. Unadjusted *p*-values less than the adjusted *p*-values are considered significant.

We set the FDR to 10% for our analysis. That is, we deemed it acceptable for 10% of significant results to be false positives. While more conservative thresholds (5%) are common, our approach aligns with the exploratory nature of this work, where identifying potential effects for future confirmatory investigation is a primary goal. In exploratory and theory-developing research like the present study (and where the cost of a false positive is relatively low compared to, for example, studying a new drug), the cost of missing true effects can be as problematic as false positives (Rothman, 1990; Tukey, 1977).

Appendix B: Initial Behaviour List (Chapter 3)

Entrepreneurship

1. Collective language
2. Brings in shared identity
3. Encourages abiding of group rules
4. Points out commonalities between individual group members
5. Comments on process or positive group dynamic
6. Recalls something from previous sessions
7. Asks question to look for commonalities
8. Hands facilitator role to participant (participant leadership)
9. Small talk: Asks participants to share info about life outside of therapy (e.g., what they did on the weekend)
10. Discusses participant values
11. Leads a group brainstorm
12. Gives an example aligned with group identity
13. Makes an inspirational comment
14. Explicitly sets a norm/rule for the group
15. Outlines or reiterates purpose of group
16. Uses participant example to explain activity
17. Provides direction on activity (being more explicit to get the group to stay on task)
18. Uses participant's language and wording in activity/psychoeducation

Prototypicality

19. Discloses a relevant personal experience
20. Joins in on a group activity
21. Discloses a feeling (that is relevant to the group)
22. Steps into participant role for a moment
23. Demonstrates personal investment in group
24. Discloses something that highlights their similarity to a specific group member
25. Models thought process around an activity

Advancement

26. Normalises experience
27. Provides reassurance
28. Checks whether something is okay/checks in with group/checks meaning of something
29. Gives group members a choice
30. Provides support to a group member
31. Encourages something that a group member has done
32. Validates something a group member says

33. Deals with difficult/disruptive behaviour
34. Prepares group for upcoming task (in case it provokes anxiety)
35. Advocates for group in response to co-facilitator request (*note: removed because rare and examples potentially identify group members/facilitators*)
36. Provides advice
37. Interacts in a polite way (thanks group, apologises to group)
38. Welcomes group member/s
39. Includes quiet or late group member in discussion
40. Cares for physical needs of a group member (e.g., sore wrist; also impresarioship?)
41. Encourages something that co-facilitator says (co-facilitator is part of group)
42. Demonstrates curiosity in something that participant says

Impresarioship

43. Tailors delivery of content or activities
44. Sets homework task (*note: removed as only happens at set times due to manual and no variance*)
45. Creates something for group (e.g., rule sheet, ball of string activity)
46. Develops or promotes group ritual
47. Creates an in joke

Appendix C: Frequencies of Behaviours Coded in Therapy Sessions (Chapter 3)

Table C.0.1 *Frequencies of behaviours coded in therapy sessions*.

Group	Lead facilitator ID	Co-facilitator ID	Session Number	Duration (mins)	Self-disclos.	Joins in	Col. lang.	Ingroup topics	Group dynamic comments	Discuss group purpose	Follower language	Normalises	Deals with diff. behavs.	Flexible w. activities	Rituals	Colead.
1	1	2	1	57.50	11	3	121	16	0	1	0	3	2	1	0	0
1	2	1	2	85.00	8	2	93	2	2	0	0	2	2	7	0	1
1	1	2	3	93.50	7	6	111	5	0	0	0	4	1	4	0	0
1	2	1	4	95.50	11	3	121	4	1	0	2	3	0	5	0	1
1	1	2	5	95.50	9	0	73	5	3	0	1	4	0	0	0	1
2	3	4	1	64.50	3	10	113	0	1	3	1	1	1	0	1	0
2	4	3	2	88.50	5	2	131	0	1	0	2	5	4	2	1	0
2	3	4	3	105.50	6	2	146	3	1	0	1	6	1	2	2	0
2	4	3	4	91.00	2	0	119	2	0	2	0	1	2	3	0	0
2	3	4	5	86.50	3	2	50	0	0	0	1	3	0	2	0	2
3	5	6	1	91.50	6	6	206	0	0	3	6	3	0	2	3	0
3	6	5	2	85.50	4	0	159	3	0	1	1	4	0	3	1	0
3	5	6	3	96.00	1	0	170	2	0	0	1	4	0	0	0	4
3	6	5	4	91.00	5	4	134	2	0	1	0	1	0	0	2	1
3	6	5	5	91.00	8	5	100	0	0	1	0	2	0	0	0	3
4	7	8	1	85.00	2	9	259	0	0	1	1	0	2	1	0	0
4	8	7	2	70.00	0	0	79	0	0	0	0	3	2	3	0	0
4	7	8	3	90.00	2	0	274	0	0	0	2	6	0	1	2	0
4	8	7	4	85.00	3	0	49	0	0	1	1	2	1	0	2	0
4	7	8	5	110.50	11	0	68	0	0	0	1	1	0	0	0	0
5	2	4	1	96.50	7	8	163	2	3	5	3	5	1	0	0	0
5	4	2	2	83.00	3	19	166	0	1	1	1	5	0	4	0	0
5	2	4	3	95.50	12	0	64	8	0	0	4	4	1	0	0	1
5	4	2	4	90.00	0	0	104	2	3	1	0	4	1	6	1	1
5	2	4	5	82.00	3	1	46	2	1	1	2	7	0	1	0	2
6	1	N/A	1	92.50	4	0	104	2	3	3	0	4	1	4	0	0
6	1	9	2	90.00	5	0	125	0	4	1	0	9	3	3	1	0
6	9	N/A	3	95.50	4	0	56	0	0	1	2	4	0	1	1	1
6	1	N/A	4	87.50	0	0	75	2	4	2	0	3	0	2	0	0
6	1	9	5	106.00	5	1	23	2	4	0	1	4	2	1	0	0

Notes. Time in mins is available footage.

Appendix D: Analysis for Each Identity Leadership Facet (Chapter 3)

Intraclass correlations indicated that a mixed-effects approach was appropriate; differences between time points explained 10.7% of the variance in prototypicality and 43.5% of the variance was explained by individual differences; 7.8% of the variance in entrepreneurship was explained by differences in time and 56.8% for individual differences; 10.1% of the variance in advancement was explained by differences in time and 55.9% for individual differences; and for impresarioship, 1.9% of the variance was explained by time and 53.4% for individual differences. For all variables, differences between therapy groups explained near-zero.

As in the main analysis for global identity leadership scores, we used the Benjamini-Hochberg method to manage the FDR for the p-values associated with the regression coefficients for (a) the main effect of each behaviour (48 tests) and (b) the interaction between time and behaviour (48 tests). Because the four facets of identity leadership are positively correlated (see Table 5.4 in main text; Benjamini & Yekutieli, 2001) and related to the overarching construct of identity leadership, we grouped them all in the same FDR adjustment. That means the Benjamini-Hochberg method was applied to a group of 96 tests (12 behaviours x four identity leadership facets x two regression coefficients, one for the main effect of the behaviour and one for its interaction with time). We specified separate models for each facet to determine its contemporaneous relationship with each behaviour (i.e., both variables were measured at all time points).

Across all facets of identity leadership, time consistently demonstrated a significant positive main effect, suggesting that identity leadership generally increases throughout sessions. After FDR correction, all main and interaction effects were nonsignificant. Results of the analysis are summarised in Tables D1 – D4.

Table D.0.1 *Mixed-effects models examining the contemporaneous relationship between identity prototypicality scores and IL behaviours*.

Prototypicality	**Time**				**Behaviour**					**Time*Behaviour**					**Model Fit**		
Model	*b*	SE	*df*	*p*	β	SE	*df*	*p*	*Sig?*	*b*	SE	*df*	*p*	*Sig?*	R^2	$X^2(2)$	p
Self-disclosure	**.20**	.04	96.05	<.001	.11	.13	121.07	.380	N	-.02	.05	103.06	.631	N	.10	0.82	.665
Joins in activities	**.19**	.04	96.63	<.001	-.23	.11	106.18	.049	N	.11	.05	106.78	.023	N	.13	5.21	.074
Collective language	**.19**	.04	96.86	<.001	-.09	.12	113.81	.440	N	.06	.04	101.64	.180	N	.11	1.89	.389
Talks about ingroup topics	**.21**	.04	96.16	<.001	.23	.11	114.94	.043	N	-.06	.04	97.80	.138	N	.12	4.07	.131
Comments on positive group dynamics	**.20**	.04	96.70	<.001	.15	.12	116.18	.233	N	-.08	.05	100.29	.091	N	.11	2.86	.240
Discusses group purpose	**.20**	.04	97.22	<.001	-.10	.12	117.45	.390	N	.05	.05	104.05	.264	N	.10	1.26	.533
Uses follower language	**.20**	.04	96.46	<.001	-.25	.12	110.60	.033	N	.05	.05	112.29	.302	N	.12	6.22	.045
Normalises experience	**.19**	.04	96.04	<.001	.11	.11	106.42	.323	N	-.12	.05	102.82	.020	N	.13	6.70	.035
Deals with difficult behaviours	**.20**	.04	96.94	<.001	.31	.12	111.27	.009	N	-.10	.05	105.58	.031	N	.13	6.73	.034
Tailors activities or structures	**.20**	.04	96.94	<.001	-.03	.12	113.23	.799	N	-.02	.05	114.63	.672	N	.10	1.28	.528
Develops group ritual	**.25**	.06	73.86	<.001	-.40	.13	85.19	.002	N	.16	.07	76.00	.019	N	.14	8.70	.013
Leads collaboratively	**.17**	.05	65.21	.002	.01	.15	70.91	.958	N	-.01	.06	73.06	.865	N	.05	0.07	.967

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no). All models *N* = 123 except "Develops group ritual", *N* = 99 (due to no instance of the behaviour in session 5), and "Leads collaboratively, *N* = 92 (due to no instance of that behaviour in session 1).

Table D.0.2 *Mixed-effects models examining the contemporaneous relationship between identity entrepreneurship scores and IL*

Entrepreneurship	**Time**				**Behaviour**					**Time*Behaviour**					**Model Fit**		
Model	*b*	SE	*df*	*p*	β	SE	*df*	*p*	*Sig?*	*b*	SE	*df*	*p*	*Sig?*	R^2	$X^2(2)$	p
Self-disclosure	**.18**	.04	95.01	<.001	.22	.11	115.37	.059	N	-.05	.04	100.00	.184	N	.10	3.52	.172
Joins in activities	**.18**	.04	95.16	<.001	-.18	.10	100.91	.084	N	.03	.04	101.01	.450	N	.09	4.26	.119
Collective language	**.18**	.04	95.86	<.001	.02	.11	109.50	.848	N	<.001	.04	99.25	.993	N	.08	0.07	.966
Talks about ingroup topics	**.19**	.04	95.27	<.001	.30	.10	109.21	.004	N	-.06	.04	96.03	.114	N	.12	8.49	.014
Comments on positive group dynamics	**.18**	.04	95.90	<.001	-.07	.11	111.44	.554	N	.01	.04	98.61	.704	N	.08	0.36	.837
Discusses group purpose	**.18**	.04	95.29	<.001	-.03	.11	111.90	.790	N	-.01	.04	100.89	.813	N	.08	0.476	.788
Uses follower language	**.18**	.04	95.41	<.001	-.01	.11	105.48	.950	N	.01	.05	106.60	.834	N	.08	0.08	.959
Normalises experience	**.18**	.04	95.30	<.001	.13	.10	103.64	.191	N	-.08	.04	100.42	.088	N	.09	2.92	.232
Deals with difficult behaviours	**.18**	.04	95.83	<.001	.02	.10	106.40	.846	N	<.001	.04	102.00	.989	N	.08	0.09	.956
Tailors activities or structures	**.18**	.04	95.48	<.001	.05	.11	107.17	.644	N	-.03	.05	108.16	.515	N	.08	0.44	.804
Develops group ritual	**.20**	.06	72.18	<.001	-.08	.12	81.34	.489	N	.05	.06	73.70	.376	N	.06	0.77	.682
Leads collaboratively	**.24**	.05	64.07	<.001	.21	.15	68.80	.160	N	-.10	.06	70.33	.071	N	.09	3.02	.221

behavs

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no). All models *N* = 123 except "Develops group ritual", *N* = 99 (due to no instance of the behaviour in session 5), and "Leads collaboratively, *N* = 92 (due to no instance of that behaviour in session 1).

Table D.0.3 *Mixed-effects models examining the contemporaneous relationship between identity advancement and IL behaviours.*

Advancement	**Time**				**Behaviour**					**Time*Behaviour**					**Model Fit**		
Model	*b*	SE	*df*	*p*	β	SE	*df*	*p*	*Sig?*	*b*	SE	*df*	*p*	*Sig?*	*R2*	$X^2(2)$	p
Self-disclosure	.21	.04	96.00	<.001	-.06	.11	115.82	.590	N	.04	.04	100.89	.311	N	.12	1.13	.569
Joins in activities	.21	.04	95.94	<.001	-.05	.10	101.76	.600	N	.01	.04	101.88	.712	N	.11	0.29	.867
Collective language	.21	.04	95.89	<.001	-.05	.10	108.89	.624	N	.06	.04	99.07	.111	N	.13	3.40	.183
Talks about ingroup topics	.21	.04	96.13	<.001	.02	.10	110.42	.815	N	-.01	.04	96.97	.788	N	.11	0.08	.961
Comments on positive group dynamics	.21	.04	95.25	<.001	.21	.10	109.87	.039	N	-.07	.04	97.77	.050	N	.13	4.62	.099
Discusses group purpose	.22	.04	96.23	<.001	-.02	.10	112.37	.837	N	.03	.04	101.69	.490	N	.12	0.69	.707
Uses follower language	.21	.04	95.61	<.001	-.20	.10	104.37	.049	N	.03	.04	105.31	.456	N	.13	6.41	.041
Normalises experience	.21	.04	95.68	<.001	-.02	.09	103.64	.821	N	-.06	.04	100.54	.170	N	.13	5.39	.068
Deals with difficult behaviours	.22	.04	95.21	<.001	.04	.10	106.03	.654	N	-.05	.04	101.93	.239	N	.12	2.00	.367
Tailors activities or structures	.22	.04	95.17	<.001	.24	.10	105.10	.019	N	-.12	.04	105.92	.006	N	.14	7.38	.025
Develops group ritual	.18	.05	71.48	<.001	-.35	.10	77.31	.001	N	.14	.05	72.29	.006	N	.09	11.38	.003
Leads collaboratively	.27	.05	65.22	<.001	.26	.13	69.56	.054	N	-.11	.05	70.90	.033	N	.12	4.32	.115

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no). All models *N* = 123 except "Develops group ritual", *N* = 99 (due to no instance of the behaviour in session 5), and "Leads collaboratively, *N* = 92 (due to no instance of that behaviour in session 1).

Table D.0.4 *Mixed-effects models examining the contemporaneous relationship between identity impresarioship and IL behaviours.*

Impresarioship	**Time**				**Behaviour**					**Time*Behaviour**					**Model Fit**		
Model	*b*	SE	*df*	*p*	β	SE	*df*	*p*	*Sig?*	*b*	SE	*df*	*p*	*Sig?*	R^2	$X^2(2)$	p
Self-disclosure	**.11**	.04	96.01	.007	.14	.12	118.42	.230	N	-.09	.04	101.80	.044	N	.05	4.30	.117
Joins in activities	**.10**	.04	95.73	.017	-.19	.11	103.37	.095	N	.09	.05	103.68	.043	N	.05	4.15	.126
Collective language	**.10**	.04	96.27	.014	.06	.11	111.49	.626	N	.02	.04	100.23	.594	N	.04	1.82	.402
Talks about ingroup topics	**.11**	.04	95.68	.005	.21	.11	111.72	.052	N	-.10	.04	96.75	.014	N	.05	6.22	.045
Comments on positive group dynamics	**.11**	.04	96.10	.010	.05	.12	113.36	.704	N	-.04	.04	99.15	.402	N	.03	0.83	.661
Discusses group purpose	**.11**	.04	95.65	.011	-.04	.12	114.20	.718	N	.01	.05	101.87	.819	N	.03	0.13	.936
Uses follower language	**.10**	.04	95.54	.016	-.08	.11	107.45	.475	N	-.02	.05	108.82	.673	N	.05	3.77	.152
Normalises experience	**.11**	.04	95.13	.011	.24	.11	104.29	.023	N	-.11	.05	100.86	.024	N	.06	5.83	.054
Deals with difficult behaviours	**.11**	.04	95.98	.011	-.02	.11	108.57	.842	N	.03	.04	103.45	.526	N	.03	0.65	.724
Tailors activities or structures	**.11**	.04	95.78	.008	.15	.11	108.64	.195	N	-.002	.05	109.75	.965	N	.05	4.80	.091
Develops group ritual	**.16**	.06	72.09	.009	-.13	.12	81.51	.282	N	.08	.06	73.67	.208	N	.04	1.60	.450
Leads collaboratively	.06	.06	65.34	.358	.05	.18	73.08	.760	N	-.003	.07	76.70	.970	N	.01	0.33	.849

Notes. Model fit = comparison to null model with no predictors except time as a fixed effect. SE = standard error. Df = degrees of freedom. Sig = significant when BH applied (Y = yes, N = no). All models *N* = 123 except "Develops group ritual", *N* = 99 (due to no instance of the behaviour in session 5), and "Leads collaboratively, *N* = 92 (due to no instance of that behaviour in session 1).